STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315337	A. BUILDING _____ B. WING _____	C 03/13/2024

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MCAULEY HALL HEALTH CARE CENTE	1633 HIGHWAY 22 WATCHUNG, NJ 07069

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint #: NJ#154270, NJ#169416, NJ#170377, NJ#170461 TYPE OF SURVEY: Recertification Survey Date: 03/12/24 Census: 68 Sample: 17 + 2 = 19 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 582 SS=C	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 582		4/22/24

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

Electronically Signed | 04/01/2024

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 582	Continued From page 1 (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.	F 582		

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F 582	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on the interview and record review, it was determined that the facility failed to issue the required Medicare Beneficiary Protection Notification. This deficient practice was identified for two (2) out of three (3) residents reviewed, Resident #10 and #170. The deficient practice was evidenced by the following: According to the Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS (Centers for Medicare & Medicaid Services)-10123, When to Deliver the NOMNC, A Medicare provider or health plan (Medicare Advantage plans and cost plans, collectively referred to as "plans") must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving covered skilled nursing, home health (including psychiatric home health), comprehensive outpatient rehabilitation facility, and hospice services. The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily. On 3/11/24 at 11:25 AM, the surveyor reviewed the facility provided list of residents who were discharged from [redacted]) covered [redacted] in the [redacted]. These residents should have received [redacted]. The surveyor reviewed three residents selected from the list. Residents #10 and #170 remained at the facility and Resident #171 was discharged from the facility.	F 582	F582 □ Medicaid/Medicare Coverage/Liability Notice This deficient practice has the potential to affect all residents. Resident #10 and #170. Resident #10 [redacted] and Resident #170 [redacted] The Social Worker or designee will deliver the completed [redacted] to the resident or their representative. If a resident who is receiving skilled [redacted] services remains in the facility, a [redacted] will also be provided to the resident or representative. [redacted] □s and/or [redacted] □s will be delivered and reviewed with the resident two (2) days before services end or the second to the last day of service if care is not being provided daily. Delivery of [redacted] can be done 1). In person; 2) by telephone with email delivery of [redacted] 3) By telephone with regular mail delivery of [redacted] and 4) Regular mail with receipt requested. The Administrator conducted in-service education for the following personnel in the facility regarding the NOMNCC: [redacted]	

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F 582	Continued From page 3 According to NJ Exec Order 26.4b1 form, Resident #170's NJ ex order 26.4b1 on NJ ex order 26.4b1 and the last covered day of NJ Exec Order 26.4b1 was on NJ Exec Order 26.4. The NJ Exec Order 26.4 that included the effective date NJ ex order 26.4b1 and the resident's representative was contacted on NJ ex order 26.4b1 at 3:45 PM to notify of the NJ ex order 26.4b1 The required NJ ex order 26 on NJ ex order 26.4b1 at 3:45 PM. Further review of the facility provided NJ Exec O form showed that Resident #10's NJ ex order 26.4b1 on NJ ex order 26.4b1 and NJ ex order 26.4 was on NJ ex order 26.4b1. NJ ex order 26.4b1 on NJ ex order 26.4b and the resident's representative was contacted on NJ ex order 26.4b at 9:15 AM to notify of the last covered day and when the member's liability begins date on NJ ex order 26.4b. The required NJ ex order 26.4b1 was also presented to the resident's representative on NJ ex order 26.4b at 9:15 AM. On 3/11/24 at 01:02 PM, the survey team met with the US FOIA (B) (6) US FOIA (B) (6) and US FOIA (B) (6) US FOIA (B) (6) The surveyor notified the facility management of the above concerns regarding NJ Exec Order 26.4b The US FOIA (B) (6) stated that the facility had no policy regarding NJ Exec Order 26.4b1 and the facility "just" followed the regulation.	F 582	To ensure compliance, at the Utilization Review (UR) Meeting weekly, it will be discussed which resident's will be coming off Medicare A services so that the NOMNC and/or SNFABN can be delivered to the resident or their representative timely. An audit will be done monthly by Social Worker or designee on one-hundred percent (100%) of all residents who have been discharged from Medicare A services to ensure that the NOMNC and/or SNAFBN□s have been completely accurately and in the appropriate time frame. Audit results will be reported monthly to the Quality Assurance Committee.	

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F 582	Continued From page 4 NJAC 8:39-4.1(a)(8), 5.1	F 582		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent documentation provided by the facility, it was determined that the facility failed to implement the	F 607	F607 - Develop/Implement Abuse/Neglect Policies	4/22/24

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F 607	Continued From page 5 facility's [NJ Exec Orde] policy to ensure a) licensed staff credentials were verified upon hire (Staff #1 and #4) This deficient practice was identified for two (2) of four (4) newly hired staff reviewed, and was evidenced by the following: The surveyors randomly selected five new employee files for license verification which revealed the following: Staff #1, a [US FOIA (b)(6)] with a date of hire of [NJ ex order 26.4b], had a New Jersey Division Consumer Affairs (NJCA) license verification printout for license verification (used to verify the license status of a nurse) which was dated [NJ ex order 26.4b] Staff #4, a [US FOIA (b)(6)]), with a date of hire of [NJ ex order 26.4b1], had a NJCA verification print out for license verification which was dated [NJ ex order 26.4b1] On 3/11/24 at 01:04 PM, during a meeting with the surveyors, [US FOIA (B) (6)] [US FOIA (B) (6)] and [US FOIA (B) (6)], the surveyor discussed the concern regarding the two newly hired staff that did not have evidence of verification prior to the date of hire. At that time, the [US FOIA (B] stated that the Human Resources staff was expected to verify the applicant's license, along with the criminal background check and reference checks. At that time, the [US FOIA (B] could not explain why the license check for Staff #1 and #4, reflected a date after the date of hire. A review of the facility policy provided, Abuse, Neglect and Exploitation of Resident's Property	F 607	This deficient practice has the potential to affect all residents. Staff #1 and #4. Staff #1 and #4 [NJ ex order 26.4] [redacted] There was no [NJ Exec Order 26.4b1] for not verifying in a timely manner. All remaining nursing licenses were re-verified. For all potential nursing employees, at the time of interview, active license in good standing will be verified with Boarding of Nursing/Consumer Affairs. [US FOIA (b)(6)] [redacted] was educated by the Administrator to ensure that this problem does not happen again. A new hire check list was created and utilized prior to orientation. Upon actual hiring, a hard copy of license will be made and put into the employee's file by the Human Resource Director or designee. The orientation check list has been modified to include RN and LPN's. RN and LPN license numbers will be added to payroll company. The Abuse Policy has been updated and all staff have been in-serviced by the Nurse Educator. A monthly audit will be done monthly by the Human Resource Director or designee of all staff who have a license/certification to make sure that all licenses/certifications are current. All audit results will be reported to the QAA committee monthly.	

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F 607	Continued From page 6 under Procedure included: [Facility Name redacted] will investigate the background or perspective new hires by checking with applicable certification, boards, and local authorities to verify that licenses, certifications, and criminal backgrounds are appropriate for employment in Long-term care facility.	F 607		
F 609 SS=D	N.J.A.C. 8:39- 9.3(b), 43.15(a) Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609		4/22/24

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F 609	Continued From page 7 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint# NJ169416 Based on interviews, review of medical records and other facility documentation, it was determined that the facility failed to report an NJ ex order 26.4b1 to the New Jersey Department of Health (NJDOH) in the required timeframe for one (1) of three (3) residents, reviewed for incident/event (Residents #57). This deficient practice was evidenced by the following: On 3/07/24 at 10:16 AM, Resident #57 was not in the room, the room was observed to be clean, the bed was positioned against the wall with the floor mat on the right-hand side of the bed. At 10:16 AM, the surveyor observed the resident in the main dining room where at that time activities were being conducted. The resident was observed sitting at a round table with three (3) other residents. At 01:15 PM, the resident was observed in the main dining room having lunch with two (2) other residents. The surveyor reviewed the hybrid (combination of both paper and electronic) medical record for Resident #57. The Admission Record (an admission summary) reflected that the resident had been admitted with NJ ex order 26.4b1	F 609	F609 Reporting of Alleged Violations Resident #57 All residents have the potential to be affected by facility□s failure to ensure timely report of NJ Exec Order 26.4b NJ Exec Order 26.4b1 of NJ Exec Order NJ Exec Order 26 NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 of residents and notifying covered individuals of their reporting responsibilities. Resident #57. In-service on Accident/Incident Reporting Policy and Procedure was completed by Nurse Educator. The Abuse, Neglect and Exploitation of Residents and Property Policy was updated to ensure that if the alleged violation involves abuse or serious bodily injury, it must be reported immediately as mandated. The update also stated that all investigation results will be reported to the Administrator, resident/patients designated representative and State Agency within five (5) working days of the incident and a corrective action must be taken for verified allegations. The Director of Nursing or designee will do Monthly audits of Accident and Incident reports to ensure that all reportable accident/incident, allegation of abuse, neglect and exploitation of residents are reported in a timely manner. Audit result	

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F 609	Continued From page 8 NJ ex order 26.4b1 . A review of Resident #57's most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated NJ ex order 26.4b1, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ out of 15, which indicated the resident NJ ex order 26.4b1 Additionally, the MDS revealed that the resident NJ ex order 26.4b1 A review of the resident's Care Plan included a NJ ex order 26.4b1 Additionally, the interventions included NJ ex order 26.4b1 NJ ex order 26.4b1 A review of the reportable event record report (FRE; Facility Reported Incident/Event) revealed the FRE was called in on NJ ex order 26.4b1 at 7:56 AM, and the event date was on NJ ex order 26.4b1 at 01:30 PM. The FRE was reported as a significant event of an NJ Exec Order 26.4b1. The event was described as follows: The event occurred in the nursing home, on the NJ Exec Order 26.4b1 of the NJ Exec Order 2 floor. According to the housekeeping staff, as she was coming off the elevator, she saw the US FOIA (b NJ Exec Order 2 the resident NJ Exec Or and NJ Exec Order activities despite the resident's NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 NJ Exec Order 2 on to NJ Exec O and NJ Exec Order 26.4b1 on the NJ Exec Or Housekeeping staff also stated that the US FOIA (b	F 609	will be reported to the Quality Assurance Committee monthly.	

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F 609	Continued From page 9	F 609		

NJ Exec Orde the NJ Exec C of the NJ Exec Order 26.4b1 causing the resident to NJ Exec Order 26.4b1.

A review of the facility investigation revealed that on US FOIA (B) (6) at 8:00 AM, the US FOIA (B) (6) US FOIA (B) (6) was called by the Human Resource Office. The Human Resource (HR) Department was informed by housekeeping staff that he/she had witnessed the US FOIA (B) (6) force a resident to attend activities despite the resident's refusal. The HR staff also witnessed the US FOIA (B) say "NJ Exec Order 26.4b1". The US FO was called in provided a signed witness statement regarding the narrative of what she witnessed on US FOIA (B) (6) at 01:30 PM -02:00 PM. On NJ Exec Order 26.4 at 02:25 PM.

The report further reflected that on US FOIA (B) (6) at around 02:35 PM, the US FOIA (B) was asked about her recollection of the events. The US FOIA (B informed the US FOIA (B and US FO that she provided 1 on 1 care to the resident at 02:00 PM, and at that time, the resident NJ Exec Order 26.4b1 to NJ Exec Orde NJ Exec Order 26.4b1 NJ Exec Orde with the US FOIA (B about NJ Exec Order 26.4b1 and stated the resident was NJ Exec Order 26.4b1 The record also reflected that the US FOIA (B explained that there were times that the resident NJ Exec Order 26.4b1 a lot of things but NJ Exec Order 26.4b1. The US FOIA US FOIA (B statements were attached to the investigation and included the staff assignments for the NJ Exec Order 2 floor.

At the conclusion of the investigation, the US FOIA (B US FOIA (B) (6) for US FOIA (B) (6)

The facility staff was in-serviced on Resident Rights from 11/29/23, through 12/18/23.

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F 609	Continued From page 10 On 3/11/23 at 11:51 AM, during an interview with the surveyors, and the US FOIA (B) (6) e US FOIA (B) (6) US FOIA (B) (6), the US FOIA (B) stated that an incident/event of NJ Exec Orde should be reported within 24 to 48 hours. At that time, the surveyor asked the US FOIA (B) if that was the same time frame in the facility's policy. The US FOIA (B) replied we will get back to you. On 3/11/23 at 01:04 PM, during a meeting with the surveyors and the US FOIA (B), the US FOIA (B) stated that the staff was educated on the process for reporting an incident of NJ Exec Orde as part of their compliance plan. A review of the provided facility policy; Abuse Neglect and Exploitation of Residents Property updated on 3/08/24, under Abuse Investigation included: All allegation involving abuse or result in serious bodily injury will be reported to the Administrator, Director of Nursing, Department of Health and Senior Services, the Ombudsman Office immediately but no later than two hours after the allegation is made ... NJAC 8:39-4.1(a)(5),9.4(f)	F 609		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a	F 623		4/22/24

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representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is

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	315337	A. BUILDING _____ B. WING _____	C 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCAULEY HALL HEALTH CARE CENTE	1633 HIGHWAY 22 WATCHUNG, NJ 07069

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transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide

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F 623	Continued From page 13 written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other pertinent facility documents, it was determined that the facility failed to provide the resident and the resident's representation written notification of the reason for transfer to the hospital and also send a copy to a representative of the Office of the State Long-Term Care Ombudsman (LTCO) for two (2) of two (2) resident's (Resident #10 and #16) NJ ex order 26.4b1 NJ ex order 26.4b1 This deficient practice was evidenced by the following: 1. A review of Resident #10's electronic medical record included the following: Resident #10's NJ ex order 26.4b1 Minimum Data Set's (DRAMDS), an assessment tool used to facilitate the management of care, for the two DRAMDS, reflected that the NJ ex order 26.4b1 [redacted] A review of the medical record did not include a written notification of the reason for transfer to the resident or resident representative and a copy to the LTCO for each transfer to the hospital. 2. A review of Resident #16's closed medical record included the following:	F 623	F623 Notice of Requirements before Transfer/Discharge This deficient practice has the potential to affect all residents. Resident #10 and #16. Confirmation of notice to responsible parties was obtained for NJ ex order 26.4b1. Any resident who is transferred on an emergent basis to a hospital or medical center (a temporary Emergency Transfer) the Social Worker or designee will notify by mail or email, the resident, or their representative of the date of transfer, the reason for transfer and the facility to which they were transferred. This notification will be made as soon as is practicable. A Notice of Transfer/Discharge protocol has been developed and all appropriate staff were in-serviced. Social Worker or designee will conduct a monthly audit to ensure no transfers were missed and proper notification was made to the resident or their representative and New Jersey Ombudsman who experienced a Temporary Emergency Transfer. All audit results will be reported	

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F 623	Continued From page 14 Resident #16's two DRAMDS's reflected that the NJ ex order 26.4b1 . A review of the medical record did not include a written notification of the reason for transfer to the resident or resident representative and a copy to the LTCO for each transfer to the hospital. On 3/11/24 at 11:24 AM, during surveyor interview, the US FOIA (B) (6) stated that she believed the US FOIA (B) (6) did the notifications. On 3/11/24 at 11:25 AM, during surveyor interview, the US FOIA (B) stated that she did not send out the notifications. She added that the nurses would call the family when a resident was transferred. On 3/11/24 at 11:31 AM, the US FOIA (B) stated that the ombudsman was not being notified when a resident was transferred to the hospital. She stated that the family was notified by a phone call or sometimes by email. On 3/11/24 at 01:34 PM, in the presence of the survey team, the surveyor notified the US FOIA (B) and US FOIA (B) (6) the concern that there was no written notification to the resident or resident representative and a copy to the ombudsman for Resident #10 and Resident #16. On 3/12/24 at 10:43 AM, in the presence of the survey team and the US FOIA (B), the US FOIA (B) (6) stated that the US FOIA (B) was working on a policy for emergency transfer notification to the family and ombudsman.	F 623	to the Quality Assurance Committee monthly.	

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F 623	Continued From page 15 The facility did not provide any additional information. N.J.A.C. 8:39-4.1(a)31,32	F 623		
F 625 SS=C	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 625		4/22/24

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F 625	Continued From page 16 Based on interview, review of the medical record, and review of other pertinent facility documentation, it was determined that the facility failed to provide the resident or resident representative written notification of the facility's bed hold policy prior to NJ ex order 26.4b1 for two (2) of two (2) resident's (Resident #10 and #16) reviewed for hospitalizations. This deficient practice is evidenced by the following: 1. A review of Resident #10's electronic medical record included the following: Resident #10's NJ ex order 26.4b1 Minimum Data Set's (DRAMDS), an assessment tool used to facilitate the management of care, for two DRAMDS, reflected that the NJ ex order 26.4b1 [redacted]. A review of the medical record did not include a written notification of the facility's bed hold policy to the resident or resident representative prior to each NJ ex order 26.4b1 2. A review of Resident #16's closed medical record included the following: Resident #16's two DRAMDS's reflected that the resident NJ ex order 26.4b1 [redacted]. A review of the medical record did not include a written notification of the facility's bed hold policy to the resident or resident representative prior to each NJ ex order 26.4b1 On 3/11/24 at 11:24 AM, during surveyor interview, the US FOIA (B) (6) [redacted]	F 625	F625 □ Notice of Bed Hold Policy Before/Upon transfers This deficient practice has the potential to affect all residents. Resident #10 and #16. Resident #16 NJ ex ord [redacted]. Resident #10 records were reviewed and upated noting Bed Hold Policy that was shared with responsible parties. A Bed Hold policy has been created, along with a written correspondence template that will be sent to the resident or resident representative. The Unit Manager or designee will identify any resident in Daily Morning Meeting (Monday-Friday) that is transferred to the hospital to initiate the Bed Hold communication form to resident or resident representative. This communication form will be sent by the Admissions Director. Staff were in-serviced by Nurse Educator. A monthly audit will be conducted monthly by the Administrator or designee of all resident's who are transferred to the hospital to make sure they have been notified. Audit results will be reported monthly to the Quality Assurance Committee.	

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US FOIA (B) (6) stated that she believed the US FOIA (B) (6) did the notifications.

On 3/11/24 at 11:25 AM, during surveyor interview, the US FOIA (B) stated that she did not send out the notifications. She added that the bed hold was usually done by admissions.

On 3/11/24 at 11:27 AM, during surveyor interview, the US FOIA (B) (6) stated that when the resident or representative signed the contract/admission agreement that there was a clause for bedholds. She added that she did not send a notification each time a resident was transferred.

On 3/11/24 at 11:31 AM, during surveyor interview, the US FOIA (B) (stated that for a resident on NJ Exec Order 26.4 there was no bed hold and for a resident on NJ Exec Order 26.4 the facility would take them back but they were not charged for the bedhold. She added that a resident that was NJ Exec Order 26.4b1 would be notified when they are transferred that if they wanted a bedhold then they would be responsible for the daily rate.

On 3/11/24 at 01:34 PM, in the presence of the survey team, the surveyor notified the US FOIA (B) (and US FOIA (B) (6) the concern that there was no written notification to the resident or resident representative of the bed hold policy for Resident #10 and Resident #16.

On 3/12/24 at 10:43 AM, in the presence of the survey team and the US FOIA (B), the US FOIA (B) stated that there was a section in the admission agreement on bedholds but that they did not have a policy. She added that the only one they notified was a

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F 625	Continued From page 18 NJ Exec Order 26.4b1 resident. She then stated that the NJ ex order 26.4b1 . The facility did not provide any additional information. A review of the facility provided undated Admission Agreement included the following: 17. In the event it becomes necessary to transport the Resident, the Resident and/or Representative agree to pay all ambulance charges. The Resident and/or Representative also agree to pay, unless otherwise covered by insurance or a third-party payer, an agreed upon rate for holding the bed vacant for a Resident until [facility name redacted] is notified to release the bed or the Resident returns to [facility name redacted]. N.J.A.C. 8:39-5.1 (a); 5.2 (a)	F 625		
F 641 SS=C	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on the interviews, record review, and review of pertinent facility documentation it was determined that the facility failed to accurately code the Minimum Data Set (MDS) for one (1) of the 19 residents reviewed, Resident #19. This deficient practice was evidenced by the following: On 3/06/24 at 10:36 AM, the surveyor observed	F 641	F641 - Accuracy of Assessments This deficient practice has the potential to affect all residents. Resident #19. The MDS was modified NJ ex order 26.4b1 to remove and correct the use of NJ ex order 26.4b1 as NJ ex order 26.4b1 . A complete audit of all current residents was	4/22/24

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F 641	Continued From page 19 the US FOIA (B) (6) medications to Resident #19 inside the resident's room while the resident was seated in a recliner chair. The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #19 as follows: According to the Admission Record (admission summary), Resident #19 was admitted to the facility with a diagnosis that NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 [redacted] A review of the resident's quarterly MDS (qMDS) with an assessment reference date (ARD) of NJ ex order 26.4b1 [redacted] revealed in Section [redacted] NJ Exec Order 26.4b Status Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which reflected that the resident's NJ ex order 26.4b1 . Section P [redacted] A review of the personalized care plan with a	F 641	completed by the MDS Coordinator to ensure that no other residents were affected. Nurses were in-serviced by the MDS Coordinator. The MDS Coordinator or designee will do an audit on six (6) random charts/MDS (three (3) from each unit) monthly to monitor for accuracy of side rail use in Section P of the MDS. In addition, a facility report of Section P in the electronic medical record will be run monthly to monitor if side rail usage is being documented/captured accurately in the MDS. Audit results will be reported monthly to the Quality Assurance Committee.	

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focus on the NJ Exec Order 26.4b1 while the resident is in bed and use it to help the resident with NJ Exec Order 26.4b1 and NJ Exec Order 26.4

Further review of the personalized care plan showed that the resident NJ ex order 26.4b1

On 3/08/24 at 11:50 AM, the survey team met with the US FOIA (B) (6) and the US FOIA (B) (6). The surveyor notified the facility management of the above findings and concerns.

On 3/11/24 at 9:13 AM, the surveyor interviewed the Registered US FOIA (B) (6) US FOIA (B) (6). The US FOIA (B) (6) informed the surveyor that she was responsible for MDS sections B, GG, H, I, J, L, M, N, O, and P. The US FOIA (B) (6) stated that the facility has a policy with regard to MDS and also follows the RAI (Resident Assessment Instrument) Manual when doing resident's MDS.

On that same date and time, the US FOIA (b)(6) informed the surveyor that responses to MDS Section NJE were auto-populated from the electronic medical records in the assessment area. The US FOIA (B) (6) stated that it was the nurse in the unit who did the assessment.

At this time, the surveyor notified the US FOIA (B) (6) of the above findings and concerns. The US FOIA (B) (6) stated that Resident #19's qMDS on NJ ex order 26.4b1 was inaccurately coded for NJ Exec Order 26.4 in Section NJE because the resident uses the NJ ex order 26.4 . She further stated that she did not check the autopopulated assessment in Section NJE and "I did not catch it

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and it was unfortunate." She added, "Unfortunately sometimes things fall through the cracks," and it was not intentional.

Furthermore, the US FOIA (B) (6) stated that it was important that the MDS was accurate because it reflects the current condition of the resident, and the plan of care should follow. The US FOIA (B) (6) acknowledged that she should have checked the assessment.

On 3/11/24 at 01:02 PM, the survey team met with the US FOIA (B) and US FOIA (B), and the surveyor notified the facility management of the above findings and concerns. The US FOIA (B) stated that she spoke to US FOIA (B) (6) about the MDS and according to them, the resident's NJ Exec Order 26 were not a NJ Exec Order 26 and should not be coded as a NJ Exec Order 26. The US FOIA (B) further stated that they were aware of the inaccurate MDS after the surveyor's inquiry.

A review of the facility's undated MDS & Care Assessment (CAA) Protocol Policy that was provided by the US FOIA (B) included the purpose: to ensure facility compliance with regulations pertaining to resident assessment and to encourage resident and or representative's input in the assessment process. To provide interdisciplinary observation and assessment to ensure the most accurate assessment of the resident's functional capacity. Procedure:...9. MDS is prepared and kept electronically on the computer. Information is to be entered directly into electronic MDS by each discipline, by population from other modules, by the MDS Coordinator. Sections are reviewed, signed, and dated by responsible parties. RN Coordinator signs for completion...

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F 641	Continued From page 22 On 3/12/24 at 10:41 AM, the survey team met with the [redacted], and the [redacted], and there was no additional information provided by the facility management.	F 641		
F 645 SS=D	NJAC 8:39-33.2(d) PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of	F 645		4/22/24

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services, whether the individual requires specialized services for intellectual disability.

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

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
Based on interviews, record review, and review

F645 - PASARR Screening for MD and ID

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MCAULEY HALL HEALTH CARE CENTE	1633 HIGHWAY 22 WATCHUNG, NJ 07069

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F 645	Continued From page 24 of pertinent facility documentation it was determined that the facility failed to accurately complete and update a NJ Exec Order 26.4b1 [redacted]) to include all NJ Exec Order 26.4b1 [redacted] diagnoses to ensure the resident was referred to the appropriate state-designated authority for NJ Exec [redacted] NJ ex order 26.4b1 evaluation and determination. This deficient practice was identified for one (1) of one (1) resident (Resident #19) reviewed for NJ ex order 26.4b1 and was evidenced by the following: On 3/06/24 at 10:36 AM, the surveyor observed the US FOIA (b)(6)US FOIA (B) (6) administer medications to Resident #19 inside the resident's room while the resident was seated in a recliner chair. The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #19 as follows: According to the Admission Record (AR, admission summary), Resident #19 was admitted to the facility with a diagnosis that included but NJ ex order 26.4b1 [redacted]	F 645	This deficient practice has the potential to affect all residents. Resident #19. Resident #19 NJ ex order 26.4b1 [redacted] If a current resident is found to NJ ex order 26.4b1 [redacted] or NJ ex order 26.4b1 [redacted] a new NJ ex order 26.4b1 [redacted] will be completed. In addition, a new NJ ex order 26.4b1 [redacted] will be completed if a current resident is transferred, admitted or readmitted to the facility following an NJ Exec Order 26.4b1 stay or equally NJ Exec Order 26.4b1 [redacted] treatment. A NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 for Resident #19 reflecting NJ ex ord [redacted]. All other resident PASRR's were reviewed and found appropriate and accurate. Nursing staff, Admission, Administrator, US FOIA (B) (6) [redacted] and US FOIA (B) (6) [redacted] were in-serviced and educated on the PASRR. Social Worker or designee will complete the referral process for the resident review to the applicable Level II authority for evaluation and determination Mental Illness - New Jersey Department of Mental Health and Addiction Services (NJ DMHAS) and New Jersey Division of Developmental Disabilities (NJ DDD) A new care plan will be developed identifying the new Mental Illness/Intellectual Disability/Developmental Disability (MI/ID/DD) diagnosis/condition. Social Worker or designee will keep a copy of the PASRR Level 1 Screen and PASRR	

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F 645	Continued From page 25 NJ ex order 26.4b1 Further review of the AR revealed that the NJ ex order 26.4b1 during the stay of the resident at the facility. NJ ex order 26.4b1 A review of the resident's quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of NJ ex order 26.4b1 revealed in Section NJ Exec Order 26.4b Status the Brief Interview for Mental Status (BIMS) score of NJ ex out of 15 which reflected that the resident's NJ ex order 26.4b1 . The qMDS in Section I Active Diagnosis included NJ ex order 26.4b1 . The NJ ex order 26.4b1 showed that the resident NJ ex order 26.4b1 Further review of hybrid medical records revealed that there was no further documentation of NJ ex order 26.4b1 to reflect the new diagnosis for NJ ex order 26.4b1 On 3/07/24 at 01:52 PM, the surveyor interviewed the US FOIA (B) (6) regarding the facility's process and policy regarding NJ Exec Order 26.4b The US FOIA (B) informed the surveyor that NJ Exec Order 26.4b was initiated from the hospital, and if there was no NJ Exec Order 26.4b provided upon admission, the US FOIA (B) would initiate NJ Exec Order 26.4b She further stated that since the US FOIA (B) started working in the facility back in NJ ex order 26.4b1 , there have been no changes from residents NJ ex order 26.4b1 . The surveyor	F 645	Level II Evaluation and Determination (if applicable) in resident's active medical record. Social Worker or designee will meet bi-weekly with the Psychiatric Nurse Practioner and Psychotherapist to ensure that the above procedures are followed in light of any new mental health or behavioral health or ID/DD diagnoses. Four (4) charts at random will be audited by the Social Worker or designee monthly and all results will be reported to the Quality Assurance Committee monthly.	

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F 645	Continued From page 26 then notified the [US FOIA (B)] of the above findings and concerns. At that same time, the [US FOIA (B)] stated that Resident #19 [NJ ex order 26.4b1 [redacted] On 3/08/24 at 11:50 AM, the survey team met with the [US FOIA (B) (6) [redacted] and the [US FOIA (B) (6) [redacted], and the surveyor notified the facility management of the above concerns and findings. A review of the undated facility's PASaRR Policy that was provided by the [US FOIA (B)] included that it is the policy of the facility that PASaRR be completed for each resident prior to admission and again at points of significant change in status. If a current resident exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a diagnosis of mental illness as defined under 42 CFR 483.100 (where dementia is not the primary diagnosis), a new PASaRR will be completed...Social Worker will keep copies of PASaRR Level I Screen and PASaRR Level II Evaluation and Determination (if applicable) in the resident's active medical record ... On 3/12/24 at 10:41 AM, the survey team met with the [US FOIA (B)], and the [US FOIA (B)], and there was no additional information provided by the facility management. NJAC 8:39-11.2(i), 27.1(a)	F 645		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		4/22/24

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F 658	Continued From page 27 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and review of other pertinent facility provided documentation, the facility failed to: a) obtain a physician's order for NJ ex order 26.4b1 and b) ensure that the required posted sign was followed according to the facility's practice and policy, and standard of clinical practice, for one (1) of five (5) residents reviewed for NJ Exec Order 26.4 control (Resident #10). This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and	F 658	F658 Services Provided Meet Professional Standards Resident #10. A physician order for NJ ex order 26.4b1 was obtained for the resident and NJ ex order 26.4b1 [redacted] All resident's on transmission-based precaution, staff and visitors that will be in contract with the NJ ex order 26.4b1 have the potential to contract NJ Exec Order 26.4 when the appropriate PPE is not used for a specific NJ Exec Order 26.4b All nurses who initiate an Isolation or Transmission based precaution were in-serviced on ensuring there is an order and a sign outside the room for the appropriate transmission-based precaution. The Infection Control Preventionist or designee will do a weekly chart audit and room check on residents/patients with infection to ensure that the necessary transmission-based precautions are ordered by the physician and that the appropriate signage is outside the resident/patient room. Audit results will be reported to the Quality Assurance	

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F 658	Continued From page 28 responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 3/06/24 at 9:46 AM, during the Entrance Conference of Surveyor #1 (S#1) and S#2 with the US FOIA (B) (6) and US FOIA (b)(6) US FOIA (B) (6) the stated that there was a resident with a diagnosis of NJ Exec Order 26.4b1 who was on NJ Exec Order 26.4b1 on the floor. The further stated that it was an expectation for visitors and staff to use full PPE (personal protective equipment) gown, gloves, mask and eye protection when entering the resident's room. On 3/06/24 at 10:38 AM, S#1 observed Resident # 10's room with a posted sign outside the door on how to use (put on or donn) PPE that included instructions for gown, gloves, mask, and eye protection. The posted sign also included how to remove (doff) the PPE. There was a NJ Exec Order 26.4b1 sign for NJ ex order 26.4b1 on the doorknob of the resident. In addition, there was a PPE bin outside the room, on top of the PPE bin was a container of disinfecting wipes, and inside the box were gowns, eye protection, NJ Exec Order 26.4b1 apparatus, and gloves. Inside, upon entering the room was a black covered bin. There was no posted sign for what kind of NJ Exec Order 26.4b1 to observe.	F 658	Committee monthly.	

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F 658	Continued From page 29	F 658		

On that same date and time, S#1 asked the US FOIA (B) (6) regarding the resident. US FOIA (B) (6) was just across the resident's room with the medication cart. US FOIA (B) (6) stated, while looking at the resident's room, that Resident #10 was on NJ ex order 26.4b1. Both the surveyor and the US FOIA did not observe a posted sign for NJ Exec Order 2 and NJ Exec Order 26.4b1 outside the resident's room.

On 3/07/24 at 10:10 AM, S#3 observed the resident's room with a PPE bin and sign on how to don and doff the PPE. There were no posted signs for NJ Exec Order 2 and NJ Exec Order 26.4b1 outside the door of the resident.

On 3/07/24 at 10:13 AM, S#3 interviewed the US FOIA (B) (6). The US FOIA informed the surveyor that Resident #10 NJ ex order 26.4b. The US FOIA confirmed that there should be a stop sign to check with the nurse first and posted a sign for contact and NJ ex order 26.4b1. The US FOIA further stated that the sign may have fallen off.

The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #10 as follows:

According to the Admission Record (admission summary), Resident #10 was admitted to the facility with a diagnosis that included but was not limited to NJ ex order 26.4b1

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F 658	Continued From page 30	F 658		

NJ ex order 26.4b1 [redacted]

The resident's comprehensive Minimum Data Set (cMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of [redacted] revealed in Section [redacted] Status Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which reflected that the resident's NJ ex order 26.4b1 [redacted]

The personalized care plan showed a focus on RSV with interventions that included but were not limited to NJ ex order 26.4b1 [redacted]

A review of the NJ ex order 26.4b1 Order Summary Report (OSR) revealed an active order dated [redacted] NJ ex order 26.4b1 [redacted]

Further review of the NJ ex order 26.4b1 OSR showed that NJ ex order 26.4b1 [redacted]

On 3/08/24 at 8:56 AM, S#1 interviewed the US FOIA (B) (6) [redacted] regarding the facility's process and standard of practice regarding [redacted] The [redacted] stated that the facility nurse would notify the [redacted] of the resident with a diagnosis of [redacted] as well as the [redacted]. The [redacted] further stated that, as an US FOIA (b)(6) [redacted] of the facility, she will make sure that the resident will be placed in both [redacted] and [redacted]

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Continued From page 31

NJ Exec Order 26.4b1 The US FOIA also stated that NJ ex order 26.4b1 , and all required PPE and posted signs for NJ Exec Order 26.4b1 will be in place as well. The US FOIA acknowledged that there should be a physician order NJ ex order 26.4b1

At that same time, S#1 notified the US FOIA of the above findings regarding Resident #10. The US FOIA stated "It's my mistake" NJ ex order 26.4b1

On 3/08/24 at 11:50 AM, the survey team met with the US FOIA (B) and the US FOIA (B), and S#1 notified the facility management of the above findings.

A review of the facility's Transmission Based Precaution Policy that was provided by the US FOIA (B) with an updated date of 01/26/23 included that the transmission-based precautions (TBP) are the second tier of basic infection control and are to be used in addition to standard precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission. Contact Precaution Precaution: use contact precaution for patients with known or suspected infections that represent an increased for contact transmission. Droplet Precaution for residents known or suspected to be infected with pathogens transmitted by respiratory droplets that are generated by a resident who is coughing, sneezing, or talking.

On 3/11/24 at 01:02 PM, the survey team met with the US FOIA (B) and US FOIA (B). The US FOIA (B) stated that there should be an order for NJ Exec Order 26.4b1 and posted a sign outside the resident's door for

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F 658	Continued From page 32 [redacted] and NJ Exec Order 26.4b1. NJAC 8:39-11.2(b)	F 658		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to: a.) maintain [redacted] control practices to reduce the risk of [redacted] during a NJ Exec Order 26.4b1 ; b.) follow a physicians order during a [redacted] treatment; c.) follow the recommendations of the wound care center physician; and d.) [redacted] and document the NJ Exec Order 26.4b1 of the [redacted] one (1) of two (2) residents reviewed for [redacted] (Resident #39). This deficient practice was evidenced by the following: On 3/06/24 at 11:13 AM, the surveyor observed that Resident #39's door had a stop sign that	F 686	F686 Treatment/Services to Prevent/Heal Pressure Ulcer Resident #39 NJ ex order 26.4b1 NJ ex order 26.4b1 [redacted] All residents that have wounds have the potential to be affected by the lack of infection control practices when providing wound treatment, failure to follow a physician's order for pressure wound treatment, failure to follow recommendations from US FOIA (b)(6) [redacted] and lack of [redacted]	4/22/24

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F 686	Continued From page 33 indicated the resident was on NJ Exec Order 26.4b1 [redacted] After donning the appropriate personal protective equipment required, the surveyor entered Resident #39's room and interviewed the resident. Resident #39 stated that he/she NJ ex order 26.4b1 [redacted]. Resident #39 stated that he/she NJ ex order 26.4b1 [redacted] and that the NJ ex order 26.4b1 [redacted] Resident #39 stated that the NJ ex order 26.4b1 [redacted] and that after he/she started getting up into a NJ ex order 26.4b1 [redacted] the NJ ex order 26.4b1 [redacted] On that same date and time, Resident #39 stated that he/she NJ ex order 26.4b1 [redacted] The surveyor asked Resident #39 if he/she was able to NJ Exec [redacted] on his/her side NJ Exec Order 2 [redacted] NJ Exec O [redacted] Resident #39 NJ ex order 26.4b1 [redacted] On 3/07/24 at 10:34 AM, the surveyor observed Resident #39's NJ ex order 26.4b1 [redacted] by the US FOIA (b)(6) US FOIA (B) (6) [redacted] of the NJ Exec [redacted] floor. After the US FOIA (B) (6) [redacted] checked the physician's order in the computer, she performed hand hygiene (HH) with an alcohol based handrub (ABHR) and then obtained the supplies for the treatment from inside the treatment cart and placed them on top of the cart. The US FOIA (B) (6) [redacted] and the surveyor donned a gown and gloves before entrance into the resident's room. The US FOIA (B) (6) [redacted] wiped the bedside table with a disinfectant wipe. The US FOIA (B) (6) [redacted] brought the supplies for the treatment into the room and placed them on the bedside which included the tubes and bottles of the medications and NJ Exec Order 26.4b1 [redacted]. The US FOIA (B) (6) [redacted] performed handwashing (HW) for 20 seconds. The US FOIA (B) (6) [redacted] dried her hands with a paper towel that she pulled	F 686	[redacted] to monitor for efficacy of treatment and/or changes in wound status. An in-service on wound care process was given by the Nurse Educator (NE) to the US FOIA (b)(6) [redacted]. In-servicing included checking current physician order to what is on the eMAR and a wound care competency was done to ensure comprehension of proper wound care treatment. All nursing staff were in-serviced on proper hand washing techniques by the NE. All nursing staff were educated/in-serviced by NE regarding PU's and PU prevention, including staff responsiveness, assessments, interventions, documentation, and reassessment. All nurses were in-serviced on wound care treatment competency annually and as needed by the NE or designee. The Assistant Director of Nursing (ADON) will do weekly measurements of all wounds and document wound measurements in the electronic medical record. Charts will be audited monthly by the Unit Manager or designee to make sure that documentation is complete on all residents who have a PU. Audit results will be reported to the QAA committee monthly. A post consult protocol was created to ensure that all recommendations for residents who go out for medical consults are carried out accurately and in a timely	

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from the dispenser. The dispenser did not automatically feed another section of paper towel and the [US FOIA (B) (6)] used the same paper towel that she dried her hands with to turn off the faucet. The [US FOIA (B) (6)] donned a pair of gloves and prepared some of the supplies on the bedside table by opening the packages of the [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] and placed them on a towel that was placed on the bedside table. The [US FOIA (B) (6)] turned the resident so [NJ ex order 26.4b1] and then doffed (took off) her gloves. The [US FOIA (B) (6)] performed HW for less than 20 seconds. She then took a paper towel from the dispenser and the dispenser did not automatically feed another section of paper towel that she could grasp and the [US FOIA (B) (6)] used the paper towel that she dried her hands with to move the dial on the side of the dispenser to feed a section of the paper towel. She then took another paper towel to turn off the faucet. The [US FOIA (B) (6)] donned a new pair of gloves and [NJ ex order 26.4b1] Resident #39's [NJ ex order 26.4b1]. The [US FOIA (b)(6)] used [NJ ex order 26.4b1] Resident #39's [NJ ex order 26.4b1]. The surveyor observed that Resident #39's [NJ ex order 26.4b1] [redacted]. The [US FOIA (B) (6)] [NJ Exec Order 26.4b1] the [NJ Exec Order 26] with a [NJ Exec Order 26.4b1] and stated that it measured [NJ ex order 26.4b1]. The [US FOIA (B) (6)] removed her gloves performed HW for 20 seconds and was able to retrieve a second clean paper towel to turn off the faucet. The [US FOIA (B) (6)] donned a new pair of gloves and [NJ ex order 26.4b1] [NJ ex order 26.4b1]. The [US FOIA (b)(6)] [NJ ex order 26.4b1] that she placed [NJ Exec O

manner. Chart checks will be done by the 11P-7A nurse or designee to ensure that the orders were transcribed and carried out correctly. Audit results will be given to the QAA committee monthly. ADON or designee will do monthly audits of four (4) resident charts who have gone out for medical consults and check if all recommendations were carried out accurately. Audit results will be reported to the QAA committee monthly.

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NJ Exec Order 26 on. The US FOIA (B) (6) did not change her gloves. The US FOIA (B) (6) NJ ex order 26.4b1 [redacted] he US FOIA (b)(6) NJ ex order 26.4b1 [redacted]. She then took a NJ Exec Order 26.4b1 and mixed the two together on the NJ ex order 26.4b1. The US FOIA (B) (6) NJ ex order 26.4b1 [redacted] The US FOIA (b)(6) NJ ex order 26.4b1 [redacted] The US FOIA (b)(6) did not use an applicator to spread the mixture. The US FOIA (B) (6) removed her gloves and performed HW. The US FOIA (B) (6) donned a new pair of gloves. NJ ex order 26.4b1 [redacted] She stated that she did not need to use the adaptic since the resident did not have any NJ Exec Order 26.4b1 on the surrounding NJ Exec O The US FOIA (b)(6) then NJ ex order 26.4b1 [redacted] The US FOIA (B) (6) did not write the date on the NJ ex order 26.4b1 prior to the NJ ex order 26.4b1 on the resident. The US FOIA (B) (6) started to clean off the bedside table, placed some of the items in a plastic bag. The US FOIA (B) (6) then reached her gloved hand into her pocket and took out a red marker. She used the red marker to date the NJ ex order 26.4b1 that was on Resident #39. The US FOIA (B) (6) then placed the red marker back in her pocket. The US FOIA (B) (6) removed her gloves and performed HW for 20 seconds. The US FOIA (B) (6) dried her hands with a paper towel. She then used her bare hand to move the dial on

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the side of the dispenser to get another paper towel. The US FOIA (B) (6) donned a new pair of gloves. The US FOIA (B) (6) took the tubes and bottles of medications and NJ Exec Order 26.4b1 off the bedside table and placed them on the treatment cart. The US FOIA (B) (6) did not wipe the bedside table with a disinfectant wipe after the treatment and placed Resident #39's belongings back on the bedside table. The US FOIA (B) (6) doffed her gown and gloves and performed HH with ABHR. The US FOIA (B) (6) wiped the tubes and bottles with a disinfectant wipe and then placed them in the treatment cart.

On 3/07/24 at 11:30 AM, the surveyor interviewed the US FOIA (B) (6) regarding the NJ Exec treatment observations. The US FOIA (B) (6) stated that she would usually get a new towel to turn off the faucet but that she tried to grab a new paper and that the paper towel dispenser was not working correctly. The surveyor asked the US FOIA (B) (6) if she should have changed her gloves after cleansing the areas. The US FOIA (B) (6) stated that she should have changed her gloves. The surveyor asked the US FOIA (B) (6) about dating the NJ Exec Order 26.4b The US FOIA (B) (6) stated that she usually dated it before she placed the NJ Exec Order 26.4 but that if she forgot to write it before that she would write the date while it was on the resident.

At that same time, the US FOIA (B) (6) confirmed that she took the red marker from her pocket and returned it to her pocket. She stated that she would usually use a clean marker. The surveyor asked the US FOIA (B) (6) if she should have wiped the bedside table after the completion of the NJ Exec treatment. The US FOIA (B) (6) stated that she completely forgot to wipe the bedside table but that she usually did.

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F 686	Continued From page 37 A review of Resident #39's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted] A review of Resident #39's modified quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that Resident #39 was [redacted]. A review of Resident #39's [redacted] Medication Administration Record/Treatment Administration Record (MAR/TAR) included the following order: Treatment to [redacted]	F 686		

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NJ ex order 26.4b1 and NJ ex order 26.4b1 the NJ ex order 26.4b1 . NJ ex order 26.4b1 and NJ ex and NJ ex order 26.4b1 NJ ex order 26.4b1 then NJ ex order 26.4b1 NJ ex order 26.4b1 , NJ ex order 26.4b1 of NJ ex order 26.4b1

The US FOIA (b)(6) did not follow the physician's order for the NJ ex order 26.4b1.

A review of Resident #39's NJ ex order 26.4b1 Assessment in the electronic medical record included the following:

NJ ex order 26.4b1 dated NJ ex order 26.4b1 NJ ex order 26.4b1 NJ ex order 26.4b1 t dated NJ ex order 26.4b1 NJ ex order 26.4b1 NJ ex order 26.4 There was no NJ Exec Order 26.4b1 of the NJ Exec Order 2

NJ ex order 26.4b1 dated NJ ex order 26.4b1 NJ ex order 26.4b1 There was no NJ Exec Order 26.4b1 of the NJ ex order 26.4

NJ ex order 26.4b1 dated NJ ex order 26.4b1

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F 686	Continued From page 39 A review of Resident #39's Progress Notes from NJ ex order 26.4b1 did not include a weekly note containing the NJ Exec Order 26.4b1 of the NJ ex order 26 NJ ex order 26.4 The facility was not monitoring the NJ Exec Order 26.4b1 of NJ ex order 26.4b1 . A review of Resident #39's Report of Consultation record for the NJ ex order 26.4b1 physician included the following under Recommendations: NJ ex order 26.4b1 A review of Resident #39's NJ ex order 26.4b1 MAR/TAR NJ ex order 26.4b1 . A review of the After Visit Summary NJ ex order 26.4b1 dated NJ ex order 26.4b1 included the following NJ ex order 26.4b1 Associated NJ ex order 26.4b1 : NJ ex order 26.4b1 ...#1 NJ ex order 26.4b1 . NJ ex order 26.4b1 A review of Resident #39' NJ ex order 26.4b1 that NJ ex ord	F 686		

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physician.

On 3/11/24 at 10:05 AM, the surveyor interviewed the US FOIA (B) (6) regarding Resident #39's NJ ex order 26.4b1 that was observed by the surveyor. The US FOIA (B) (6) stated that the nurse should get a new paper towel to close the faucet. She added that the handle/dial on the paper towel dispenser was dirty. The US FOIA (B) (6) stated that the nurse should not use the same paper towel that she dried her hands with to turn the faucet off. She added that if she did then she should have washed her hands again or performed HH with an ABHR.

On that same date and time, the US FOIA (B) (6) stated that the nurse should have placed all the medications, creams, pastes in a medicine cup and that if they were in a cup and used an applicator would not need to change gloves. She added that if the nurse was grasping the tubes or bottles that they were not considered clean and would need to change gloves. The US FOIA (B) (6) stated that she taught the nurses to place them in medicine cups and not bring the tubes into the room. The US FOIA (B) (6) stated that the nurse should have used a tongue depressor to spread the ointment/cream across the buttock and not a gloved hand.

Furthermore, the US FOIA (B) (6) stated that the date should be written on the dressing prior to it being placed on the resident. The US FOIA (B) (6) stated that the nurse should not have taken the marker from her pocket and should not have placed it back in her pocket. The US FOIA (B) (6) stated that the nurse should have wiped the table at the end of the treatment.

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F 686	Continued From page 41 On 3/11/24 at 01:40 PM, in the presence of the survey team, the surveyor notified the US FOIA (B) (6) and US FOIA (B) (6)) the concerns regarding Resident #39's NJ ex order 26.4b1 , the physician's order was not followed and that the NJ ex order 26.4b1 recommendations were not followed. On 3/12/24 at 10:50 AM, in the presence of the survey team and the US FOIA (B) , the US FOIA (B) stated that the US FOIA (B) (6) updated Resident #39's NJ ex order 26.4b1 order and that the US FOIA (B) (6) was inserviced on NJ Exec treatments. On 3/12/24 at 11:03 AM, surveyor interviewed the US FOIA (B) regarding NJ Exec O assessments. The US FOIA (B) stated that the weekly NJ Exec O assessment did not contain a NJ Exec Order 26.4b1 of the NJ Exec She added that if the resident was seen by the NJ Exec Order care nurse that a NJ Exec Order 26.4b1 would be in the progress note. On 3/12/24 at 11:14 AM, the surveyor interviewed the US FOIA (b)(6) regarding Resident #39's NJ ex order 26.4 The US FOIA (b)(6) stated that a NJ ex order 26.4b1 #39. She added that the NJ Exec Order 26.4b1 was on the NJ Exec Order care center consult sheet. The surveyor asked the US FOIA (b)(6) if Resident #39 NJ ex ord . The US FOIA (b)(6) stated that Resident #39 NJ ex order 26.4b1 She added that Resident #39's NJ ex o On 03/12/24 at 11:40 AM, the surveyor interviewed the US FOIA (B) regarding Resident #39's	F 686		

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F 686	Continued From page 42 NJ ex order 26.4b1 . The US FOIA (B) stated that the skin assessments should have the NJ Exec Order 26.4b1 recorded weekly to monitor the NJ Exec Order 26.4b1 of the treatment and monitor for any NJ Exec Order 26.4b1 in the NJ ex order 26.4b1 . In the presence of the survey team, the surveyor notified the US FOIA (B) and US FOIA (B) the concern that Resident #39's NJ ex order 26.4b1 . The facility did not provide any additional information. A review of the facility provided policy titled, "Skin Breakdown Prevention and Treatment" with an updated date of 02/13/24, included the following: Policy It is the policy of [name redacted] that all residents will be assessed for risk of skin breakdown and appropriate strategies developed to prevent and treat pressure ulcers/skin abnormalities. Procedure Skin Management Program: 1. All residents will be considered at risk for skin breakdown on admission. An interim care plan will be implemented to include but not limited to daily skin check, weekly skin assessment, and pressure relieving mattress ... 4. Resident's skin will be observed daily by CNAs performing personal hygiene. Any skin abnormality or change in skin condition will immediately be reported to the nurse. 5. Head to toe skin assessment by the nurse will take place at least once a week as per the resident's shower schedule ... 10. At the time of identification of a change in a resident's skin integrity and weekly thereafter until healed, a full description will be documented in the resident's medical record.	F 686		

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F 686	Continued From page 43 11. Wound care consultant is available for any significant wound .... 12. Treatment recommendations of consultant services will be made available by the unit nurse to the resident's physician and consultation reports added to the medical record. 13. An interdisciplinary team will discuss and evaluate wound progress at least weekly. Any recommendations to improve the outcome of the wound will be added to the resident's care plan ... A review of the facility provided policy titled, "Hand Hygiene" with an updated date of 11/29/22, included the following: How to Perform Handwashing: ... Dry your hands using a clean paper towel and discard in the proper receptacle or air dry them. Use another clean paper towel to close the faucet and dispose it properly .... N.J.A.C. 8:39-27.1	F 686		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation, it was determined that the facility failed to ensure: a) that appropriate care was provided for the [redacted] and b) care plan was developed	F 698	F698 Dialysis Resident #20. An order to [redacted] A plan of care was also placed	4/22/24

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F 698	Continued From page 44 with regard to the care of the NJ ex order 26.4b1 access site. This deficient practice was identified for one (1) of one (1) resident (Resident #20) NJ ex order 26.4b1 and was evidenced by the following: On 3/06/24 at 10:41 AM, the surveyor observed Resident #20 was seated in a wheelchair wearing NJ ex order 26.4b1, with a call bell within reach, and with a NJ ex order 26.4b1. The resident stated that NJ ex order 26.4b1 at around 01:30 PM pick up. NJ ex order 26.4b1 The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #20 as follows: According to the Admission Record (admission summary), Resident #20 was admitted to the facility with a diagnosis that included but was not limited to NJ ex order 26.4b1 NJ ex order 26.4b1 The resident's annual Minimum Data Set (aMDS),	F 698	to ensure that the NJ ex order 26.4b1 . All diaylsis residents have the potential to have undetected infection from their permacath when site is not assessed for signs and symptoms of infection daily. The hemodialysis care policy was updated to include after dialysis and daily assessment of permacath site for bleeding and infection. All nurses were in-serviced on hemodialysis care policy. The Unit Manager or designee will do a weekly audit on dialysis resident/patient charts to ensure that permacath insertion site is assessed for signs and symptoms of infection. Chart audit will be reported to the Quality Assurance Committee monthly.	

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an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of NJ ex order 26.4b1 revealed in Section NJ E NJ Exec Order 26.4b Status, Brief Interview for Mental Status (BIMS) score of NJ ex out of 15 which reflected that the resident's NJ ex order 26.4b1 . The aMDS in Section NJ E Special Treatments, Procedures, and Programs included that the NJ ex order 26.4b1 .

The NJ ex order 26.4b1 Order Summary Report (OSR) revealed that there was no order to NJ ex order 26.4b1

A review of the personalized care plan showed that there was no mention of the NJ ex order 26.4b1

Further review of the hybrid medical records revealed that there was no routine documentation that the facility NJ ex order 26.4b1

On 3/07/24 at 12:10 PM, the surveyor interviewed the US FOIA (B) (6) regarding the resident's NJ ex order 26.4b1 . The surveyor asked what was the facility's process, policy, and procedure regarding checking of resident's NJ ex order 26.4b1 . The US FOIA (b)(6) stated that they monitor the NJ ex order 26.4b1 and document it in the NJ ex order 26.4b1 Then, the US FOIA (B) (6) showed the binder of the resident's NJ ex order 26.4b1 where she pointed out the first part "To be completed by nurse prior to NJ ex order 26.4b1 " as follows: Access site: NJ ex order 26.4b1

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NJ ex order 26.4b1 [redacted]

The above information about the access site was also listed in the same paper but in the bottom part of the NJ Exec O "To be completed by licensed nurse post-NJ Exec Order 26 treatment.

On that same date and time, US FOIA (B) (6) informed the surveyor that the first and the bottom part of the NJ Exec O should be filled out by the facility nurses and the middle part of the NJ Exec O by the NJ Exec Order 26 center.

At this time, the surveyor then asked the US FOIA (B) (6) what about the days that the resident was not in NJ ex order 26.4b and how the facility monitored the access site. The US FOIA (B) (6) stated "Let me look first," then she went to the electronic medical record, and checked the electronic Treatment Administration Record (eTAR). The US FOIA (B) (6) stated that it was the responsibility of the in-charge nurse US FOIA (B) (6) to make sure that there was an order from the physician on routine monitoring of the NJ ex order 26.4b1 and to be reflected in the eTAR for the nurses to sign. The US FOIA (B) (6) further stated that there was no order for monitoring the NJ ex order 26.4b1 . The US FOIA (B) (6) also stated that it should be in the eTAR to make sure that the resident NJ ex order 26.4b1 [redacted]. The US FOIA (B) (6) further stated that she did not know why it was missed.

Furthermore, the surveyor asked the US FOIA (B) (6) if the care for the NJ Exec Order 2 NJ Exec Order 26.4b1 should be in the care plan of the resident and the US FOIA (b)(6) stated "yes." The US FOIA (B) (6) had no answer as to

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MCAULEY HALL HEALTH CARE CENTE	1633 HIGHWAY 22 WATCHUNG, NJ 07069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 47 why there was no care plan for NJ ex order 26.4b1 [redacted] On 3/08/24 at 11:50 AM, the survey team met with the US FOIA (B) (6) [redacted] and the US FOIA (B) (6) [redacted] and the surveyor notified the facility management of the above findings and concerns. The US FOIA (B) (6) stated that the US FOIA (B) (6) called the US FOIA (B) (6) [redacted] yesterday for an order. The US FOIA (B) further stated that the order for NJ ex order 26.4b1 [redacted] were done after the surveyor's inquiry. According to the US FOIA (B) (6) there was no general policy for NJ Exec Order 26.4b1 [redacted] NJAC 8:39-27.1(a)	F 698		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a	F 732		4/22/24

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F 732	Continued From page 48 daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that the posted Resident Care Staffing Report (24-hour staffing report) was up to date and provided accurate information. This deficient practice was evidenced by the following: On 3/06/24 at 8:55 AM, the surveyors entered the facility and observed the posted 24-hour staffing report which was dated 3/06/24. The resident census was not included. The staffing report did not indicate if a Registered Nurse, was on duty. The posting indicated the number of licensed nursing staff and certified nursing staff on a shift. The shift did not specify the total number and actual hours worked by the licensed and unlicensed nursing staff directly responsible for	F 732	F732 - Posted Nurse Staffing Information This deficient practice has the potential to affect all residents. The Staffing Coordinator or designee will run report each morning and post at the front entrance. A Staffing Policy has been created and all appropriate staff were in-serviced. At the time of finding, information board in foyer area was updated to reflect current nusre statting and census. Staffing will be monitored daily by Staffing Coordinator or designee throughout the day as changes occur and will be updated accordingly. Staffing Coordinator or designee will do a monthly audit to make sure that all the necessary	

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F 732	Continued From page 49 resident care. At 9:15 AM, the US FOIA (B) (6) informed the surveyors that the census was 68 without bed hold. At 9:20 AM, during an interview with the surveyor, the US FOIA (b)(6) informed the surveyor that she posted the 24-hour staffing report located at the front door vestibule. The US FOIA (b)(6) stated that the US FOIA (B) (6) and the US FOIA (B) instructed her on which information was required to be posted. She also stated that she was not instructed to include the census. At 12:51 PM, in the presence of three surveyors, the US FOIA (B) (6) stated that she was not the US FOIA (B) from the last survey and that she did not know the census had to be added to the 24-hour staffing report At that time, in the presence of two surveyors, and the US FOIA (B) (6) the surveyor discussed the concern regarding the inaccuracy of the posted 24-hour staffing report. At that time, The US FOIA (B) stated she would review the regulation. On 3/07/24 at 8:51 AM, the surveyors observed the posted 24-hour staffing report dated 3/07/24, and the census was included. However, the 24-hour staffing report did not indicate if a Registered Nurse, was on duty. The posting indicated the number of licensed nursing staff and certified nursing staff on a shift. The shift did not specify the total number and actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care.	F 732	updates/changes were made. Audit results will be given to the Quality Assurance Committee monthly.	

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F 732	Continued From page 50 At 10:03 AM, during a meeting with the surveyors, the US FOIA (B) stated that she and the US FOIA (B) gave the receptionist the information to post for the 24-hour staffing report. The US FOIA (B) stated she had not checked the regulation to ensure compliance. On 3/08/24 at 11:51 AM, during a follow-up meeting with the surveyors the US FOIA (B) stated the 24-hour staffing report posting had been resolved and the accurate information was posted. At 01:04 PM, during a meeting with the surveyors, the US FOIA (B) stated that they have educated the US FOIA (b)(6) and the US FOIA (b)(6) regarding information required to be on the 24-hour staffing report. On 3/12/24 at 9:52 AM, the US FOIA (B) confirmed the facility had no policy on staffing. N.J.A.C. 8:39-41.2 (a)(b)(c)	F 732		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755		4/22/24

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F 755	Continued From page 51 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility provided documents, it was determined that the facility failed to: a.) maintain a system of record keeping of DEA (Drug Enforcement Administration) Form-222 (a federal narcotic requisition form used for ordering controlled substances), that ensured drug records were in order, and controlled dangerous substance (narcotics medications), with high potential for abuse were tracked with detail to enable prompt identification of loss or potential diversion of controlled substance; and b.) develop a policy and procedure for narcotic medications which included record keeping of DEA Form-222. This deficient practice was evidenced by the following:	F 755	F755 Pharmacy A house stock narcotic ordering and tracking protocol, together with a DEA 222 tracking log was developed to ensure that drug records were in order and controlled dangerous susbstance with high potential for abuse were tracked with detail to enable prompt identification of loss or potential for diversion. All residents taking house stock narcotics has the potential to be affected by facility's inability to maintain a record keeping system for DEA 222 form. A policy was created. The US FOIA (B) (6) US FOIA (B) (6) US FOIA (B) (6) and US FOIA (B) (6),	

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F 755	Continued From page 52 On 3/11/24 at 8:45 AM, in the presence of the US FOIA (B) (6), the surveyor reviewed the facility provided binder that contained the DEA 222 forms. A review of the binder included the following non-executed (blank forms that were not used yet to order controlled substances) DEA 222 forms: Order Form Number NJ Exec Order 26.4b1 Order Form Number NJ Exec Order 26.4b1 Order Form Number NJ Exec Order 26.4b1 Order Form Number NJ Exec Order 26.4b1 Order Form Number NJ Exec Order 26.4b1 Order Form Number NJ Exec Order 26.4b1 Order Form Number NJ Exec Order 26.4b1 Order Form Number NJ Exec Order 26.4b1 There was no DEA 22 form with Order Form Number [redacted]. There was not a copy of an executed (form filled out with an order for controlled substances) DEA 222 form with the Order Form Number [redacted]. There was no log of the numbers of the DEA 222 forms to account for what numbers were received and what numbers had been used to order medications through the pharmacy. At 8:51 AM, the surveyor interviewed the US FOIA (B) regarding the process of the DEA 222 forms. The US FOIA (B) stated that she would fill out the DEA 222 form and send it to the pharmacy. She added that she did not make a copy of the form and keep it. The surveyor asked the US FOIA (B) how she knew what was ordered and if what medication received was what was ordered. The US FOIA (B) stated that when the medication was received it would come with a different paper from the pharmacy listing the medication and the amount. The US FOIA (B) then stated that she was contacting the pharmacy to	F 755	were in-serviced on the house stock narcotic ordering and tracking protocol and the use of DEA 222 tracking log as a system of record keeping for DEA 222 form. The Administrator or designee will conduct a monthly audit of the DEA form tracking log against the DEA 222 form on hand. DEA 222 form tracking log audit results will be reported to the Quality Assurance Committee monthly.	

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F 755	Continued From page 53	F 755		

get a copy of the executed DEA 222 form.

On 3/11/24 at 10:50 AM, the surveyor asked the [redacted] for a policy related to controlled substances and DEA 222 form. The [redacted] stated that she did not think the facility had a policy.

On 3/11/24 at 11:48 AM, the [redacted] stated that the pharmacy faxed over a copy of the missing DEA 222 form. The surveyor reviewed the form and asked what the importance was for keeping track of the DEA 222 forms. The [redacted] stated that it was important to keep track of what was ordered and what was received to prevent diversion and make sure the right amount was received. She added that it was important to know the form numbers to make sure no one else was using them.

On 3/11/24 at 01:36 PM, in the presence of the survey team, the surveyor notified the [redacted] and [redacted] the concern that there was no accountability/log for the DEA 222 forms. The surveyor requested a policy on narcotics. The [redacted] stated that the facility did not have a policy on narcotics.

On 3/12/24 at 10:46 AM, in the presence of the survey team and [redacted], the [redacted] stated that the facility did not have a policy regarding the ordering procedure for narcotics and that she created a process on 3/11/24. She added that she created a tracking log for the DEA 222 forms that will be in the binder moving forward.

The facility did not provide any additional information.

A review of the backside of the DEA Form-222

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F 755	Continued From page 54 included the following: Instructions for DEA Form 222 (see Title 21 CFR Part 1035 for details) ... Part 1. Purchaser Information ... 6. The order form must be signed and dated by the purchaser on the day it is submitted for filling. Purchaser must make a copy of the order form for its records before mailing the original to the supplier ... Part 5. Controlled Substance Receipt 1. The purchaser fills out this section on its copy of the original order form. 2. Enter the number of packages received and date received for each line item. 3. Purchaser must keep its copy of each executed order form and all copies of unaccepted or defective forms and any attached statements or other related documents available for inspection for a period of two years. N.J.A.C. 8:39-29.1(e);29.4(k);29.7(c)	F 755		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident	F 842		4/22/24

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F 842	Continued From page 55	F 842		

that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-

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F 842	Continued From page 56 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent documents, it was determined that the facility failed to maintain complete and readily accessible medical records. This deficient practice was identified for one (1) of seventeen (17) residents reviewed (Resident #16). This deficient practice was evidenced by the following: On 3/11/24 at 10:41 AM, the surveyor reviewed Resident #16's closed electronic medical record. Resident #16's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with NJ ex order 26.4b1 [redacted] Review of the electronic medical record information on some of the sections only went to	F 842	F842 Resident Records - Identifiable Information Resident #16 medical records are consolidated in one file only; subdivided by number of NJ ex order 26.4b1 . All residents have the potential to be affected by the facility's inability to maintain complete and readily accessible medical records. A medical record maintenance protocol was created to ensure that all of resident's medical records are completed and readily accessible. The US FOIA (b)(6) [redacted] US FOIA (B) (6) , US FOIA (B) (6) and US FOIA (b)(6) were in-serviced on the medical record maintenance protocol by US FOIA (b)(6) US FOIA (B) (6) or designee will do a monthly audit on 2 current resident charts and 1 closed chart to check for completeness and accessibility. Audit	

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F 842	Continued From page 57 NJ ex order 26.4b1 which was a NJ ex order 26.4b1 NJ ex order 26.4b1. The surveyor could not review any information in the electronic medical record prior to the NJ ex order 26.4b1 in NJ ex order 26.4b [redacted] On 3/11/24 at 10:57 AM, the surveyor notified the US FOIA (b)(6) [redacted] that the complete medical record was not accessible in the computer system. On 3/12/24 at 9:27 AM, the US FOIA (b)(6) [redacted] informed the surveyor that the electronic medical record was fixed. The surveyor reviewed the electronic medical record and the complete medical record was not accessible prior to the NJ ex order 26.4b1 in NJ ex order 26.4b1. On 3/12/24 at 10:10 AM, in the presence of the survey team, the surveyor notified the US FOIA (B) and US FOIA (B) (6) [redacted] the concern that the facility did not maintain complete and readily accessible medical records for Resident #16. On 3/12/24 at 10:52 AM in the presence of the survey team and US FOIA (B) [redacted], the US FOIA (B) [redacted] stated that she notified the computer system again about the issue and was waiting for a response. The facility did not provide any additional information. N.J.A.C. 8:39-35.2	F 842	results will be reported to the Quality Assurance Committee monthly.	
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may	F 849		4/22/24

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do either of the following:
(i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.
(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately

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

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the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

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

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F 849	Continued From page 61 with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record and other facility documentation, it	F 849	F849 Hospice Services	

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F 849	Continued From page 62 was determined that the facility failed to ensure the consistent coordination/communication was provided between facility staff and [NJ ex order 26.4b] staff to meet the resident's needs (Resident #26). This deficient practice was identified for one (1) of two (2) [NJ ex order 26.4b1] This deficient practice was evidenced by the following: On 3/06/24 at 10:12 AM, during the initial tour, the surveyor observed Resident #26 sleeping on a [NJ Exec Order 26.4b1] with [NJ Exec Order 26.4b1]. The surveyor reviewed the hybrid (combination of both paper and electronic) medical record for Resident #26. According to the Admission Record (an admission summary), the resident was admitted to the facility with diagnoses that included [NJ ex order 26.4b1] The quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated [NJ ex order 26.4b1], reflected a Brief Interview for Mental Status (BIMS) was not conducted since the resident [NJ ex order 26.4b1] A review of the active Order Summary Report (OSR) revealed a physician order (PO) for [NJ ex order 26.4b1] with a start date of [NJ ex order 26.4b] The Care Plan (CP) included a focus that the	F 849	Resident #26. A [NJ ex order 26.4b] log was created and filed in a binder at the nurse's station to keep track of all [NJ Exec Order 26] personnel who visit the resident/patient. All [NJ ex order 26.4b] notes were retrieved and filed in the resident's chart. [US FOIA (b)(6)] and liaison were informed of expectations that all [NJ ex order 26.4b] notes will be filed in the resident's chart and recommendations endorsed to charge nurse at time of visit. All residents admitted to hospice care services have the potential to be affected by the lack of communication between the hospice care team and nursing staff. A hospice communication protocol and a hospice binder were created to ensure that all hospice visits to the resident are recorded and that all recommendations are communted to the charge nurse. All appropriate staff were in-serviced. The Unit Manager or designee will do a weekly audit of the hospice log and ensure that all hospice nurse visits has a corresponding note and that all recommendations are carried out. Hospice log and chart audit results will be reported to the Quality Assurance Committee monthly.	

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F 849	Continued From page 63 resident was under NJ ex order 26.4b1 [redacted], initiated on [redacted]. The hybrid medical record for the resident revealed a NJ ex order 26.4b1 by the [redacted] Nurse [redacted] in the paper medical record, dated [redacted], and an electronic documentation by a facility nurse in the electronic Medical Record (eMR), [redacted], that the resident was NJ ex order 26.4b1 who at that time had no recommendation. A review of a nursing Progress Note (PN) dated [redacted], revealed the resident was [redacted] on the [redacted] next to his/her bed. The bed was in a [redacted] and the NJ ex order 26.4b1 [redacted]. The resident NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 NJ Exec Order 26.4b1 [redacted], NJ ex order 26.4b1 [redacted] NJ Exec Order 26.4b1 [redacted] NJ Exec Order 26.4b1 [redacted]. There was no documentation that reflected [redacted] was informed of the [redacted]. On 03/07/24 at 10:58 AM, during an interview with the surveyor, the US FOIA (b)(6) [redacted] stated that the NJ ex order 26.4b1 visited with the assigned resident in the morning and before visiting with the [redacted] resident the [redacted] would check in with the assigned nurse on the floor. At the end, of the [redacted] visit the aid would show the nurse on duty at the facility what tasks they have completed and the nurse on the floor would sign off on the completed tasks. At that time, the [redacted] explained that the [redacted] visited	F 849		

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in the evening and the recommendations/communication record would be placed in the chart, flagged for the nurses to review, and communicated with the nurse on duty verbally.

At that time, the US FO stated they only had one NJ ex order 26.4b provider.

On 03/07/24 at 12:05 PM, the surveyor and the US FOIA (b)(6) reviewed the hybrid medical record for the resident.

At that time, the US FOIA (b)(6) stated the US FO visited every 14 days but was unsure.
The resident was admitted to [name redacted] NJ ex order 26.4b on NJ ex order 26.4b and the NJ ex o visit did not occur during her shift.

At that time the US FOIA (b)(6) confirmed that hybrid medical record contained only two communication records which were the paper documentation on NJ ex order 26.4b, and an eMR documentation made by the facility nurse on NJ ex order 26.4b.

At that time, the US FOIA (b)(6) confirmed the communication record from NJ ex order 26.4b1 could not be located. The US FOIA (b)(6) acknowledged it should have been, and stated she would call NJ Exec Order 26 to retrieve the communication records. The US FOIA (b)(6) could not recall when she last checked the resident's record to ensure collaboration and communication between NJ ex order 26.4b and the facility occurred.

At that time, the US FOIA (b)(6) confirmed the resident NJ ex order 26.4b1, and that they had no written documentation that the incident was

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F 849	Continued From page 65 communicated to [NJ Exec Order 26] and confirmed it should have been. At that time, the [US FOIA (b)(6)] stated that the communication record was important to collaborate and communicate changes in the resident's condition. In this case after a [NJ ex o] the communication would have initiated the [US FO] to also assess the resident. A review of the faxed document from [NJ ex order 26.4b] dated [NJ ex order 26.4b], reflected the following dated visits by [NJ ex order 26.4b]: 1. [NJ ex order 26.4b1], communication record from [NJ ex order 26.4b] on file. Facility PN reflected that [NJ ex order 26.4b] saw the resident, and made recommendations. 2. [NJ ex order 26.4b1], no communication record on file. 3. [NJ ex order 26.4b1], no communication record on file. 4. [NJ ex order 26.4b1], no communication record on file. 5. [NJ ex order 26.4b1] no communication record on file. 6. [NJ ex order 26.4b1], no communication record on file. 7. [NJ ex order 26.4b1], no communication record on file. 8. [NJ ex order 26.4b1], no communication record on file. 9. [NJ ex order 26.4b1], no communication record on file. 10. [NJ ex order 26.4b1], no communication record on file. 11. [NJ ex order 26.4b1], no communication record on file. 12. [NJ ex order 26.4b1] no communication record on file. 13. [NJ ex order 26.4b1], no communication record on file.	F 849		

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F 849	Continued From page 66 14. NJ ex order 26.4b1, no communication record on file. 15. NJ ex order 26.4b1, no communication record on file. 16. NJ ex order 26.4b1, no communication record on file. 17. NJ ex order 26.4b1, no communication record on file. 18. NJ ex order 26.4b1, no communication record on file. 19. NJ ex order 26.4b1, no communication record on file. 20. NJ ex order 26.4b1, no communication record on file. 21. NJ ex order 26.4b1, no communication record on file. Facility PN reflected that NJ Exec Order 26 was in the facility, saw the resident, and had no recommendation. 22. NJ ex order 26.4b1, no communication record on file. 23. NJ ex order 26.4b1, no communication record on file. 24. NJ ex order 26.4b1, no communication record on file. 25. NJ ex order 26.4b1, no communication record on file. 26. NJ ex order 26.4b1, no communication record on file. 27. NJ ex order 26.4b1, no communication record on file. 28. NJ ex order 26.4b1, no communication record on file. The communication reflected that in nine months, 26 out of 28 visits had no documented collaboration/communication between NJ ex order 26.4b and the facility regarding Resident #26. Further review of the NJ ex order 26.4b fax was a written	F 849		

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note from [name redacted] NJ Exec Order 26 that reflected "no paper recommendations in our record, policy is they [US FOIA] are supposed to write recommendation a recommendation order page, leave at facility and bring back a copy to NJ Exec Order 26 office".

On 3/08/24 at 11:51 AM, during a meeting with the surveyors, the US FOIA (B) (6) and the US FOIA (B) (6) the surveyor discussed the concern regarding the lack of coordination and communication between NJ Exec Order 26 and the facility.

On 3/11/24 at 01:04 PM, during a meeting with the surveyors, and the US FOIA (B), the US FOIA (B stated she had reached out to the liaison of [name redacted] NJ Exec Order 26.4 Moving forward a tracking of the US FOIA visit and communication record was changed and the US FOIA (B communicated the expectation with [name redacted] NJ Ex Order 26.4b

At that time, the US FOIA (B stated that she was assured in writing by the NJ Exec Order 26 liaison that the new protocol initiated by the US FOIA (B will be followed and the current US FOI was educated on the process to write the recommendation for each patient on every visit.

A review of the undated facility provided policy; Hospice Program indicated under section 11. The unit manager on the unit is designated to coordinate care provided to the resident by our facility staff and the Hospice staff she is responsible for the following:
b. Communicating with Hospice care representatives and other health care providers participating in the provision of care for terminal illness, related conditions, and other conditions to

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F 849	Continued From page 68 ensure quality of care for the resident and family. A review of the facility provided Hospice Inpatient, Respite and Home Care Services Agreement dated May 3, 2023, under section B. Initiation and Coordination of Impatient and Respite Services subsection 4. The Hospice nurse shall coordinate the services provided to each patient with facility staff by reviewing the Hospice plan of care ... NJAC 8:39-27.1(a)	F 849		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance	F 868		4/22/24

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F 868	Continued From page 69 activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on the interview and record review, it was determined that the facility failed to ensure that the US FOIA (B) (6) US FOIA (B) (6) US FOIA (B) (6), or designee attended the quarterly Quality Assurance (QA) meetings. This was identified for three (3) of the three (3) quarterly QA meetings reviewed. This failure had the potential to affect all 68 residents who currently live in the facility. The deficient practice was evidenced by the following: The surveyor reviewed the QA meeting sign-in sheets for the last three (3) quarters dated June 30,2023, September 30, 2023, and January 12, 2024. The sign-in sheets for those three (3) quarters revealed no US FOIA (B) signatures to show that the US FOIA (B) was in attendance for June 30, 2023, and January 12, 2024, QA meetings. There were no US FO signatures to show that the US F was in attendance for June 30, 2023, QA meeting, and there were no US FOIA signatures to show that the US FOIA or a designee attended the QA meeting on September 30, 2023.	F 868	F868 - QAA Committee This deficient practice has the potential to affect all residents. Attendance logs monitored for any staff member who attended and were in-serviced by Administrator. Quality Assurance and Assessment meetings will continue to be held on a monthly basis. The Administrator or designee will attend all Board of Director meetings, report on and solicit input on all QAPI activities on a regular basis. The Administrator or designee will be responsible for assuring that all QAPI activities and required documentation is provided. The Administrator or designee will ensure that all required parties are in attendance to comply with the regulation and results will be reported monthly to the QA Committee.	

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F 868	Continued From page 70 On 3/11/24 at 10:15 AM, the surveyor interviewed the US FOIA (B) (6) US FOIA (B) (6), who confirmed the abovementioned concerns. The US FOIA (B) stated that she knows the regulations require those individuals to attend. No further information was provided. On 3/11/24 at 10:30 AM, the surveyor interviewed the US FOIA (B), who stated that she was not sure why she did not sign. She did not recall attending the meeting. The QAPI (Quality Assurance Performance Improvement) plan provided to the survey team revealed that the US FOIA US FOIA (B), and US F should be an active member of the organization's quality committee, and the US FOIA (B) (6) US FOIA (b)(6), etc.) should participate in the QAPI activities. As evidence by the following: "Guiding Principles" section which revealed #3. In QAPI includes all employees, all departments, and all services provided. It further revealed, "Guidelines for Governance and Leadership Responsibility and Accountability" section, "the administrator has the responsibility and is accountable to the board of trustees for ensuring that QAPI is implemented throughout our organization. QAPI activities and discussion will be a standing item on our board of trustees meeting agenda. The US FOIA (b)(6) will attend all board of director meetings, report on and solicit input on all QAPI activities on a regular basis. The administrator is responsible for assuring that all QAPI activities and required documentation is provided to our corporation." N.J.A.C. 8:39-33.1 (b)	F 868		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ	F 921		5/10/24

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	315337	A. BUILDING _____ B. WING _____	C 03/13/2024

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MCAULEY HALL HEALTH CARE CENTE	1633 HIGHWAY 22 WATCHUNG, NJ 07069

(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 921	Continued From page 71 CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Complaint# NJ154270 Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to maintain: a) the residents' patio in a safe and homelike condition for one (1) of two (2) patios, b) the laundry area in a safe and sanitary condition, and c) a safe and sanitary environment in one (1) of three (3) kitchenettes in accordance with the facility procedures and federal regulations, and were identified during the environment tour of the facility. This deficient practice was evidenced by the following: 1. A review of the 4/22/22 at 9:37 AM phone interview of another surveyor with the anonymous resident's Responsible Party (RP) revealed that according to the RP (also known as the caller), the following was the physical environment outside of the facility's building: -ripped screens in a common area, porch area where the residents hang out. -one screen was ripped by the front door. -The paint was coming off the lower panels in the front of the building On 3/06/24 at 9:14 AM, during the first day of the survey, the surveyor observed one ripped screen	F 921	F921 Safe/Functional/Sanitary/Comfortable Environment All residents have the potential to be affected by this deficient practice of not maintaining a safe, functional, sanitary, and comfortable environment for residents, staff, and visitors. The ripped screens have been replaced (5/2/2024). Repair of outside panels was completed by 5/10/2024. The laundry room ceiling vent and surrounding two (2) panels with the brownish discoloration have been cleaned and replaced. Once a week the vent in the laundry room will be cleaned. An accountability log sheet will be posted which is to be signed and checked off when completed. The laundry room will be checked at the beginning and end of each shift for cleanliness. The log sheet will be audited by the Housekeeping Director or designee weekly and audit results will be reported to the QAA committee monthly. The 2nd floor kitchenette ice machine outside vent grid with brown colored	

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F 921	Continued From page 72 window by the left side front entry of the facility with a chair in that area. There were also multiple lower panels in the front of the building where the paint was coming off. On 3/06/24 at 11:03 AM, the surveyor toured the laundry area in the presence of the US FOIA (b)(6), who had been working in the facility as an outside contractor for five years. Upon entry to the laundry area, the surveyor observed grayish substances on the ceiling vent and surrounding two tiles with brownish discoloration. The US FOIA informed the surveyor that a week ago there was a plumbing issue that was resolved, which was why there was a brownish discoloration on two ceiling tiles. The US FOIA stated that the grayish substances on the ceiling vent were an accumulation of dust. The US FOIA stated that there was no accountability log for cleaning the ceiling vent. On that same date and time, both the surveyor and the US FOIA observed a puddle of water on the floor and the surrounding floor area was stained with brownish discoloration. The US FOIA stated that there should be no water on the floor for safety and that the floor should have been cleaned. There was no accountability log for cleaning the floor. On 3/06/24 at 11:27 AM, the surveyor interviewed the US FOIA (B) (6) US FOIA (B) (6) in the presence of the survey team regarding the ripped screen by the front door. The US FOIA (B) stated that it was scheduled for replacement because it was a customized size, and required ordering, this coming spring and part of the preventative maintenance schedule. The surveyor asked for the document regarding	F 921	sediment was cleaned. The full-size refrigerator door gasket was cleaned and the right lower cracked drawer was replaced. The outside of the refrigerator bottom vent that was splattered with brown sticky debris was cleaned. The glass coffee pot with white flake sediment was discarded and replaced. The trash can with no lid or containment was discarded and replaced with a new trash can with a lid. The wall above the trash can which was stained and had brown sticky substance on the wall was cleaned. The wall above the trash can was cleaned and the jar of fish spread was discarded. Each morning, housekeeping will clean all areas of the kitchen, such as sweep and mop floor, wipe down counters, clean inside and outside of refrigerator, ice machines, walls, and empty out trash. A housekeeping (accountability) log book was developed (3/11/2024) where an employee can document the need for any housekeeping services. All staff (nursing, kitchen, and pantry staff) were in-serviced by the Housekeeping Director on the function and use of this new accountability log book to ensure communication is passed through the proper channels. The housekeeping accountability log book will be audited monthly on both floors in each kitchenette by the Housekeeping Director or designee and audit results will be reported to the QAA committee. The housekeeping accountability log book was developed to communicate between nursing, as well as other departments and	

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F 921	Continued From page 73 the ripped screen and she said she will get back to the surveyor. On 3/06/24 at 01:10 PM, the US FOIA (b)(6) provided a copy of the facility's Maintenance Department Preventative Maintenance Spring List schedule as follows: 1. Replacing all broken screen window 2. Replacing all a/c (airconditioned) filters 3. Cleaning the roof and drainage 4. Cleaning the a/c condenser unit Further review of the above preventative maintenance spring list revealed that there was no mention of the front of the building's lower panels paint. On 3/07/24 at 10:46 AM, the surveyor interviewed the US FOIA about the above findings and concerns. The US FOIA informed the surveyor that he was unable to remember when this year he recommended to the US FOIA (B) about repainting the front building panel to make it a little better. The surveyor then asked the US FOIA why he recommended to repaint the front building panel. The US FOIA stated, to improve the structure of the building, for the cleanliness and homelike environment of the residents who live here. He further stated that it was also his responsibility as a US FOIA to make that recommendation to the US FOIA (B) (6) because it was the US FOIA (B) who would decide. The US FOIA also stated that as per US FOIA (B) there was no budget for now. He further stated that the recommendations were all verbal and not documented. On 3/07/24 at 11:50 AM, the surveyor and the US FOIA went outside the building and observed the ripped	F 921	the housekeeping department. Housekeeping will sign as an indication that problem/issue was taken care of. Housekeeping Director or designee will check the accountability log book in the morning to see if any issues/problems are noted, and check again at the end of the day to make sure any issue/problem was taken care of. Housekeeping Director or designee will audit logs daily to make sure that all concerns were addressed. Audit results will be reported to Quality Assurance Committee monthly. Dietary staff or designee will do a daily check in the refrigerator to discard any food or items that have expired or do not belong in the resident refrigerator. Dietary staff or designee will notify Food Service Director or designee of any issues/problems to be related to the appropriate department. All dietary staff were in-serviced by the Food Service Director on the protocol. The Food Service Director or designee will check each kitchenette on both units weekly to monitor for cleanliness of the kitchenettes and refrigerators, as well as checking for any spoiled or expired foods. Weekly results will be reported to the QAA committee monthly.	

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F 921	Continued From page 74	F 921		

screen in the common area entrance of the building where a chair was located. The [US FOIA] stated that during summer and when the weather was nice, residents come out and sit in the chair to hang out.

At that same time, both the surveyor and the [US FOIA] observed the lower panels in the front area of the building with paint coming off. The [US FOIA] stated that he was aware of the paint coming off which was why he previously recommended that to the [US FOIA (B)], and the answer was there was no budget, and that he could only recommend.

Furthermore, both the surveyor and the [US FOIA] observed three plastic screen panels coming out from three airconditioned systems in residents' rooms, facing the front of the facility's main entrance on the right side of the building. The [US FOIA] stated that it only happened probably the last storm and "yes," it should have been fixed.

On that same date and time, the surveyor also notified the [US FOIA] of the concern regarding the laundry area. The surveyor and the [US FOIA] also went inside the laundry area and the two tiles were replaced and the air vent was still with grayish substances which the [US FOIA] stated yesterday as dust.

The [US FOIA] stated that it was not due to plumbing issues that the two tiles had brownish discoloration, it was because of the condensation from the washers and dryers in the laundry. He further stated that the maintenance staff did work on it and now fixed after surveyor's inquiry.

On 3/08/24 at 11:50 AM, the survey team met with the [US FOIA (B)] and the US FOIA (B) (6)

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F 921	Continued From page 75	F 921		

and the surveyor notified the facility management of the above findings and concerns.

On 3/11/24 at 01:02 PM, the survey team met with the [US FOIA (B)] and [US FOIA (B)]. The [US FOIA (B)] stated that the facility had no policy with regard to the environment.

2. On 3/11/24 at 11:14 AM, the surveyor toured the [NJ Exec] floor kitchenette. Observations were made of the following:

~Ice machine bottom outside vent had brown colored sediment in the vent grid.
~Full size refrigerator: the door gasket around door was dirty with particles in the grooves of the rubber and parts of the rubber gasket were torn. The surveyor also observed was the right lower drawer was cracked on front panel and brown debris and hair were noted under the cracked drawer. The outside of the refrigerator bottom vent was splattered with brown sticky debris at the base of the refrigerator.
~coffee pot glass carafe had white flake sediment crusted on internal bottom.
~trash can: no lid or containment top noted lined with a trash bag.
~wall above trash can: observed sediment, stains, and brown sticky substance on the wall
~shelving units under countertop housed a jar of fish spread that was opened, unlabeled and undated,

On 3/11/24 at 11:26 AM, the surveyor interviewed floor staff [US FOIA (B) (6)] [US FOIA (B)] who stated, the nursing staff was to notify the kitchen if items are expired, need restock or things are soiled, and they will take care of it. They come every morning to stock the kitchen and check

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F 921	Continued From page 76	F 921		

refrigerator temperature.

On 3/11/24 at 11:31 AM, the surveyor interviewed the US FOIA (B) (6)) who stated, the kitchen staff was responsible for stocking the refrigerator and keeping the temperature log up to date daily. Housekeeping was responsible for the cleaning. She further elaborated that juice, health shakes crackers and graham were stocked by the dietary department. But "I" expect my staff to report to me if there are any cleaning or maintenance issues. Then "I" will report it to the proper department either housekeeping or maintenance depending on the problem.

On 3/11/24 at 11:49 AM, the surveyor interviewed the US FOIA (B) The US FOIA (B) stated that it was her expectation to have clean kitchenette and the door be closed. She further stated that she expected staff to notify her and housekeeping if there was something soil, and/or maintenance if there was something broke. Housekeeping was a verbal notification and maintenance was a log notification. The US FOIA (B) also stated that it was every departments responsibility to maintain a clean and sanitary environment.

On 3/11/24 at 01:05 PM, the survey team met with the US FOIA (B) and US FOIA (B), and the surveyor notified the facility management of the above findings.

On 3/11/24 at 01:35 PM, the surveyor interviewed the US FOIA who stated, we make sure the counters, sink, refrigerator, and floors were clean, strip and wax the floors as well, kitchenettes were on a daily schedule. The US FOIA added that anyone can notify the department with an issue. The US FOI further stated that it was verbal notification and

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F 921	Continued From page 77 there was no accountability log. The US FO stated that it was his expectation that the kitchenette was cleaned, disinfected and suitable for residents or staff to use. A review of the facility's housekeeping and laundry service agreement with an outside source, which was provided by the US FOIA (B), revealed; 1.) Scope of work: commencing on 5/16/2016, the company will provide such housekeeping and laundry management, supervision, labor, and materials as company determines necessary, in its discretion, to provide the services identified in exhibit A. a further review of exhibit A includes but is not limited to: Full-service housekeeping and laundry service shall be provided. On 3/12/24 at 12:16 PM, the survey team met for an Exit Conference with the US FOIA (B) and US FOIA (B). The facility management had no additional information provided. NJAC 8:39-31.4(a)(b)(f)	F 921		
F 944 SS=E	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure the facility staff	F 944	F944 QAPI Training This deficient practice has the potential to	4/22/24

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F 944	Continued From page 78 had mandatory training that outlined and informed staff of the elements and goals of the facility's Quality Assurance and Performance Improvement (QAPI) program for five (5) of five (5) Certified Nurse Assistants (CNAs) reviewed for mandatory education. The deficient practice was evidenced by the following: The surveyor requested five (5) random CNA education files for the year 2023. A review of the facility form, Employee Official Inservice Transcript for [facility name redacted] for the 2022 to 2023 revealed the log did not include the mandated QAPI education training. On 3/11/24 at 11:51 AM, during a meeting with the surveyors, the US FOIA (b)(6) and the US FOIA (b)(6) the surveyor discussed the concern regarding the missing in-services for the CNAs. At 01:04 PM, during a meeting with the surveyors, the US FOIA (B) stated they had no policy and/or procedure for the US FOIA (B) mandatory education. At that time, the US FOIA (B) confirmed that they did not do annual in-service for the QAPI program. On 3/12/24 at 10:41 AM, during a follow-up meeting with the surveyors, and the US FOIA (B), the US FOIA (B) stated the in-services for QAPI should have been done and moving forward it has been added to the list of yearly mandatory training for the CNAs. No additional information was provided.	F 944	affect all residents. The mandatory educational training for QAPI has been added to the facility orientation for all new employees, as well being added to the yearly mandatory training. Staff was in-serviced regarding QAPI training by the Nurse Educator. A policy has been created for the Mandatory In-services. All staff have been in-serviced. Mandatory in-services will be monitored monthly by the Nurse Educator or designee. Audit results will be reported monthly to the Quality Assurance Committee.	

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F 944	Continued From page 79 N.J.A.C. 8:39-9.3(2),33.1	F 944		
F 949 SS=E	Behavioral Health Training CFR(s): 483.95(i) §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.70(e). This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility failed to ensure the facility staff had the mandatory behavioral health training for five (5) of the five (5) Certified Nursing Assistants (CNAs) reviewed for mandatory education. The deficient practice was evidenced by the following: The surveyor requested five (5) random CNA education files for the year 2023. A review of the facility form, Employee Official Inservice Transcript for [facility name redacted] for 2022 to 2023 revealed the log did not include the mandated behavioral health education training. On 3/11/24 at 11:51 AM, during a meeting with the surveyors, the US FOIA (B) (6) [redacted] and the US FOIA (B) (6) [redacted], the surveyor discussed the concern regarding the missing in-services for the CNAs. At 01:04 PM, during a meeting with the surveyors,	F 949	F949 Behavioral Health Training All facility residents, staff, contract workers and volunteers have the potential to be affected by the lack of Behavioral Health Mandatory training. Behavioral Health training for all facility staff, contract workers and volunteers was completed by Nurse Educator. An audit form has been initiated to confirm completion of all mandatory inservices by staff. This will be completed for all new hires before being allowed to work independently. A Mandatory Education policy that includes Behavioral Health training was created to outline all Mandatory Education as required by the State and Federal regulations for existing staff, contract workers and volunteers at facility. All required mandatory trainings must be completed on anniversary of hire for facility staff or annually for contract worker	4/22/24

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F 949	Continued From page 80 the [redacted] stated they had no policy and/or procedure for the CNA mandatory education. At that time, the [redacted] confirmed that they did not do annual in-service for the behavioral health training. On 3/12/24 at 10:41 AM, during a follow-up meeting with the surveyors, and the [redacted], the [redacted] stated the in-services for behavioral health training should have been done and moving forward it has been added to the list of yearly mandatory training for the CNAs. No additional information was provided. NJAC 8:39-9.3(2), Appendix B XI-5	F 949	and volunteers as stated in the policy. Monthly audits will be conducted by the Nurse Educator or designee for education hours of staff on their anniversary month to ensure that all the mandatory education has been given and the required number of education hours are being met. Audit results will be reported to the QA committee monthly.	

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H 000	Initials Comments The facility is not in compliance with N.J.A.C. Title 8 Chapter 43E- General Licensure Procedures and Standards Applicable To All Licensed Facilities.	H 000		
H5790	8:43E-13.4(d) UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM A licensed healthcare facility or program shall retain a completed copy of the Universal Transfer Form sent with a patient when a patient is transferred as part of the patient's medical record. This REQUIREMENT is not met as evidenced by: Based on interview, review of the medical records and other facility documentation, it was determined that the facility failed to maintain a copy of the New Jersey Universal Transfer Form (UTF) as part of the medical record for two (2) of two (2) residents reviewed for hospitalizations (Resident #10 and Resident #16). This deficient practice is evidenced by the following: Reference: New Jersey Administrative Code 8:43 E General Licensure Procedures and Standards: Section 8:43E-13.4 - Mandatory use of Universal Transfer Form	H5790	H5790 - Universal Transfer Form: Mandatory Use of Form This deficient practice has the potential to affect all residents. Resident #10 and #16. A policy was developed for use of Universal Transfer Form and all nursing staff was in-serviced. [redacted]) for resident #10 and #16. Copies of UTF were received by facility and placed into resident's chart. For all residents sent out to hospital an	4/22/24

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

Electronically Signed | 04/01/24

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	061813	A. BUILDING: _____ B. WING _____	C 03/13/2024

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MCAULEY HALL HEALTH CARE CENTE	1633 HIGHWAY 22 WATCHUNG, NJ 07069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H5790	Continued From page 1 (a) A licensed healthcare facility or program shall use the Universal Transfer Form, HFEL-7, provided as N.J.A.C. 8:43E-13 Appendix, incorporated herein by reference, and available on the Department's website at http://web.doh.state.nj.us/apps2/forms/, in either paper or electronic version, whenever a patient is transferred to another licensed healthcare facility or program. 1. Emergency departments are exempt from mandatory use of the Universal Transfer Form, but shall follow hospital procedures regarding documentation. (b) A licensed healthcare facility or program shall complete all sections of the Universal Transfer Form, to the best of the licensed healthcare facility or program's ability. 1. The Universal Transfer Form is not complete if medication information is not attached. (c) A licensed healthcare facility or program shall send a completed, paper copy of the Universal Transfer Form with a patient when a patient is transferred. (d) A licensed healthcare facility or program shall retain a completed copy of the Universal Transfer Form sent with a patient when a patient is transferred as part of the patient's medical record. 1. A review of Resident #10's electronic medical record included the following: Resident #10's discharge return anticipated Minimum Data Set's (DRAMDS), an assessment tool used to facilitate the management of care, for two DRAMDS NJ ex order 26.4b1 [redacted]. A review of the medical record did not include a copy of the UTF for Resident #10's NJ ex order 26.4b1	H5790	audit form has been initiated for all discharges. Random monthly audits of three (3) residents/patients who were transferred to another care facility will be conducted by Unit Manager or designee. All audit results will be reported monthly to the Quality Assurance Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061813	A. BUILDING: _____ B. WING _____	C 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCAULEY HALL HEALTH CARE CENTE	1633 HIGHWAY 22 WATCHUNG, NJ 07069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H5790	Continued From page 2 NJ ex order 26.4b1. The medical record had a copy of the UTF that the NJ ex order 26.4 l provided when the resident NJ ex order 26.4b1 on NJ ex order 26.4b1 and NJ ex order 26.4b1. 2. A review of Resident #16's closed medical record included the following: Resident #16's two DRAMDS's reflected that the NJ ex order 26.4b1 A review of the medical record did not include a copy of the UTF for Resident #16's NJ ex order 26.4b1. The medical record had a copy of the UTF that the NJ ex order 26.4l provided when the NJ ex order 26.4b1 on NJ ex order 26.4b1 and NJ ex order 26.4b1 On 3/12/24 at 9:13 AM, the surveyor interviewed the Director of Nursing (DON) regarding the UTF. The DON stated that when a resident was transferred to the hospital that the nurses filled out a UTF but that the facility did not keep a copy of the UTF. The surveyor asked if the facility had a policy regarding UTF. The DON stated that the facility did not have a policy. On 3/12/24 at 10:10 AM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and DON the concern that the facility did not keep a copy of the UTF for Resident #10 and Resident #16. On 3/12/24 at 10:41 AM, in the presence of the survey team and LNHA, the DON stated that she put in a request to the hospital to get a copy of the UTFs for both resident's medical record. The facility did not provide a policy.	H5790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061813	A. BUILDING: _____ B. WING _____	C 03/13/2024

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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) COMPLETE DATE
H5790	Continued From page 3 The facility did not provide any additional information.	H5790		
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documents, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the day shift as mandated by the State of New Jersey for: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,	S 560	S560 - Mandatory Access to Care This deficient practice has the potential to affect all residents when there is a staffing shortage. A staffing policy was created to include the new minimum staffing requirements for nursing homes in New Jersey. All nursing staff was in-serviced by the Director of Nursing.	4/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061813	A. BUILDING: _____ B. WING _____	C 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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) COMPLETE DATE
S 560	Continued From page 4 codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. For the 2 weeks of staffing prior to survey from 02/18/2024 to 03/02/2024 for the 03/12/2024, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: -02/24/24 had 7 CNAs for 69 residents on the day shift, required at least 9 CNAs. -02/25/24 had 8 CNAs for 69 residents on the day shift, required at least 9 CNAs. On 3/11/24 at 10:51 AM, during a meeting with three surveyors, the Director of Nursing (DON) stated she was aware of the regulations for staffing and for the most part the facility was meeting the regulations for State and Federal. At 11:26 AM, the Licensed Nursing Home Administrator (LNHA) stated the facility had no	S 560	Staffing is reviewed by Staffing Coordinator and Director of Nursing (DON) on a daily basis to ensure there is adequate staffing for all shifts. With all call outs, attempts are made to secure mandated staffing and bonus incentives will continue to be offered to CNA's to ensure that all shifts are staffed appropriately. Efforts to hire more staff will continue to be ongoing until there is adequate staff to provide care to all the residents. Until that time, facility will offer incentive bonuses, as well as utilize jinternal an external resources to increase recruitment in the event of staffing shortages. Staffing schedules will be reviewed/audited by the Director of Nursing or designee daily to make sure that the staff-to-resident ratios are being met on a daily basis. Audit results will be reported monthly to the QA committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061813	A. BUILDING: _____ B. WING _____	C 03/13/2024

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S 560	Continued From page 5 policy or procedure other than following the regulations for Staffing ratios. On 3/12/23 at 9:16 AM, during an interview with the surveyor, the Staffing Coordinator (SC) stated she was also in charge of the Central Supply since September of 2023. The SC stated she had no knowledge of the ratios but knew that she had to schedule five (5) CNAs on both floors. At that time, the SC stated that the facility did not work with an outside agency but was able to offer bonus incentives after asking the DON and or the LNHA. She also stated that she begged and spoke with the facility staff nicely to try and cover the missing shifts. The SC confirmed that she was aware that at times the facility was not meeting the five (5) CNA staffing for both floors that she was instructed to schedule.	S 560		
S1915	8:39-29.1(e) Mandatory Pharmacy (e) If the facility keeps emergency injectable or oral controlled substances, a current Drug Enforcement Administration registration and Controlled Dangerous Substance registration for that location shall be available. (See N.J.S.A. 24.21-10 for registration requirements; registration application procedures are specified at N.J.A.C. 8:65-1.4.) This REQUIREMENT is not met as evidenced by: Based on the observation and interview with the facility administration, it was determined that the facility failed to maintain a current Controlled Dangerous Substances (CDS) registration for the	S1915	S1915 - Mandatory Pharmacy This deficient practice has the potential to affect all residents.	4/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1915	Continued From page 6 facility's location. This deficient practice was evidenced by the following: Reference: 21 CFR 1301.12 Separate registrations for separate locations. (a) A separate registration is required for each principal place of business or professional practice at one general physical location where controlled substances are manufactured, distributed, imported, exported, or dispensed by a person. On 3/11/24 at 8:45 AM, in the presence of the Director of Nursing (DON), the surveyor reviewed the facility provided binder that contained the DEA 222 forms and the Medical Director's CDS registration certificate. A review of the CDS registration certificate indicated the address listed was the Medical Director's practice location and not the facility's location. At 8:51 AM, the surveyor interviewed the DON regarding the certificate. The DON confirmed that the certificate did not have the facility address listed. On 3/11/24 at 10:50 AM, the surveyor asked the DON for a policy related to controlled substances and DEA 222 form. The DON stated that she did not think the facility had a policy. On 3/11/24 at 01:36 PM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and DON the concerns that there was no accountability/log for the DEA 222 forms and that the medical	S1915	Medical Director applied during survey for updated DEA license that will have facility address, along with the updated DEA 222 form. New license has been received with correct address and updated DEA 222 Form on 4/13/2024. US FOIA (b)(6) had been inserviced by Nurse Educator. Audits will be conducted on a monthly basis by the Administrator or designee to make sure that all providers licensure is kept up to date. Audit results will be reported to QA committee monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1915	Continued From page 7 director license for ordering narcotics for the facility did not have the facility's address listed on it. On 3/12/24 at 10:46 AM, in the presence of the survey team and LNHA, the DON stated that the facility did not have a policy. The LNHA stated that she spoke to the medical director and he stated that the license had his own practice address. The LNHA stated that they were not aware it had to have the facility's address.	S1915		

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
315337 Y1	A. Building B. Wing Y2	5/16/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MCAULEY HALL HEALTH CARE CENTE	1633 HIGHWAY 22 WATCHUNG, NJ 07069

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 F0609	Correction	ID Prefix F0921	Correction	ID Prefix	Correction
Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. # 483.90(i)	Completed	Reg. #	Completed
LSC	04/22/2024	LSC	05/10/2024	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	
3/13/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315337 Y1	A. Building B. Wing Y2	5/16/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MCAULEY HALL HEALTH CARE CENTE	1633 HIGHWAY 22 WATCHUNG, NJ 07069

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ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0582	Correction	ID Prefix	F0607	Correction	ID Prefix	F0609	Correction
Reg. #	483.10(g)(17)(18)(i)-(v)	Completed	Reg. #	483.12(b)(1)-(5)(ii)(iii)	Completed	Reg. #	483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed
LSC		04/22/2024	LSC		04/22/2024	LSC		04/22/2024
ID Prefix	F0623	Correction	ID Prefix	F0625	Correction	ID Prefix	F0641	Correction
Reg. #	483.15(c)(3)-(6)(8)	Completed	Reg. #	483.15(d)(1)(2)	Completed	Reg. #	483.20(g)	Completed
LSC		04/22/2024	LSC		04/22/2024	LSC		04/22/2024
ID Prefix	F0645	Correction	ID Prefix	F0658	Correction	ID Prefix	F0686	Correction
Reg. #	483.20(k)(1)-(3)	Completed	Reg. #	483.21(b)(3)(i)	Completed	Reg. #	483.25(b)(1)(i)(ii)	Completed
LSC		04/22/2024	LSC		04/22/2024	LSC		04/22/2024
ID Prefix	F0698	Correction	ID Prefix	F0732	Correction	ID Prefix	F0755	Correction
Reg. #	483.25(l)	Completed	Reg. #	483.35(g)(1)-(4)	Completed	Reg. #	483.45(a)(b)(1)-(3)	Completed
LSC		04/22/2024	LSC		04/22/2024	LSC		04/22/2024
ID Prefix	F0842	Correction	ID Prefix	F0849	Correction	ID Prefix	F0868	Correction
Reg. #	483.20(f)(5), 483.70(i)(1)-(5)	Completed	Reg. #	483.70(o)(1)-(4)	Completed	Reg. #	483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)	Completed
LSC		04/22/2024	LSC		04/22/2024	LSC		04/22/2024

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

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
315337 Y1	A. Building B. Wing Y2	5/16/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MCAULEY HALL HEALTH CARE CENTE	1633 HIGHWAY 22 WATCHUNG, NJ 07069

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0921	Correction	ID Prefix F0944	Correction	ID Prefix F0949	Correction
Reg. # 483.90(i)	Completed	Reg. # 483.95(d)	Completed	Reg. # 483.95(i)	Completed
LSC	05/10/2024	LSC	04/22/2024	LSC	04/22/2024

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?
3/13/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061813 Y1	A. Building B. Wing Y2	5/16/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix H5790	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:43E-13.4(d)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/22/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/13/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061813 Y1	A. Building B. Wing Y2	5/16/2024 Y3

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix S1915	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-29.1(e)	Completed	Reg. #	Completed
LSC	04/22/2024	LSC	04/22/2024	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	

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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?
3/13/2024	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315337	A. BUILDING **01** B. WING _____	**03/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCAULEY HALL HEALTH CARE CENTE	**1633 HIGHWAY 22** **WATCHUNG, NJ 07069**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 03/11/2024 and 03/13/2024, and McAuley Hall Health Care center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. The building is a 3-story building that was built in January 1966, It is composed of Type I fire resistant construction. The facility is divided into 7- smoke zones. The facility has a 200 KW Diesel Emergency Generator that supplies power to 100 % of the facility. The facility has 74 certified beds. At the time of the survey the census was 68.	K 000		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility	K 293	Residents affected by this deficient	4/22/24

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

Electronically Signed | 04/01/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315337	A. BUILDING **01** B. WING _____	**03/13/2024**

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K 293	Continued From page 1 provided documentation on 02/08/2024 and 02/09/2024 in the presence of facility management, it was determined that the facility failed to provide one (1) illuminated exit sign to clearly identify the exit access path to reach an exit discharge door. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 Reference: New Jersey Uniform Construction Code 5:23: International Building Code, 1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge." 2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible	K 293	practice: All Residents have the potential to be affected by this. Measure and systematic changes to ensure that this deficient practice will not occur again: The Maintenance Director hired an electrician to install a continuously illuminated exit sign. This sign is now serviced by the emergency lighting system. This work was completed on 3/27/24. To Monitor the continuous effectiveness of this change: The Director of Maintenance or designee will do weekly checks to ensure that all exit signs are illuminated and ensure that all exit signs are illuminated and work when using our emergency lighting. These findings will be reported at the quarterly QA meetings.	

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K 293	Continued From page 2 from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in an exit access corridor is more than 100 feet or listed viewing distance for the sign, whichever is less, from the nearest visible exit sign." On 3/11/2024 (day one of survey) during the survey entrance at approximately 9:01 AM, a request was made to the US FOIA (B) (6) US FOIA (B) (6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility was a three-story (3) building with sixty-eight (68) Resident sleeping rooms, common areas and offices. There were six (6) designated exit discharge doors that Residents,Visitors and Staff could use to exit the building in the event of an emergency. Starting at approximately 9:24 AM on 3/11/2024 and continued on 3/13/2024 presence of the facility's US FOIA (B) a tour of the building was conducted. During the building tour on 3/13/2024 at approximately 11:48 AM, the surveyor observed inside the ground floor exit access corridor next to the Conference room, the facility utilizes one (1) photoluminescence exit sign above the corridor exit access door. This photoluminescence exit sign was not serviced by the emergency lighting system. The US FOIA (B) confirmed the finding at the time of observation.	K 293		

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K 293	Continued From page 3 The US FOIA (b)(6) was informed of the Life Safety Code deficiency during the survey exit on 3/13/2024 at approximately 01:05 PM. Fire Safety Hazard. NFPA Life Safety Code 101 2012 -7.7 NFPA 101:2012- 19.2 Means of Egress Requirements NJAC 8:39 -31.1 and 8:39 -31.1 (c) NFPA Life Safety Code 101 2012 -7.7	K 293		
K 345 SS=E	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 interview and documentation review on 3/11/2024 and 3/13/2024 in the presence of the facility management, it was determined that the facility failed to ensure smoke detection sensitivity was checked every alternate year of the facility smoke detectors, in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010) Edition Section 14.4.5.3.2. This deficient practice was identified for one (1) of one (1) fire alarm systems and was evidenced by the following: Reference:	K 345	Residents affected by this deficient practice: All residents have the potential to be affected by this deficient practice. Measures or systematic changes to ensure that this deficient does not reoccur: Director of Maintenance brought in our fire protection vendor. They completed the Sensitivity Testing of all smoke detectors. We received a Certificate of Completion on 3/21/2024.	4/22/24

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K 345	Continued From page 4 Fire Protection Association (NFPA) 72. National Fire Alarm and Signaling Code: - 10.4.3.2.2 Sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 10.4.3.2.3 On 3/11/2024 (day one of survey) during the survey entrance at approximately 9:01 AM, a request was made to the US FOIA (B) (6) to provide all mandatory inspections that had been conducted from 01/01/2022 through 3/10/2024 for review later. The surveyor also requested the [redacted] to provide a copy of the last smoke detectors sensitivity testing. The surveyor also notified the [redacted] that he might have to call the Fire Alarm and Detection inspection vendor and ask to obtain a copy of the last smoke detector sensitivity testing. Later at approximately 12:55 PM on 3/11/2024, the surveyor reviewed the following semi-annual Fire Alarm and Detection system inspections that were provided and read in part: - 4/25/2022, no evidence of smoke detector sensitivity testing performed. - 10/26/2022, no evidence of smoke detector sensitivity testing performed. - 4/20/2023, no evidence of smoke detector sensitivity testing performed. - 10/05/2023, no evidence of smoke detector sensitivity testing performed. - 11/30/2023, no evidence of smoke detector sensitivity testing performed. This review of the testing reports revealed no reference to a smoke detection sensitivity testing.	K 345	Monitoring of the continued effectiveness of this systemic change: The Director of Maintenance has added this service to our vendors contract. This will now be tested annually by our vendor. Next Inspection scheduled for March 2025. Reports will be made at the quarterly QA meetings.	

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K 345	Continued From page 5 Later at approximately 02:30 PM, the surveyor made a request to the US FOIA (B) to place a phone call to the Fire Alarm and Detection Vendor to obtain a copy of the last smoke detector sensitivity testing. On 3/13/2024 (day two of survey) at approximately 9:12 AM, during an interview with the facility's US FOIA (B), the surveyor asked, "If he called the Fire Alarm and Detection Vendor to obtain a copy of the last smoke detector sensitivity testing." The US FOIA (B) told the surveyor that the smoke detector sensitivity testing had not been done. The US FOIA (B) confirmed the finding at the times of the observations. The US FOIA (b)(6) was informed of the Life Safety Code deficiency during the survey exit on 3/13/2024 at approximately 01:05 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345		
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation on 3/11/2024 and 3/13/2024 in the presence of facility	K 355	Residents affected by this deficient practice: All residents have the potential to be	4/22/24

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K 355	Continued From page 6 management, it was determined that the facility failed to perform a six (6) year maintenance for seven (7) of 33 portable fire extinguishers observed and inspected, as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and there after at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. - 7.3.1.2.1 Six-Year Internal Examination. Every six (6) years, stored-pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable internal examination procedures as detailed in the manufacture's service manual and this standard.	K 355	affected by this deficient practice. Measure or systemic changes to ensure that this deficient practice does not reoccur: Our vendor was called into our building. We have replaced the 7 fire extinguishes noted to be out of compliance with the 6 year internal examination regulation, all dated June 2017. The listing of all fire extinguishers log will be checked yearly by the Maintenance Director or designee so that this deficiency does not reoccur and put our residents at risk. Monitoring the systematic effectiveness of these changes: The Maintenance Director or designee, will monitored to ensure compliance with the 6 year internal check. The Maintenance Director or designee will keep a log on all fire extinguisher's in the building. That log book will be check annually by the Maintenance Director or designee. Those fire extinguishers that are close to the 6 year mark will be reported to our vendor so that all parties can meet the regulation. Any findings will be reported at the quarterly QA meeting.	

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K 355	Continued From page 7 The findings include the following, On 3/11/2024 (day one of survey) during the survey entrance at approximately 9:01 AM, a request was made to the US FOIA (B) (6) US FOIA (B) (6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility was a three-story (3) building with sixty-eight (68) Resident sleeping rooms, common areas and offices. Starting at approximately 9:24 AM on 3/11/2024 and continued on 3/13/2024 in the presence of the facility's US FOIA (B) a tour of the building was conducted. During the two (2) day tour of the facility, the surveyor observed and inspected thirty-three (33) portable fire extinguishers in various locations that were annually inspected June 2023 with the following, On 3/11/2024: 1) At approximately 9:59 AM, the surveyor observed on the second floor next to the East corridor Resident shower room, one (1) ABC-Type fire extinguisher with a six-year (6) Maintenance collar attached to the extinguisher dated June 2017. 2) At approximately 11:03 AM, the surveyor observed on the first floor next to the Oxygen storage room, one (1) ABC-Type fire extinguisher with a six-year (6) Maintenance collar attached to the extinguisher dated June 2017.	K 355		

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K 355	Continued From page 8 3) At approximately 11:35 AM, the surveyor observed on the first floor across from Resident room #135, one (1) ABC-Type fire extinguisher with a six-year (6) Maintenance collar attached to the extinguisher dated June 2017. On 3/13/2024, 4) At approximately 10:58 AM, the surveyor observed on the ground floor across from the Maintenance office, one (1) ABC-Type fire extinguisher with a six-year (6) Maintenance collar attached to the extinguisher dated June 2017. 5) At approximately 11:12 AM, the surveyor observed on the ground floor inside the Commercial Laundry room, one (1) ABC-Type fire extinguisher with a six-year Maintenance collar attached to the extinguisher dated June 2017. 6) At approximately 11:17 AM, the surveyor observed on the ground floor across from the Maintenance room, one (1) ABC-Type fire extinguisher with a six-year (6) Maintenance collar attached to the extinguisher dated June 2017. 7) At approximately 11:17 AM, the surveyor observed on the ground floor inside the "ADL Therapy " room, one (1) ABC-Type fire extinguisher with a six-year (6) Maintenance collar attached to the extinguisher dated June 2017. The US FOIA (B) confirmed the findings at the times of observations. The US FOIA (b)(6) was informed of the Life Safety Code deficiency during the survey exit on	K 355		

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K 355	Continued From page 9 3/13/2024 at approximately 01:05 PM. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 3/11/2024 and 3/13/2024, it was determined that the facility failed to maintain the integrity of smoke barrier partitions for three (3) of six (6) smoke barrier walls inspected as evidenced by the following: On 3/11/2024 (day one of survey) during the survey entrance at approximately 9:01 AM, a request was made to the US FOIA (B) (6) US FOIA (B) (6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified	K 372	Tag 0372 Residents affected by this deficient practice: All residents have the potential to be affected by this deficient practice. Measure or systemic changes to ensure that this deficient practice does not reoccur: The three areas noted with this deficiency have been corrected by the Director of Maintenance as evidenced the the attached photos. Monitoring the continued effectiveness of	4/22/24

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K 372	Continued From page 10 the facility was a three-story (3) building with seven smoke zones. Starting at approximately 9:24 AM on 3/11/2024 and continued on 3/13/2024 in presence of the facility's [US FOIA (B)] a tour of the building was conducted. During the two (2) days tour of the facility, the surveyor observed the following smoke barrier walls failed to maintain the 1/2 hour fire rated construction as required by code in the following locations, On 3/11/2024, 1) At approximately 9:37 AM, the surveyor observed above the ceiling tiles of the double smoke doors next to Resident room #201, one (1) 1" hole with 3 low voltage wires running through the smoke barrier wall. The penetration was observed on both sides through the smoke barrier wall, indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. 2) At approximately 10:38 AM, the surveyor observed above the ceiling tiles of the double smoke doors next to Resident room #101, one (1) approximately 3" black pipe running through the smoke barrier wall that had an approximately 1" gap around the black pipe. The penetration was observed on both sides through the smoke barrier wall, indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment.	K 372	the systematic change: The Maintenance Director or designee will round building monthly to look for any areas that may be in violation of this regulation. Any findings on monthly rounds will be reported at the quarterly QA meeting.	

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K 372	Continued From page 11 3) At approximately 10:42 AM. the surveyor observed above the ceiling tiles of the double smoke doors next to Resident room #118, one BX electrical cable running through an approximately one inch penetration through the smoke barrier wall. The penetration was observed on both sides through the smoke barrier wall, indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. The US FOIA (B) confirmed the findings at the times of the observations. The US FOIA (B) (6) was informed of the Life Safety Code deficiency during the survey exit on 3/13/2024 at approximately 01:05 PM.	K 372		
K 374 SS=D	Fire Safety Hazard. NJAC 8:39- 31.2(e). Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum	K 374		4/22/24

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MCAULEY HALL HEALTH CARE CENTE	**1633 HIGHWAY 22** **WATCHUNG, NJ 07069**

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K 374	Continued From page 12 clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 3/11/2024 and 3/13/2024, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire and smoke protection. This deficient practice was identified for one (1) of nine (9) sets of corridor smoke barrier doors tested and was evidenced by the following: Reference 1: Life Safety Code 101, 2012 Edition, - 8.5.4.1, Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grills. The clearance under the bottom of a new door shall be a maximum of 3/4 of an inch. On 3/11/2024 (day one of survey) during the survey entrance at approximately 9:01 AM, a request was made to the US FOIA (B) (6) US FOIA (B) (6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility was a three-story (3) building with seven smoke zones. Starting at approximately 9:24 AM on 3/11/2024 and continued on 3/13/2024 in the presence of the facility's US FOIA (B) an inspection tour of the building was conducted.	K 374	Residents affected by this deficient practice: All residents are potentially affected by this deficient practice. Measure or systemic changes to ensure that this deficient practice does not reoccur: The Maintenance Director added a self closing door hinge to correct this deficiency. This is evidenced by the accompanying photo. Maintenance Director will monitor these self closing fire doors monthly. Monitoring the effectiveness of this change: all self closing doors will be tested on a monthly basis by the Maintenance Director or designee and a log book was set up to monitor this. Any findings will be brought to the administrator immediately and discussed at the quarterly QA meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315337	A. BUILDING **01** B. WING _____	**03/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCAULEY HALL HEALTH CARE CENTE	**1633 HIGHWAY 22** **WATCHUNG, NJ 07069**

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K 374	Continued From page 13 During the two (2) days tour of the facility the surveyor performed closure tests of the nine (9) sets of double smoke doors and one (1) single smoke door with-in the smoke barrier walls in the facility with the following results, On 3/11//2024: 1) At approximately 9:37 AM, the surveyor observed that the "Dutch" door on the second (2nd) floor leading into the "Nursing Station" had no means to self-close the door into its frame. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. A review of the facility supplied lay-out identified this "Dutch" door adjacent to the Nursing Station was with in the smoke barrier wall construction on the 2nd floor. The US FOIA (B) confirmed the findings at the time of observation. The US FOIA (b)(6) was informed of the Life Safety Code deficiency during the survey exit on 3/13/2024 at approximately 01:05 PM.	K 374		
K 911 SS=D	Life Safety Code 101, 2012 Edition. N.J.A.C. 8:39-31.1(c), 31.2(e) Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but	K 911		4/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315337	A. BUILDING **01** B. WING _____	**03/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCAULEY HALL HEALTH CARE CENTE	**1633 HIGHWAY 22** **WATCHUNG, NJ 07069**

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K 911	Continued From page 14 are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 3/11/2024 and 3/13/2024, in the presence of facility management, it was determined that the facility failed to ensure that one (1) of six (6) electrical outlets located next to a water source (with-in 6 feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection as required. This deficient practice was evidenced by the following: Reference: National Fire Protection Association (NFPA) 101, 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70, 210.8 Ground-Fault Circuit-Interrupter Protection for Personal, Ground-fault circuit-interruption for personal shall be provided as required in 210.8 (A) through (C). The ground-fault circuit-interrupter shall be installed in readily accessible location. (B) Other than Dwelling Units. All 125-volt, single phase, 15- and 20- ampere receptacles installed in locations specified in 210.8 (B) (1) through (8) shall have ground-fault circuit-interrupter protection for personal. (5) Sinks-- where receptacles are installed within	K 911	Residents affected by this deficient practice: All residents have the potential to be affected by this deficient practice. Measure or systemic changes to ensure that this deficiency does not reoccur. The Director of Maintenance had the duplex outlet(located in the ADL Therapy Room and only 5 feet from a water source) de-energized and covered to be in compliance with this regulation. This is evidenced by the attached photo. Quarterly checks will be done throughout the building. Monitoring the continued effectiveness of the systemic change: The Maintenance Director or designee will round the building to ensure that we are compliant with this regulation. Results of quarterly checks will be reported to the QA Committee at the quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315337	A. BUILDING **01** B. WING _____	**03/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCAULEY HALL HEALTH CARE CENTE	**1633 HIGHWAY 22** **WATCHUNG, NJ 07069**

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K 911	Continued From page 15 1.8 M (6 feet) of the outside of a sink. On 3/11/2024 (day one of survey) during the survey entrance at approximately 9:01 AM, a request was made to the US FOIA (b)(6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility was a three-story (3) building with sixty-eight (68) Resident sleeping rooms, common areas and offices. Starting at approximately 9:24 AM on 3/11/2024 and continued on 3/13/2024 in presence of the facility's US FOIA (b) a tour of the building was conducted. During the two (2) days tour of the facility, the surveyor observed and tested six (6) electrical outlets in wet (with-in 6 feet of a sink) locations with one (1) electrical outlet that failed to de-energize when tested in the following location, On 3/13/2024 at approximately 11:59 AM, the surveyor observed, measured and recorded in the ground floor "ADL Therapy" room, one (1) Duplex electrical outlet located five (5) feet to the left of the sink when tested with a Ground Fault Circuit Interrupter (GFCI) tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. The US FOIA (b) confirmed the finding at the times of the observations. The US FOIA (b)(6) was informed of the Life Safety Code deficiency during the survey exit on	K 911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315337	A. BUILDING **01** B. WING _____	**03/13/2024**

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MCAULEY HALL HEALTH CARE CENTE	**1633 HIGHWAY 22** **WATCHUNG, NJ 07069**

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K 911	Continued From page 16 3/13/2024 at approximately 01:05 PM. Safety Hazard. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		

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
315337 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/16/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MCAULEY HALL HEALTH CARE CENTE	1633 HIGHWAY 22 WATCHUNG, NJ 07069

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 K0293	04/22/2024	LSC K0345	04/22/2024	LSC K0355	04/22/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0372	04/22/2024	LSC K0374	04/22/2024	LSC K0911	04/22/2024
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	
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	
3/13/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO