STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315378	A. BUILDING _____ B. WING _____	C 03/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & HEALTH CARE CENTER	**129 MORRIS TURNPIKE NEWTON, NJ 07860**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is 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 #s: NJ00171520, NJ00170797, NJ00169688, NJ00169710 STANDARD SURVEY: 3/12/2024 CENSUS: 61 SAMPLE SIZE: 26 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 550		3/28/24

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

Electronically Signed | 03/28/2024

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F 550	Continued From page 1 her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, it was determined that the facility failed to maintain NJ Exec Orde during mealtime for a resident who needed NJ Exec Order 26.4b1. This deficient practice was observed for 2 of 5 NJ Exec Order 2 floor dining room residents reviewed, Resident #10 and Resident #24 and was evidenced by the following:	F 550	Specific Corrective Action 1. DON/Designee in serviced the US FOIA (b)(6) [redacted]. about proper way of providing assistance in feeding a residents that maintains respect and dignity. 2. US FOIA (b)(6) in serviced about	

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F 550	Continued From page 2 1. On 3/4/24 at 12:16 PM, the surveyor observed Resident #10 in the NJ Exec Order 2 floor dining room seated in a NJ Exec Orde chair NJ Exec Order 26.4b1 being NJ Exe their lunch. The surveyor observed that the resident's NJ Exec Order 26 U.S. FOIA (b) (6)) was standing behind the resident while reaching over the resident's right side to NJ Exec O them. The surveyor interviewed the NJ Exec Order 26 U.S. FOIA on 3/4/24 at 12:21 PM who stated, she was aware that any staff should be seated in eye to eye level while NJ Exec Order 26 any resident. The NJ Exec Order 26 U.S. FOIA further stated that it was not appropriate to stand while NJ Exec Order 26 A review of the Admission Record for Resident #10 revealed that the resident was admitted to the facility with diagnoses which included but were not limited t NJ Exec Order 26.4b1 A review of the Resident #10's NJ Exec Order 26.4b1 MDS, an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b, reflected that Resident #10 had a BIMS score of NJ Exe out of 15, indicating NJ Exec Order 26.4b1 The MDS further reflected that the resident required NJ Exec Order 26.4b1 assistance for NJ Exec Order 2 2. On 3/4/24 at 12:16 PM, the surveyor observed Resident #24 in the NJ Exec Order 2 floor dining room seated in a wheelchair being NJ Exe their lunch. The surveyor observed that the Certified Nurse Aide #1 (CNA #1) was standing over the resident while NJ Exec Order 26 them.	F 550	proper way of providing assistance in feeding a resident that maintains respect and dignity; promote and enhance the resident's quality of life. 3.DON/Designee updated the Feeding Policy to include the proper way of feeding a resident Identification All residents have the potentials to be affected by deficient practice. Systemics Changes The Director of Social Worker Services will service all staff about Respect and Dignity and Resident's Rights monthly times 3 months and quarterly thereafter. All certified Nursing assistants from hospice care services will be in-serviced on the facility's feeding policy on the first day of duty by DON/Designee Charge nurse on unit will observed, supervised and monitor all certified nursing assistants or certified nursing assistant from other health care services during mealtimes to ensure the proper way of providing assistance in feeding a residents and maintaining respect and dignity at every meal times daily Monitoring	

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F 550	Continued From page 3 The surveyor interviewed CNA #1 on 3/4/24 at 12:55 PM who stated that all staff should be seated next to the resident while assisting them during NJ Exec Order 26 time. CNA #1 further stated that she was aware that she was standing while NJ Exec Order 26 the resident and shouldn't be. A review of the Admission Record for Resident #24 revealed that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Exec Order 26.4b1 [redacted]. A review of Resident #24's Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26 reflected that Resident #24 had a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15, indicating NJ Exec Order 26.4b1. The MDS further reflected that the resident required NJ Exec Order 26.4b1 or NJ Exec Order 26.4 assistance for NJ Exec Order Review of the Feeding Policy did not have any direction related to the appropriate way to feed a resident. On 3/11/24 at 3:30 PM, the U.S. FOIA (b) (6) [redacted] and the U.S. FOIA (b) (6) [redacted] were made aware of the surveyor's dining observation. They both agreed that the CNA's should be seated next to the resident when NJ Exec Order 26 N.J.A.C. 8:39-4.1(a)12	F 550	DON/Designee will do a QAPI in proper way of providing feeding assistance to residents during mealtimes monthly x 3months and quarterly thereafter. The report will be submitted to the Administrator and will be discussed during the quarterly meeting.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		3/28/24

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F 658	Continued From page 4 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility staff failed to follow acceptable standards of clinical practice for 1. not accurately documenting the resident's [NJ Exec Order 26.4b1] of a medication, 2. not adequately documenting in the Administration Record to indicate that the [NJ Exec Order 26.4b1] were done according to physician's order (PO) to 2 of 16 residents reviewed, Resident #11 and Resident #18. This 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 or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." 1. On 3/8/24 at 8:06 AM, the State Surveyor observed the start of medication pass with the Licensed Practical Nurse (LPN#1) on the [NJ Exec] floor.	F 658	Specific Corrective Action 1. The Licensed staff identified who left the medication with the resident without making sure if the resident took it refused and signed as given was in serviced on Medication pass and Medication refusal policy. 2. All licensed staff identified not documenting the daily weights were re-educated in appropriate documentation on weight refusal and missing weight information in the RMAR (Resident Medication Administration record). 3. All licensed staff were in-service by DON/Designee to ensure that acceptable standards of clinical practice is accurately documenting residents refusal of a medication and accurately documenting weight in RMAR. Identification All residents have the potential to be affected by this deficient practice. Systemic Changes	

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F 658	Continued From page 5 On 3/8/24 at 8:16 AM, LPN#1 entered the room belonging to Resident #19. Resident #18 was [NJ Exec Order 26] and identified the medication in the cup as [NJ Exec Order 26.4b1] to LPN#1. Resident #18 explained that she didn't need the [NJ Exec Order 26.4b1] last night, so she saved it to give to the nurse in the morning. The surveyor reviewed the [NJ Exec Order 26.4b1] Physician Orders (PO) which included an order for [NJ Exec Order 2]) daily at bedtime for [NJ Exec Order 26.4b1] HOLD for [NJ Exec Order 26.4b1] This was first ordered by the Physician for Resident #18 on [NJ Exec Orde]. Review of the [NJ Exec Order 26.4b1] electronic medication administration record (eMAR) revealed that the [NJ Exec Order 26.4b1] was scheduled to be administered at 9:30 PM. Review of the documentation on [NJ Exec Orde] of the eMAR provided a nurse's signature expressing that the [NJ Exec Order 2] was administered to Resident #18 at 9:30 PM. On 3/8/24 at 12:00 PM, the surveyor discussed the situation with the [U.S. FOIA (b) (6)] and the [U.S. FOIA (b) (6)]). The [U.S. FOIA (b)] stated that the administering nurse should always wait until the medication is [NJ Exec Order 26.4b1] or [NJ Exec Order 2] by the resident and document accurately on the eMAR. The [U.S. FOIA (b)] continued explaining that if the medication is [NJ Exec Order 2] by the resident, it should be documented that way. 2. On 3/6/24 at 10:07 AM, the surveyor reviewed the [NJ Exec Order 26.4b1] PO form that reflected an order dated [NJ Exec Order 26] under Monitoring to " [NJ Exec Orde]	F 658	All licensed staff will report weights on all residents with physician's order for daily weights monitoring to the DON/Designee in a 24-hour report and will be discussed during daily clinical meetings monthly x 3 months and quarterly thereafter Don/Designee and Dietitian will conduct a weekly weight review on residents with daily weight monitoring x 3 months and quarterly there after Monitoring A QAPI will be done by DON/Designee to ensure that acceptable standard of clinical practice is accurately documenting resident's refusal of a medication and accurately documenting weight in RMAR monthly X3 months and quarterly thereafter. The reports will be submitted to the administrator and will be discussed during quarterly meeting.	

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F 658	Continued From page 6	F 658		

resident every day at 7:00 AM before breakfast."

A review of the form titled "Resident Medication Administration Record" (RMAR) for [NJ Exec Order 26.4b1] showed a PO to [NJ Exec Orde] resident every day at 7:00 AM before breakfast. The PO also indicated that nurses had to sign and document the [NJ Exec Order] of the resident.

The surveyor observed that for the month of [NJ Exec Order 26.4b1] RMAR , the nurse's failed to document that the [NJ Exec Order] was obtained for [NJ Ex] out of [NJ Ex] days.

A review of the [NJ Exec Order 26.4b1] RMAR revealed that the nurses failed to document that the [NJ Exec Order] was obtained for [NJ Ex] out of [NJ Ex] days.

The surveyor interviewed the Registered Nurse (RN) #1 who was assigned to Resident #11 could not explain why the administration RMAR were blank, not signed daily and [NJ Exec Order 26] were not documented.

A review of the facility's Policy and Procedure titled, "Weight and Weight change Management" revealed under procedure #4. "All weights (daily, weekly, monthly) are to be documented in the electronic medical record or appropriate designated form."

On 3/11/24 at 3:30 PM, the surveyor discussed this issue related to the missing signatures as well as required [NJ Exec Order 26] with the [U.S. FOIA (b)] and [U.S. FOIA (b) (6)]. There was no additional information provided.

NJAC 8:39 - 27.1

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F 686	Continued From page 7	F 686		
F 686 SS=D	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: REPEAT DEFICIENCY Based on observation, interview, and record review it was determined that the facility failed to provide care and services consistent with professional standards of practice for a resident with a NJ Exec Order 26.4b1 This deficient practice was identified in 1 of 2 residents, Resident #1, reviewed for NJ Exec Order 26.4b1 care and prevention. The deficient practice was evidenced by the following: On 3/4/24 at 11:25 AM, the surveyor observed Resident #1 lying in bed in their room. Resident #1 was NJ Exec Or NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1. Resident #1 stated they had a NJ Exec Order on their NJ Exec Order 26.4 that was treated daily by the nurses and a NJ Exec Order doctor would visit weekly.	F 686	Specific Corrective Action: 1. LPN #2 that was observed performing the treatment for Resident #1 was re-educated on facility is NJ Exec Order 26.4b1 and was observed for skill competency test for NJ Exec Order treatment administrator. 2. LPN #2 that was observed performing the treatment for resident #1 was in-service to check the physicians order prior to treatment administration. The staff must call the physician for order clarification or order is different from the facility policy. Identification:	3/28/24

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F 686	Continued From page 8 On 3/7/24 at 10:06 AM, the surveyor observed Licensed Practical Nurse (LPN) #2 provide NJ Exec Order treatment to Resident #1's NJ Exec Order 26.4b1. LPN #2 provided the surveyor a copy of the resident's treatment order. The physician order dated NJ Exec Order 26 read, "NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 apply NJ Exec Order to NJ Exec NJ Exec Order 26.4b1, to NJ Exec Order 26 with NJ Exec Order 26.4b1 BID [two times a day]". On 3/7/24 at 10:11 AM, the surveyor observed LPN #2 remove the old NJ Exec Order 26.4b1 from the NJ Exec Orde and aNJ Exec Order 26.4b1. LPN #2 NJ Exec Order 26.4b1 to the resident's NJ Exec Order 26.4 then used an NJ Exec Order 26.4b1 and patted the NJ Exec Order 26.4b1. LPN #2 did not use NJ Exec Order 2 to NJ Exec Order 26.4b1 as documented in the physician's order. On 3/7/24 at 10:16 AM, the surveyor observed LPN #2 NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1. LPN #2 then applied a NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1 and NJ Exec Order 26 it with a NJ Exec Orde On 3/7/24 at 10:25 AM, the surveyor interviewed LPN #2 about the NJ Exec Order treatment observation and order. LPN #2 acknowledged that the physician's order was to be followed and the order should have been clarified with the physician for NJ Exec Order 26.4b1 to be used for the treatment. The surveyor asked LPN #2 about NJ Exec Order 26.4b1. LPN #2 stated she did not see any concern with the method used when NJ Exec Order 26.4b1.	F 686	All residents have the potential to be affected by the deficient practice. Systemic Changes: 1. Unit Manager/Charge Nurses will do a monthly audit on all treatment orders to ensure that orders are written appropriately which includes the cleansing direction, location of the wound, medication/ointment, type of dressing and frequency and to clarify if the treatment order is differs from the facility policy. Reports will be submitted to the DON/Designee monthly. 2. Wound care nurse/Designee will do a monthly wound care treatment observation on all nurses x3 months and quarterly thereafter. Reports will be submitted to the DON/Designee. Monitoring: 1. A monthly QAPI will be done by DON/Designee on wound care treatment orders to ensure that physician wound orders are written appropriately x 3months and quarterly thereafter. Reports will be submitted to the administrator and will be discussed during the quarterly meeting. 2. A monthly QAPI for wound treatment observation will be done by DON/Designee monthly x3 and quarterly thereafter. Report will be submitted to the	

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F 686	Continued From page 9 The surveyor reviewed the hybrid (paper and electronic) medical record of Resident #1 which revealed the following: The Resident Face Sheet (an admission summary) documented Resident #1 had diagnoses that included but were not limited to, [redacted]. The Quarterly Minimum Data Set (MDS) assessment, dated [redacted] which indicated the facility assessed the resident's [redacted] using a Brief Interview for Mental Status (BIMS). The resident scored a [redacted] out of 15 which indicated that the [redacted]. The MDS assessment also indicated the resident had a [redacted]. A review of the electronic treatment administration record (ear) included a physician's order [redacted] which read, [redacted] with [redacted] apply [redacted] to [redacted], to [redacted] with [redacted] BID [two times a day]". There were no other treatment orders documented for the resident's [redacted] A physician's order dated [redacted] read "[redacted] Assessment ...Every week on Monday at 7:00-3:00 pm ..." A physician's order dated [redacted] read [redacted] [redacted] company] for [redacted] care ..." A review of [redacted] progress notes by the nurses,	F 686	administrator and will discussed during the quarterly meeting.	

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F 686	Continued From page 10	F 686		

did not include assessment or documentation of the NJ Exec Order 26.4b1. The progress notes dated and documented location ' and . A review of the additional progress notes from and revealed there was only documentation for the and no documentation of any other

On 3/7/24 at 12:00 PM, the U.S. FOIA (b) (6) provided the facility's care policy. The surveyor requested from the consultant documentation for Resident #1, which were not found in the resident's chart.

On 3/7/24 at 2:05 PM, LPN #2 provided consultant documentation for Resident #1.

A review of the physician consultant's notes from to revealed there was no documentation and assessment of the NJ Exec Order 26.4b1. A review of the consultant notes from to revealed there was documentation for the . There was no documentation found of any other

On 3/11/24 at 1:35 PM, the surveyor interviewed LPN #2, in the presence of the about Resident #1's current and only documentation for the in the medical records. LPN #2 stated the resident's was on the and there was no on the . The stated they would follow up to provide documentation of the resident's and clarify the of the resident's . LPN #2 provided the contact phone number for the consultant

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F 686	Continued From page 11	F 686		

physician.

On 3/11/24 at 1:52 PM, the surveyor placed a phone call to the NJ Exec Order consultant physician. There was no answer, and a message was left to return a call to the surveyor. The NJ Exec Order consultant physician did not return a call to the surveyor.

On 3/11/24 at 3:17 PM, the surveyor informed the U.S. FOIA (b) (6) , and LPN #2 were made aware of the concerns observed during the NJ Exec Order treatment and for the assessment of the resident's NJ Exec Order 26.4 The U.S. FOIA and U.S. FOIA (b) stated appropriate NJ Exec Order NJ Exec Order 26.4b1 would be for the NJ Exec Order to be NJ Exec Order 26.4 with a NJ Exec Orde from the NJ Exec Order 26.4b1 . The U.S. FOIA acknowledged each NJ Exec Order treatment should have individual treatment orders. The U.S. FOIA (b) stated the facility would provide additional information.

On 3/12/24 at 12:03 PM, the U.S. FOIA informed the surveyor she assessed Resident #1 with LPN #2 and stated the resident had the NJ Exec Order 26.4b1 and a NJ Exec Order 26.4b1. The U.S. FOIA stated there was NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1 in the treatment referred to the NJ Ex . The U.S. FOIA could not say if the NJ Ex was previously documented. The U.S. FOIA stated she would provide further information.

On 3/12/24 at 12:40 PM, the U.S. FOIA provided a wound progress note dated NJ Exec Order 26. . The document indicated the NJ Exec Order 26.4b1 NJ Exec Order NJ Exec Or was on NJ Exec Order 2 . The U.S. FOIA could not provide a verbal response as to why there was no previous documentation for the resident's NJ Exec Order and how

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F 686	Continued From page 12	F 686		

the [NJ Exec Order] onset was determined to be on [NJ Exec Order 2]. The [U.S. FOIA] stated she would have to follow up with the nurses to determine what happened to the [NJ Exec Order] assessment and documentation. There was no additional information was provided by the facility.

The surveyor reviewed the facility's policy titled, "WOUNDS: PRESSURE ULCERS & ULCERS OF DIFFERENT TYPES", which had an updated date of 2/23/16. Under I. Assess, it read: "Assess the individual for pressure ulcers and/or risk of developing pressure ulcers: ...3. Weekly if actual ulcer is present to determine staging, effectiveness of current treatment, interventions, and healing process..." Under C. Documentation, it read: " ...Resident with wound: Resident Wound Form, Resident Medical Record, TAR, Resident Plan of Care: to be conducted weekly, at a minimum, and shall include, but not be limited to: ...a. location and staging, b. size, c. exudate, d. pain, if present including nature and frequency, e. wound bed, f. description of wound edges and surrounding tissue, g. infections related to ulcer, if applicable; h. dressings and treatment selection; effectiveness; i. general progress toward healing ..."

The surveyor reviewed the facility policy titled "Weekly Skin Assessment" with a reviewed date of 5/20/23. Under Policy it read, "It is the policy of this facility [to] do a weekly skin assessment to ensure that resident skin integrity is intact and to prevent development of pressure any ulcers and detection of any skin condition that jeopardizes the resident's skin integrity." Under Procedure it read, "1. A physician's order will be obtained for all residents for a weekly skin assessment. Weekly skin assessment will be conducted

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F 686	Continued From page 13 weekly during scheduled shower day by nurse assigned on the resident. Documentation will be by the nurse for any findings in [electronic medical record]. MD will be notified if there are abnormal findings." N.J.A.C. 25.2 (c); 27.1 (a)(e)	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: NJ00169688 NJ00169710 Based on interview, and record review, it was determined that the facility failed to ensure that Resident #10 who was at NJ Exec Order 26.4b1, accurately investigated the cause of NJ Exec Order 26.4, the prevention of NJ Exec Order 26.4b1, including NJ Exec O that resulted in NJ Exec Order 26.4b1. This deficient practice was identified for 1 of 3 residents reviewed for falls. Review of NJ Exec Order 26.4b1 for Resident #10 revealed that they had NJ Exec Order, on NJ Exec Order 26.4 and NJ Exec Order 26.4 with NJ Exec Order 2. A review of the Investigation reports for the NJ Exec O	F 689	Specific Corrective Action: 1. Resident #10 - A NJ Exec Order 26.4b1 was completed to update information that help identify the factors that placed resident to be a NJ Exec Order 26.4b1. The assessment was reviewed by the IDCP team and discussed the diagnosis that was identified as a contributory factor that increases the resident NJ Exec Order 26.4b1 as but not limited to NJ Exec Order 26.4b1 All staff providing care for Resident #10 were in-service. 2. The IDCP team met to discuss Resident #10 care plan update for NJ Exec	3/28/24

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F 689	Continued From page 14 that occurred on NJ Exec Order 26.4 and NJ Exec Order 26.4, revealed that they did not include NJ Exec Order 26.4b1 of the NJ Exec O Review of the investigations report supported that there was no appropriate Intervention evaluation or interventions put in place after the resident's NJ Exec O relating to the resident's NJ Exec Order 26.4b1 Resident #10's care plan (CP) was not appropriate or specific to the resident's individualized needs including the resident's NJ Exec Order 26.4b1 which NJ Exec Order 26.4b1. The surveyor reviewed Resident #10's medical records. On 3/4/24 at 10:59 AM, the surveyor observed Resident #10 in the day room seated in a NJ Exec Orde chair NJ Exec Order 26.4b1 A review of the Admission Record for Resident #10 revealed that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Exec Order 26.4b1 . A review of Resident #10's NJ Exec Order 26.4b1 Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4, reflected that Resident #10 had a BIMS score of NJ Ex out of 15, indicating a NJ Exec Order The following were the reported and documented	F 689	The IDCP team updated intervention for NJ Ex that are appropriate for the root cause of the NJ Exec Identification: All residents have the potential to be affected by the deficient practice. Systemic Changes: DON/Designee will do a root cause analysis review on all incident and accident report after the completion of the incident/accident investigation to ensure that care plan will have an appropriate intervention monthly DON/Designee will do an audit on all incident/accident report to ensure that causal factor was identified and care plan has appropriate intervention monthly All licensed staff were in-service regarding the proper investigation of any incident/Accident Report to ensure that the root cause of the fall incident has been identified to ensure that appropriate intervention is in placed to prevent further fall/incident monthly x3 months and quarterly thereafter. Incident/Accident Report will be reviewed by Interdisciplinary (IDCP) team during the clinical meeting daily to ensure all information and statements are available	

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F 689	Continued From page 15 NJ Exec Order 26.4b1: 1. On NJ Exec Order 26.4 at 7:50 PM NJ Ex incident report revealed NJ Exec Order 26.4b1 resulting in NJ Exec Orde which included NJ Exec Order 26.4b1 to the NJ Exe, NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b and NJ Exec Order 26 noted to NJ Exec Order 26.4b1 and NJ Exec Order 2 on the NJ Exec Ord A review of the form titled, "Employee/Witness Statement Form" documented by Certified Nursing Assistant #4 (CNA #4) stated, "was cleaning the resident the resident NJ Exec Order and NJ Exe of the bed". On 3/7/24 at 10:45 AM, the surveyor interviewed CNA #1 who was the regular CNA for Resident #10. CNA #1 stated that occasionally when the resident was NJ Exec Order 26.4b1, the resident would NJ Exec Order 26.4b1 The surveyor asked CNA #1 if there were any documented medical alerts related to Resident #10's NJ Exec Order 26.4b1 in the medical records or CNA tasks to aid the facility staff in taking care of the resident. CNA #1 could not locate any type of medical alert indicating the NJ Exec Order 26.4b1 A review of the resident's CP activity report titled; "NJ Exec Ord revealed that there were no interventions added to address the resident's occasional NJ Exec Order 26.4b1. On 3/11/24 at 3:30 PM, the survey team discussed the above concerns to the facility's U.S. FOIA (b) (6), U.S. FOIA (b) (6) and Licensed Practical Nurse #2. The facility could not provide further information. The U.S. FOIA also agreed that the investigation was	F 689	for any further investigation needed and that causal factor of the incident/Accident is identified to be able to provide appropriate intervention for the care plan to prevent further incident/Accident. The Interdisciplinary Team (IDCP) team will weekly Fall meeting. Monitoring: A QAPI will be done by DON/Designee on all Incident/Accident Report to ensure that causal factor is identified and appropriate intervention for the care plan was in placed to prevent further Incident/Accident monthly x 3 months and quarterly thereafter. Report will be submitted to the administrator and will be discussed during the quarterly meeting	

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F 689	Continued From page 16 not thoroughly assessed and evaluated to determine the [NJ Exec Order 26.4b1].	F 689		

2. On 11/13/23 at 12:45 PM [NJ Ex] incident report revealed an [NJ Exec Order 26.4b1] resulting in [NJ Exec Orde] which [NJ Exec Order 26.4b1] to [NJ Exec Order 26.4] which required hospitalization.

A review of the form titled, "Incident/Accident Report" documented by Licensed Practical Nurse #3 (LPN #3) stated, "After resident eat lunch with [U.S. FOIA] staff (feeder) and after nurse left the dining room after all residents finished eating, [U.S. FOIA] staff starting to pull up all resident from dining room, resident [NJ Exec Order 26.4b1] and was [NJ Exec Order 26.4] from [NJ Exec Order 26.4] ...".

A review of the staffing for the week of Complaint staffing from [NJ Exec Order 26.4b1] to [NJ Exec Order 26.4b1], the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows:

[NJ Exec Order 26.4b] had 5 CNAs for 66 residents on the day shift, required at least 8 CNAs.
- [NJ Exec Order 26.4] had 6 CNAs for 66 residents on the day shift, required at least 8 CNAs.

The staffing report revealed that on [NJ Exec Order 26.4b], the facility was short of CNAs in the day shift.

A review of the progress notes dated [NJ Exec Order 26.4b] and documented by the U.S. FOIA (b) (6) reflected that Resident #10 was screened due to [NJ Exec Order 26.4b1]. The [U.S. FOIA (b)] documented, "Resident had [NJ Exec Order] recently. [NJ Exec O] Upon investigation, the resident was left unattended in the dining room with [NJ Exec Orde] chair completely upright instead [NJ Exec Order 26.4b1]."

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F 689	Continued From page 17 A review of the resident's CP activity report titled; [redacted] revealed that there were no interventions found indicating that the resident required the use of [redacted]. On 3/11/24 at 3:30 PM, the surveyor discussed the above concerns to the facility's [redacted] and Licensed Practical Nurse #2. The [redacted] agreed that the investigation was not conducted and assessed thoroughly for the [redacted] incident on [redacted]. The [redacted] stated that the staffing was short on the day of the second [redacted] incident which was [redacted]. No further information was provided. NJAC 8:39-27.1(a); 31.4(a); 33.1(d)	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to: a) ensure appropriate [redacted] equipment in accordance with facility and [redacted] control policies, b) ensure a resident received [redacted] as ordered by the physician.	F 695	Specific Corrective Action RN #1 and LPN #3 were re-educated to ensure appropriate storage of [redacted] equipment in accordance with the facility and infection control policies; ensuring	3/28/24

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F 695	Continued From page 18 This deficient practice was identified in 3 of 3 residents (Resident #11, #12 and #58), reviewed for NJ Exec Order 26.4b1 care. The deficient practice was evidenced by the following: 1. On 3/4/24 at 11:14 AM, during the initial tour in Resident #11's room, the surveyor observed an NJ Exec Order 26.4b1 connected to the resident's NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 dated NJ Exec O. The resident was observed with eyes closed with the NJ Exec Order 26.4b1 in place. A review of the Admission Record (AR) for Resident #11 reflected that the resident was admitted to the facility with diagnoses that included but not limited to NJ Exec Order 26.4b1 . A review of the Resident #11's Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated NJ Exec Orde reflected that the Brief Interview for Mental Status was not conducted due to the resident NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 . A review of the NJ Exec Order 26.4b1 Physician's Order (PO) revealed that there was a PO dated NJ Exec Orde with NJ Exec O NJ Exec Order 26.4b1 ; NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 , and NJ Exec weekly - label with name and date every Wednesdays 11pm-7am shift. On 3/4/24 at 11:22 AM, Registered Nurse #1 (RN #1) assigned to Resident #11 was brought inside the room and during the interview, RN #1 verified	F 695	that a resident received oxygen as ordered by the physicianby DON/Designee Resident#11 and Resident #12 - NJ Exec Order 26.4b1 set up were changed and dated by charged nurse on the unit. A new zip lock was provided with a date for the NJ Exec Order 26.4b1 and NJ Exec Orde for storage when not in used All Licensed staff were re-educated by DON/Designee on Oxygen Administration Policy to ensure that oxygen tubing is stored properly when not in use by placing it in zip lock bag with a date; that oxygen tubing and humidifier are dated and change weekly by 11-7 shift; and to check the oxygen delivery rate is the same the physician's order. Identification All residents have the potential to be affected by this deficient practice. Systemic Changes 1. 11-7 shift Unit nurse will do an audit weekly to identify residents on oxygen therapy. The report will be submitted to the DON/Designee which includes information when oxygen equipment was	

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F 695	Continued From page 19 that the date on the NJ Exec Orde were NJ Exec Orde. RN#1 further stated that the NJ Exec Order 26.4b1 was scheduled to be changed weekly by the night shift (11pm-7am). The surveyor reviewed the facility's Policy and Procedure titled, Oxygen Administration under "#4. Nasal Cannula/face mask: Connect tubing to humidifier outlet and adjust liter flow as ordered ....Nasal Cannula/face mask will be changed by weekly and PRN." 2. On 3/4/24 at 10:47 AM, the surveyor observed Resident #12, resting in bed in their room. Resident #12 opened NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 to the surveyor. Resident #12 was receiving NJ Exec Order 26.4b1 which was attached to a NJ Exec Order 26.4b1 The surveyor observed a NJ Exec Order 26.4b1 attached to the NJ Exec Order 26.4b1 that was dated NJ Exec Order 26. and there was no visible date on the NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 setting was not visible to the surveyor due to position of the equipment at the bedside. On 3/4/24 at 12:57 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #2 about	F 695	change such as tubing and humidifier with the date; and the oxygen flow rate matches with the physician's order; zip lock bag is provided with date to store the oxygen equipment when not in use x 3months and quarterly 2. All Licensed nurse on all shifts will submit a report every shift to the DON/Designee identifying residents that receives oxygen therapy; tubing and humidifier were dated; and that the oxygen flow rate matches with the physician's order monthly x 3 months and quarterly thereafter Monitoring 1. A QAPI will be done by DON/Designee to ensure appropriate storage of oxygen equipment in accordance with facility and infection control policies; ensure a resident received oxygen as ordered by the physician monthly x 3 months and quarterly thereafter. The report will be submitted to the Administrator and will be discussed during the quarterly meeting.	

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F 695	Continued From page 20	F 695		

Resident #12's NJ Exec Order 26.4b1 and equipment. LPN #2 stated the resident was ordered to receive NJ Exec Order 26.4b1 LPN #2 further explained NJ Exec Order 2 equipment such as NJ Exec Orde and NJ Exec Order 26.4b1 were changed weekly. LPN #2 accompanied the surveyor to the resident's bedside to check the resident's NJ Exec Order 2 equipment and setting on the NJ Exec Order 26.4b1 LPN #2 stated the NJ Exec Order 26.4b1 should have been changed and could not speak to why the bottle was not changed.

The NJ Exec Order 26.4b1 was set at NJ E LPN #2 immediately adjusted the setting to NJ Exec Order and stated the resident should be receiving NJ Exec Order as per physician's order. LPN #2 could not explain why the resident's NJ Exec Order 26 was NJ Exec Order 26.4b1 and stated the NJ Exec Order 2 setting should only be adjusted by the nurse. LPN #2 further stated "I did not check it NJ Exec Order 26 this morning" and it should be checked at least two times per day.

On 3/5/24 at 9:47 AM, the surveyor reviewed Resident #12's electronic medical record (EMR).

The Resident AR (a summary of important information about the resident) revealed that Resident #12 was admitted with diagnoses that included, but were not limited to, NJ Exec Order 26.4b1

A comprehensive Minimum Data Set (MDS), an assessment tool to facilitate care, dated NJ Exec Order 26.4b, indicated that the facility assessed the resident's NJ Exec Order 26.4b1 using a Brief Interview for Mental Status (BIMS). The resident scored a NJ out of 15 which indicated that the resident's had NJ Exec Order 26.4b

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F 695	Continued From page 21 NJ Exec Order 26.4b1. Section [redacted] of the MDS documented the resident received [redacted]. A review of the physician's orders and the [redacted] eMAR documented a physician's order dated [redacted] which read, "NJ Exec Order 26.4b1 via [redacted] Schedule: Every Day at 7:00 am-3:00 pm; 3:00 pm-11:00 pm; 11:00 pm-7:00 am ..." A review of the [redacted] electronic treatment record (eTAR) documented an entry for a physician's order dated [redacted] which read, "NJ Exec Order 26.4b1, [redacted] (If in use), and [redacted] Weekly - Label with Name and Date Schedule: Every Week on Wednesday at 11:00 pm-7:00 am ..." The entry on [redacted] was signed as completed by the 11-7 shift nurse and the entry on [redacted] was left blank. A review of the [redacted] eTAR documented an entry for a physician's order dated [redacted] read, "Check Label and Date on [redacted] and [redacted] every shift Schedule: Every Day at 7:00 am-3:00 pm; 3:00 pm-11:00 pm; 11:00 pm-7:00 am ..." The entries were signed as completed by the nurses on the eTAR. The entry on [redacted] was left blank and not signed. On 3/5/24 at 2:20 PM, the U.S. FOIA (b) (6) [redacted] provided the facility's [redacted] administration policy. A review of the facility policy titled "Oxygen Administration" with a revised date of March 2023 read under Procedures #3 Humidifiers Bottle: " ...f. Set the flow meter to the rate ordered by the physician ...h. Label humidifier with date and time opened ...h. Humidifier bottle will be changed	F 695		

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F 695	Continued From page 22 weekly and PRN 11-7 shift ..." 3. On 3/11/24 at 1:20 PM, Resident #58 was observed by the surveyor, outside of the room, seated in a wheelchair and NJ Exec Order 26.4b1 in the hallway. On 3/11/24 at 1:24 PM, the surveyor inspected Resident #58's room. Inspected resident's room with LPN#3. The surveyor along with LPN#3 identified that the NJ Exec Order 26.4b1 dated NJ Exec Orde, was stored in Resident #58's nightstand drawer, not in bag, along with the resident's call bell. LPN#3 stated that the NJ Exec Order 26.4b1 should be stored in a bag to prevent NJ Exec Order 26.4b1 not in a drawer with the call bell. Review of the resident's (AR) reflected that Resident #58 was admitted to the facility with medical diagnoses that included but were not limited to NJ Exec Order 26.4b1 . A review of the Quarterly MDS, an assessment tool used to facilitate the management of care, dated NJ Exec Order 2 documented that the resident had a BIMS score of NJ Ex out of 15 indicating that the resident had a NJ Exec Order 26.4b1 . Review of the NJ Exec Order 26.4b1 eMAR indicated an entry that was signed and completed by the nurse (11PM-7AM) on NJ Exec Orde reflecting a Physician's order (PO) which began on NJ Exec Orde. The PO explains, "NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1 (If in use), and NJ Exec O Weekly-Label with Name and Date Protocol: Label both bag and NJ Exec Orde with name and date."	F 695		

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F 695	Continued From page 23 Review of Resident #58's Care Plan which began [NJ Exec Order 26.4], under [NJ Exec Order 26.4b1] that documents, "All shifts will check [NJ Exec Order 26.4] and [NJ Exec Order 26.4b1] for date/time every shift: place in plastic bag when not in use." Review of the facility Oxygen Administration: Nasal Cannula or Mask policy updated on 5/16/23 which specifies, "Points to Remember: 3. Between use, keep cannula or mask in a clean plastic bag at the machine or draped over regulator on tank." On 3/11/24 at 3:17 PM, the surveyor informed the [U.S. FOIA (b) (6)] and LPN #2 of the above concerns. The [U.S. FOIA (b) (6)] stated [NJ Exec Order 26.4b1] was the responsibility of the 11-7 shift and staff would be provided re-education. There was no additional information provided by the facility. NJAC 8:39-27.1(a) NJAC 8:39-19.4(a)(k)	F 695		
F 711 SS=F	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and	F 711		3/28/24

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F 711	Continued From page 24 §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to assure that the physician responsible for supervising the care of residents completed monthly progress notes . This deficient practice continued over several months for 15 of 16 residents reviewed, Resident #18, #19, #58, #117, #10, #20, #38, #56, #61, #64, #42, #50, #1, #12 and #16 reviewed for physician progress notes and current physician orders. This deficient practice was evidenced by the following: 1. On 3/07/24 at 10:41 AM, the surveyor reviewed Resident #18's hybrid medical records. Review of Resident #18's Admission Record (AR) reflected that Resident #18 was admitted to the facility with medical diagnoses that included but were not limited [redacted] Review of the Medical Progress Notes (PN) written by Physician #1, from [redacted] to [redacted] were held in "DRAFT" by Physician #1 documenting a letter (Z, C, A) to keep the place. No other information was evidenced in the Medical PN.	F 711	Systemic Corrective Action: 1. Physician #1 and Physician #2 were in-service about facility's Medical Service Documentation Policy. 2. Physicians #1 and Physician's #2 were in-service that progress notes must be completed during their visit and if unable to complete on the same day, a progress notes whether electronic or paper must be completed after 4 weeks. 3. All licensed staff where in-service to ensure that physician will document during their visit, total program care that includes medications, treatments, and updates as necessary in the Electronic Health Record(EHR) or paper progress notes with doctor's signature. 4. All license staff were re-educated to document in the EHR progress notes acknowledging the attending physician's visit. Identification: All residents have the potential to be	

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F 711	Continued From page 25 2. On 3/07/24 at 10:50 AM, the surveyor reviewed Resident #19's hybrid medical records. Review of Resident #19's AR reflected that Resident #19 was admitted to the facility with medical diagnoses that included but were not limited to NJ Exec Order 26.4b1 [redacted] Review of the Medical PN written by Physician #1, from NJ Exec Order 26.4b to NJ Exec Order 26 were held in "DRAFT" by Physician #1 documenting a letter (Z, C, A) to keep the place. No other information was evidenced in the Medical PN. 3. On 3/11/24 at 12:28 PM, the surveyor reviewed Resident #58's hybrid closed medical records. Review of Resident #58's AR reflected that Resident #58 was admitted to the facility with medical diagnoses that included but were not limited to NJ Exec Order 26.4b1 [redacted] Review of the Medical PN revealed that on NJ Exec Order 2 and NJ Exec Order 26 there was no evidence of any Physician documentation. The facility could not find the missing Medical PN documented by Physician #2. 4. On 3/07/24 at 11:16 AM, the surveyor reviewed	F 711	affected by this deficient practice. Systemic Changes: Unit Licensed nurse will do a monthly audit on EHR physician's progress notes/paper physician's progress notes to ensure that physician's have signed their monthly orders and progress notes were done x 12 months Monitoring: A QAPI will be done by DON/Designee to ensure that all attending physicians/Alternate see residents at least one every thirty days to review total program of care which includes medication, treatments and necessary updates during visit and monthly physician's order were signed monthly x12 months. The quarterly report report will be submitted to administrator and will be discussed during the quarterly meeting.	

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F 711	Continued From page 26 Resident #117's hybrid medical records. Review of Resident #117's AR reflected that Resident #117 was admitted to the facility with medical diagnoses that included but were not limited to NJ Exec Order 26.4b1 [redacted]. Review of the Medical PN revealed that the [redacted] to [redacted] Medical Progress Notes (PN) were held in "DRAFT" by Physician #1 documenting a letter (Z, C, A) to keep the place. No other information was evidenced in the Medical PN. 5. On 3/06/24 at 1:11 PM, the surveyor reviewed Resident #10's hybrid medical records. Review of Resident #10's AR reflected that Resident #10 was admitted to the facility with medical diagnoses that included but were not limited to NJ Exec Order 26.4b1 [redacted]. Review of the Medical PN revealed that from [redacted] through [redacted] were missing. The facility could not find the missing Medical PN documented by Physician #2. 6. On 3/11/24 at 1:10 PM, the surveyor reviewed Resident #20's hybrid medical records. Review of Resident #20's AR reflected that Resident #20 was admitted to the facility with medical diagnoses that included but were not limited to NJ Exec Order 26.4b1 [redacted].	F 711		

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Review of the Medical PN revealed that the [NJ Exec Order 2] to [NJ Exec Order 2] monthly Medical PN were held in "DRAFT" by Physician #1 documenting a letter (Z, C, A) to keep the place. No other information was evidenced in the Medical PN.

7. On 3/6/24 at 10:07 AM, the surveyor reviewed Resident #38's hybrid medical records.

Review of Resident #38's AR reflected that Resident #38 was admitted to the facility with medical diagnoses that included but were not limited to NJ Exec Order 26.4b1 [redacted]

Review of the Medical PN revealed that from [NJ Exec Order 26.4] through [NJ Exec Order 2] were missing. The facility could not find the missing Medical PN documented by Physician #2.

8. On 3/04/24 at 11:02 AM, the surveyor observed Resident #56 lying in bed in their room. The resident was [NJ Exec Or] NJ Exec Order 26.4b1, and [NJ Exec Order 26.4b1] [redacted]

The surveyor reviewed the hybrid medical records of Resident #56 which revealed the following:

The Resident Face Sheet documented that Resident #56 had diagnoses that included but were not limited, NJ Exec Order 26.4b1 [redacted]

A review of Resident # 56's hybrid medical records revealed that from [NJ Exec Orde] to [NJ Exec Orde] monthly Medical Progress Notes (PN) were held in draft in the electronic medical record (EMR),

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included PPNs that had no information documented within the entry and remained in "draft" by Physician #1 documenting a letter (Z, C, A) to keep the place. No other information was evidenced in the Medical PN.

9. On 3/4/24 at 1:45 PM, the surveyor observed Resident #61 lying in bed in their room. The resident was NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1

The surveyor reviewed the hybrid medical records of Resident #61 which revealed the following:

The Resident Face Sheet documented that Resident #61 had diagnoses that included but were not limited, NJ Exec Order 26.4b1

A review of Resident # 61's hybrid medical records revealed that from NJ Exec Order to NJ Exec Order monthly Medical Progress Notes (PN) were held in draft in the electronic medical record (EMR), included PPNs that had no information documented within the entry and remained in "draft" by Physician #1 documenting a letter (Z, C, A) to keep the place. No other information was evidenced in the Medical PN.

10. On 3/7/24 at 11:26 AM, surveyor reviewed the closed electronic medical record of Resident #64, the resident was admitted on NJ Exec Order 26.4 and discharged to the hospital on NJ Exec Order 26.4. The electronic medical record revealed the following:

The Resident Face Sheet documented that Resident #64 had diagnoses that included but were not limited, NJ Exec Order 26.4b1

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NJ Exec Order 26.4b1

A review of Resident #64's hybrid medical records revealed that from NJ Exec Order 26.4 to NJ Exec Order 26.4b monthly Medical Progress Notes (PN) were held in draft in the electronic medical record (EMR), included PPNs that had no information documented within the entry and remained in "draft" by Physician #1 documenting a letter (Z, C, A) to keep the place. No other information was evidenced in the Medical PN.

A review of the facility's policy titled, "Medical Service Documentation Policy" with a reviewed date of 5/23/2023 under Procedure read: "2. Each resident must be seen by their attending physician or alternate at least once every thirty (30) days. The resident's total program of care, including mediation and treatments is viewed and revised as necessary. A progress note is written and signed by the Attending Physician at the time of each visit and he/she signs all orders ..."

On 3/11/24 at 3:17 PM, the survey team met with the U.S. FOIA (b) (6) U.S. FOIA (b) (6)), and LPN #2 who were informed of the above concerns for physician progress notes. The U.S. FOIA (b) could not speak to why the physicians were not entering their notes when visiting residents in the facility. There was no additional information provided by the facility.

11. On 3/7/24 at 11:05 AM, the surveyor reviewed Resident #42's hybrid medical records.

The Resident Face Sheet documented that Resident #42 had diagnoses that included but were not limited NJ Exec Order 26.4b1 ,

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NJ Exec Order 26.4b1 .

A review of the Medical Progress Notes (PN) written by Physician #1, from NJ Exec Order 2 to NJ Exec Orde were held in "DRAFT" by Physician #1 documenting a letter (Z, C, A) to keep the place. There was no other information evidenced in the Medical PN.

12. On 3/7/24 at 11:07 AM, the surveyor reviewed Resident #50's hybrid medical records.

The Resident Face Sheet documented that Resident #50 had diagnoses that included but were not limited to, NJ Exec Order 26.4b1

A review of the Medical Progress Notes (PN) written by Physician #1, from NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 were held in "DRAFT" by Physician #1 documenting a letter (Z, C, A) to keep the place. There was no other information evidenced in the Medical PN.

On 3/7/24 at 11:55 AM, the survey team interviewed Physician #1 over the phone regarding the medical PN for his residents. Physician stated he visited the residents in the facility and would write the medical PN at a later time. Physician #1 stated the medical PN that were in draft were not completed and the letter in the entry was a place holder to remind him to complete the note after visiting with the resident. Physician #1 acknowledged medical PN should be completed at the time of visiting the resident and available for the resident's medical record.

13. On 3/11/24 at 1:10 PM, the surveyor reviewed

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F 711	Continued From page 31 Resident #1's hybrid medical records. The Resident Face Sheet documented that Resident #1 had diagnoses that included but were not limited, NJ Exec Order 26.4b1 [redacted] The surveyor with LPN #4 reviewed the resident's paper and electronic medical records. There was no PN found for NJ Exec Order 26.4b1 to indicate a face-to-face visit and examination of Resident #1. 14. On 3/11/24 at 1:10 PM, the surveyor reviewed Resident #12's hybrid medical records. The Resident Face Sheet documented that Resident #12 had diagnoses that included, but were not limited to, NJ Exec Order 26.4b1 [redacted] The surveyor reviewed the resident's paper and electronic medical records. There were no PN found for NJ Exec Order 26.4b1 to indicate a face-to-face visit and examination of Resident #12. 15. On 3/11/24 at 1:10 PM, the surveyor reviewed Resident #16's hybrid medical records. The Resident Face Sheet documented that Resident #16 had diagnoses that included NJ Exec Order 26.4b1 [redacted]. The surveyor reviewed the resident's paper and electronic medical records. There were no PN found for NJ Exec Order 26.4b1 to indicate a face-to-face visit and examination of Resident #16.	F 711		

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F 711	Continued From page 32 A review of the facility's policy titled, "Medical Service Documetation Policy" with a reviewed date of 5/23/2023 under Procedure read: "2. Each resident must be seen by their attending physician or alternate at least once every thirty (30) days. The resident's total program of care, including mediation and treatments is viewed and revised as necessary. A progress note is written and signed by the Attending Physician at the time of each visit and he/she signs all orders ..." On 3/11/24 at 3:17 PM, the survey team met with the U.S. FOIA (b) (6) U.S. FOIA (b) (6)), and LPN #2 who were informed of the above concerns for physician progress notes. The U.S. FOIA (b) could not speak to why the physicians were not entering their notes when visiting residents in the facility. There was no additional information provided by the facility.	F 711		
F 755 SS=D	NJAC 8:39-23.2(b)(d) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(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		3/28/24

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F 755	Continued From page 33 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, and record review, it was determined that the facility failed to ensure that narcotic medication shift to shift sign in and out sheet was accurately signed. This deficient practice was identified for 1 of 3 units inspected during the facility unit inspection process. This deficient practice was evidence by the following: On 3/4/24 at 1:00 PM, the State Surveyor inspected the 2nd floor medication Cart A. During the inspection the State Surveyor reviewed the Narcotic Inventory book. All Narcotics stored in the medication cart were in order and The Narcotic Count shift to shift sign in sheet was found to have empty areas.	F 755	Specific Corrective Action: License staff identified with missing signature on the shift on shift sign in and sign out was re-educated on Narcotic Accountability Policy to ensure that narcotic medication shift to shift sign in and sign out sheet was accurately signed. All Licensed staff were re-educated on Narcotic Accountability Policy Identification: All residents have the potential to be affected by the deficient practice.	

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F 755	Continued From page 34 Review of the Narcotic Count Shift to Shift sign in sheet was found to lack nurse's signatures on 3/1/24 Outgoing Nurse 11:00 PM, 3/3/24 Incoming Nurse 3:00 PM and 3/4/24 Outgoing Nurse 11:00 PM. On 3/4/24 at 1:10 PM, the State Surveyor interviewed the Registered Nurse (RN#1) who stated that the sheet should be signed by every incoming and outgoing nurse on each shift. The surveyor reviewed the Narcotics Accountability Policy with a documented facility review date of 5/16/23 which states, "It is the policy of the facility to ensure that all narcotics are counted daily by two nurses and enter in the log." Under the Procedure 1. Section, "All Narcotics given must be documented in the narcotic accountability sheet. At the end of the shift, narcotics must be counted with two nurses. Outgoing and incoming nurses must count every end of the shift and sign the narcotic count form." On 3/5/24 at 10:00 AM, the surveyor discussed the discrepancy related to the shift sign in and out narcotic sheet with the U.S. FOIA (b) (6) [redacted] and the U.S. FOIA (b) (6). No further information was provided. NJAC 8:39-29.4(g)	F 755	Systemic Changes: DON/Designee will do a weekly audit to ensure that shift sign in and sign out sheet was accurately signed x3months and monthly thereafter. Monitoring: A QAPI will be done by DON/Designee on shift to shift sign in and sign out sheet was accurately signed weekly x3months and monthly thereafter. The report will be submitted to the Administrator and will be discussed during the quarterly meeting.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater;	F 759		3/28/24

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F 759	Continued From page 35 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to maintain a medication error rate below 5%. The surveyor observed 2 nurses administer 26 doses of medication to 3 residents and there were 3 errors which resulted in a medication error rate of 11.54 %. The deficient practice was evidenced by the following: On 3/8/24 at 8:06 AM, the State Surveyor observed the start of medication pass with the Licensed Practical Nurse (LPN#1) on the NJ Exec floor. 1. On 3/8/24 at 8:14 AM, LPN#1 administered NJ Exec Order 26.4b1 to Resident #19. The surveyor noted that the computer screen reviewed by LPN#1 documented NJ Exec Order 26.4b1 on the electronic medical administration record (eMAR). After Resident #19 medication administration was completed the surveyor interviewed LPN#1. LPN#1 stated that NJ Exec Order 26.4b1 was the same as NJ Exec Order 26.4b1 Review of the NJ Exec Order 26.4b1 Physician's Order (PO) revealed an order for NJ Exec Order 26.4b1 tablet that began on NJ Exec Orde. On 3/8/24 at 12:00 PM, the surveyor interviewed the U.S. FOIA (b) (6) who explained that the formula for NJ Exec Order 26.4b1 is different than that of NJ Exec Order 26.4b1.	F 759	Specific Corrective Action: 1. LPN #1 was re-educated on Medication Pass Policy and Medication pass competency observation Validation was done by DON/Designee/Pharmacy consultant. 2. LPN #1 was in-service on five rights on medication Administration. The staff must call the pharmacy for information about the drug if the label is different from the medication order. Label is different from the medication order. 3. LPN #1 was in-service to observe cautionary warning during the Administration medication and the adverse reaction if cautionary warning will not be followed. All licensed staff will be in-service on medication Administration techniques including cautiomary warning. Identification All residents have the potential to be affected by the deficient practice. Systemic Changes: All licensed nurse will be in-service on Medication Administration techniques to ensure that medication is administered	

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F 759	Continued From page 36 2. On 3/8/24 at 8:14 AM, LPN#1 administered NJ Exec Order 26.4b1 to Resident #19. The surveyor noted that the computer screen reviewed by LPN#1 documente NJ Exec Order 26.4b1 once daily with food on the (eMAR). LPN#1 did not offer any food to Resident #19 at the time of medication administration. After Resident #19 medication administration was completed the surveyor interviewed LPN#1. LPN#1 stated that she only offers food when the resident requests it. LPN#1 informed the surveyor that breakfast is served at about 9:00 AM. Review of the NJ Exec Order 26.4b1 Physician's Order (PO) revealed an order for NJ Exec Order 26.4b1 1 tablet once daily with food that began on NJ Exec Orde. On 3/8/24 at 1:00 PM, the surveyor interviewed the U.S. FOIA (b) (6)) who explained that NJ Exec Order 26.4b1 would be administered with food to avoid any NJ Exec Order 26.4b1 3. On 3/8/24 at 8:24 AM, LPN#1 administered NJ Exec Order 26.4b1 to Resident #18. The surveyor noted that the computer screen reviewed by LPN#1 documented NJ Exec Order 26.4b1 once daily on the eMAR. The surveyor observed that there was a cautionary sticker on the medication packaging that read, "Take with Food or Milk." LPN#1 did not offer any food to Resident #19 at the time of medication administration.	F 759	correctly, which includes the right drug, right time, right route, right dose, and right patient monthly x 3 months and quarterly thereafter. One license nurse will be observed for Medication Pass competency validation every shift by DON/Designee/Pharmacy Consultant for Medication Administration technique weekly x3 months and quarterly thereafter. Monitoring: A QAPI will be done by DON/Designee on Medication Pass Observation to all licensed staff Monthly x3 months and quarterly thereafter. The report will be submitted to the Administrator and will be discussed during the quarterly meeting.	

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F 759	Continued From page 37 After Resident #18 medication administration was completed the surveyor interviewed LPN#1. LPN#1 stated that she only offers food when the resident requests it. LPN#1 informed the surveyor that breakfast is served at about 9:00 AM. Review of the NJ Exec Order 26.4b1 Physician's Order (PO) revealed an order for NJ Exec Order 26.4b1 once daily for [redacted] days that began on NJ Exec Order 26. On 3/8/24 at 1:00 PM, the surveyor interviewed the US FOIA (b) who explained that NJ Exec Order 26.4b1 would be administered with food or milk due to the NJ Exec Order 26.4b1. The US FOIA (b) added that the manufacturer recommends taking NJ Exec Order 26.4b1 with food or mild to minimize NJ Exec Order 26.4b1. On 3/8/24 at 12:00 PM, the errors noted during medication passage were discussed with the U.S. FOIA (b) and U.S. FOIA (b) (6) The U.S. FOIA (b) and U.S. FOIA (b) could not explain why these errors resulted and did not provide any further information. NJAC 8:39-29.2 (d)	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		3/28/24

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F 761	Continued From page 38 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to properly store and refrigerate medication at the required temperature. This deficient practice was observed for 1 of 2 facility units inspected during the initial facility unit inspection. The deficient practice was evidenced by the following: On 3/4/24 at 1:00 PM, the State Surveyor accompanied by the RN#1 inspected the 2nd floor locked medication refrigerator located in the locked medication room. The thermometer located inside the refrigerator was found to be 32 degrees Fahrenheit (F) upon inspection. The State Surveyor inspected the medication that was in the refrigerator at the time: 1. 17x10 milliliter (ml) Insulin Pens	F 761	Specific Corrective Action 1. The 2nd Floor locked medication refrigerator that was registering 32 degrees had the thermostat was adjusted and set at 36degrees. 2. The Daily Freezer/Refrigerator Temperature Log Form with the instructions "refrigerator should be between 36degrees and 41degrees" has been updated. The daily Freezer/Refrigerator Temperature Log Form instruction "Refrigerator should be between 36degrees to 46degrees "which is the facility Medication Storage Policy. All staff were in service of the updated Daily Freezer/Refrigerator Temperature Log. All staff were in-service to report to Maintenance if the temperature is below or above the temperature range of	

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F 761	Continued From page 39 2. 1x3.7 (ml) Calcitonin Salmon Nasal Spray 3. 3x2.5 ml Latanoprost Ophthalmic Solution 0.005% 4. 1x1ml Tuberculin Purified Protein Derivative Diluted Aplisol 5. 1x30 ml opened Lorazepam Intensil Oral Concentrate 2mg/ml 6. 1x30 ml sealed Lorazepam Intensil Oral Concentrate 2mg/ml Upon inspection all the medications seemed to be in good condition The State Surveyor interviewed RN#1 who explained that the refrigerator temperature is inspected daily by the 11PM-7AM shift nurse. The State Surveyor then reviewed the Daily Freezer/Refrigerator Temperature Log which was documented as checked on 3/4/24 at 12:00 AM with a recorded temperature of 40 degrees F. The documented instructions on the log stated, "Refrigerators should be between 36 degrees F and 41 degrees F." Review of the Medication Storage Police revised by the facility on 5/22/23 documents, "Medications will be stored in a manner that maintains the integrity of the product, ensures safety of the customers, in accordance with state Department of Health guidelines and are accessible only to licensed nursing and pharmacy personnel." Review of the Procedure section H details, "Medications requiring refrigeration will be stored in a refrigerator that is maintained between 2-8 degrees Celsius (36-46 degrees F)." On 3/4/24 at 1:30 PM, the surveyor discussed the	F 761	36degrees to 46degrees. 3. RN was in-service on the medication storage policy on the medication requiring refrigeration maintained between 36-46degreesF on (2-8degrees)Celsius. All licensed staff were in-service on medication refrigeration temperature policy. Identification All residents have the potential to be affected by the deficient practice. Systemic Changes All licensed nurse were in-service to ensure that medication is stored and refrigerated at the required temperature monthly x 3 months and quarterly thereafter. The daily refrigerator temperature log will be checked daily to ensure within the specified range of 36-46degrees F by unit charge nurse in each floor. Daily temperature log will be written daily on the 24-hour report to be reviewed by the DON during the clinical meeting daily x 3 months All licensed nurse were in-service on the refrigerator log temperature documentation within the specified range of 36-46degrees F monthly x 3 months	

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F 761	Continued From page 40 discrepancy related to the 2nd floor refrigerator temperature with the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6). No further information was provided. NJAC 8:39- 29.4(b)2	F 761	and quarterly. Monitoring A QAPI will be done by the DON/Designee on proper storage and refrigeration on medication at the required temperature monthly x 3 months and quarterly thereafter. The report will be submitted to the administrator and will be discussed during the quarterly meeting.	
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. 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 prepare vegetables in the proper consistency for 2 of 4 residents (Resident #5 and #36) reviewed on a NJ Ex Order 26.4b1 This deficient practice was evidenced by the following: On 3/5/24 at 11:30 AM, the surveyor observed the lunch tray line. The U.S. FOIA (b) (6) requested a mechanical soft diet tray (mechanical soft diet is a type of diet that involves foods that are physically soft, making them easier to eat without the need for extensive chewing), which contained three whole fish sticks, regular	F 805	Specific Corrective Action: Resident #5 and Resident #36 with NJ Exec Order 26.4b1 will have their tray with meal already in a NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 directly from the kitchen. All dietary staff were in service that all modified diet will be prepared in an appropriate consistency directly from the kitchen before delivering it to the units to be served to the residents. Diet manual was updated. Identification:	3/28/24

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F 805	Continued From page 41 mixed vegetables (carrots, broccoli, and cauliflower) and mashed potatoes. The Surveyor interviewed the U.S. FOIA in reference to the fish sticks and vegetables served whole for a mechanical soft diet. The U.S. FOIA explained, "they do serve mechanical soft residents whole fish stick and regular mixed vegetables because they are considered fork mash-able or fork tender." The U.S. FOIA identified that the U.S. FOIA or resident will be able to mash the food with a fork at tableside. The Surveyor asked if mechanical soft diet consistency is considered chopped (bite size pieces) or minced (ground consistency)? The U.S. FOIA verified, "mechanical soft is considered minced consistency." 1. On 3/5/24 at 12:05 PM, the surveyor observed Resident #5 in their room with CNA #3 at bedside, on the NJ Exec Order 2 floor. CNA #3 stated the resident is on NJ Exec Order 26.4b1. The surveyor observed Resident #5 holding the whole fish stick and taking small bites as well as whole vegetables on the resident's tray. On 3/5/24 at 12:07 PM, the surveyor interviewed CNA #3 who verified that Resident #5 was on NJ Exec Order 26.4b1. CNA #3 explained that the fish sticks are soft, and the fish is minced within the fish stick breading. The surveyor observed CNA #3 cutting the mixed vegetables with a knife. The surveyor reviewed the International NJ Exec Order 26.4b1 which is a framework for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 for people with NJ Exec Order 26.4b1. Documentation on the NJ Exec Order NJ Exec O Levels & Information explains that NJ Exec Order 26.4b1 NJ Exec	F 805	All residents have the potential to be affected by the deficient practice. Systemic Changes: A weekly audit will be done by RDN or CDM to ensure that texture modified foods are prepared and delivered to the unit at the correct texture x 3 months and quarterly thereafter Monitoring: A QAPI will be done Dietitian on all modified diets to ensure the meals that are served to the residents on modified diet have proper consistency monthly x3 months and quarterly thereafter. The report will be submitted to the administrator and will be discussed during the quarterly meeting.	

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F 805	Continued From page 42	F 805		

that is NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 describes that a NJ Exec Order 26.4b1 can be NJ Exec Order 26.4b1. It also states that the food can be NJ Exec Order 26.4b1 "NJ Exec Order 26.4b1 A knife is not required to cut food but may be used to help load fork/spoon."

The surveyor reviewed Resident #5 Admission Face Sheet indicated the resident had diagnosis which included but not limited to: NJ Exec Order 26.4b1

A review of the quarterly Minimum Data Set dated NJ Exec Order 26 reflected a BIMS score of NJ out of 15 which indicated NJ Exec Order 26.4b1. A review of the Physician Orders (PO) NJ Exec Order 26, reflected a physician's order dated NJ Exec Order 26, for NJ Exec, NJ Exec Order 26.4b1, NJ Exec Order 26.4b1.

A review of the resident's individualized care plan reflected a focused area dated NJ Exec Order 26.4 and last reviewed NJ Exec Orde, that the resident has potential NJ Exec Order 26.4b1 due to dx. Interventions included but were not limited to: provide NJ Exec as NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1

A review of the treatment and encounter notes with a completed date NJ Exec Order 26. Precautions NJ Exec Order 26.4b1 Contraindications: No contraindications present. NJ Exec Order 2 Resident (Rt) treatment for NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 Rt able to NJ Exec Orde

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F 805	Continued From page 43 NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 noted with treatment NJ Exec Order 26.4b1 No overt signs and symptoms of NJ Exec Order 26.4b1. Response to treatment: Response to session interventions actively participates with skilled interventions, compliant with skilled interventions and compliant with trained techniques. Oral intake: NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 2. On 3/5/24 at 11:50 AM, the surveyor inspected the NJ Exec Order 26 floor dining room and observed Resident #36 seated in a wheelchair at a table. Resident #36 was observed receiving their lunch tray from CNA #1. Resident #36's lunch tray ticket read, "NJ Exec Order 26.4b1" and was observed with intact fish sticks, intact mixed vegetables, and mashed potatoes. The surveyor observed CNA #1 cut the fish sticks and mixed vegetables with a fork and knife. On 3/5/24 at 11:55 AM, the surveyor interviewed CNA #1 in reference to Resident #36's NJ Exec . CNA #1 explained that the resident is on NJ Exec Order 26.4b1 which is considered NJ Exec Order 26.4b1. CNA #1 indicated that since the resident's food had to be cut with a knife, it would probably not be considered to be NJ Exec Order 26.4b1 The surveyor reviewed Resident #36 Admission Face Sheet (Face Sheet is a one page an admission summary) indicated the resident had diagnosis which included but not limited to: NJ Exec Order 26.4b1 A review of the quarterly Minimum Data Set, an assessment tool, dated NJ Exec Order 26 reflected a Brief	F 805		

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F 805	Continued From page 44	F 805		

Interview of Mental Status (BIMS) score of [redacted] indicating the resident [redacted].

A review of the Physician Orders (PO) [redacted], reflected a physician's order dated [redacted], for [redacted]

A review of the resident's individualized care plan reflected a focused area dated [redacted], that the resident may be at [redacted] in [redacted] related to [redacted] and [redacted] Interventions included but were not limited to: [redacted] and monitor intake and tolerance.
No recent [redacted] available. [redacted] stated they are a new [redacted] company in the facility and has only been in the facility for a week.

On 3/5/24 at 11:55 AM, the surveyor interviewed the [redacted]) on the [redacted] floor dining as the [redacted] was not in the building. The surveyor had the [redacted] check an identified "[redacted]" containing tray prior to it being served to a resident. The [redacted] acknowledged that the food did not look [redacted], but stated if the food is [redacted] it is considered [redacted] oft. The [redacted] revealed that he was not sure if the food needs to be cut with a knife, it be considered [redacted]. The [redacted] explained that he would consult with the [redacted] as it was their expertise.

On 3/6/24 at 11:05 AM, the surveyor interviewed the [redacted] The [redacted] explained that residents can be served whole foods that must be fork [redacted]. The [redacted]

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F 805	Continued From page 45	F 805		

established that foods need to be NJ Exec Order 26.4b1 [redacted] and should not need to be cut with a knife. The U.S. FOIA established that any foods that need to be cut with a knife, need to be cut in NJ Exec Order 26.4b1 [redacted] which should be done in the kitchen.

On 3/6/24 at 1:30 PM the U.S. FOIA provided the surveyor with diet information titled, Mechanical Soft Diet, no reviewed date was noted. The U.S. FOIA stated that the information can be found in their diet manual. The provided diet information stated, "the mechanical soft diet is designed to minimize the amount of chewing necessary to ingest food and increase the ease of swallowing. The diet is used for individuals with chewing and swallowing problems due to irritation of the mouth, lack of teeth, surgery, therapy, or dysphagia. Grinding foods with a commercial food processor can modify the texture of the foods. Menu planning guidelines follow the regular diet with the following changes: meats are ground to the consistency of ground meat, serve soft and diced fruits and vegetables." The diet information also included a reference guide with all food groups broken into two categories: food recommended and foods to limit. Under the vegetables food group for foods recommended it states, "soft and diced vegetables and foods to limit included: broccoli and cauliflower." Under the fish food group for foods recommended, it states, "ground breaded fish and foods to limit whole fish."

On 3/11/24 at 1:30 PM, the survey team met with U.S. FOIA (b) (6) [redacted]) and U.S. FOIA (b) (6) [redacted]) to review concerns. The U.S. FOIA (b) stated all residents on

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HOMESTEAD REHABILITATION & HEALTH CARE CENTER	129 MORRIS TURNPIKE NEWTON, NJ 07860

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F 805	Continued From page 46 NJ Exec Order 26.4b1, the food should have been prepared in the kitchen and not cut at table side to ensure all foods are prepared to the correct size. No further information was provided. N.J.A.C. 8:39 - 17.4(a)	F 805		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices as well as store, label, and discard potentially hazardous foods in a manner to prevent food borne illness. This deficient practice was observed and	F 812	Specific Corrective Action: All milk containers and condiment cups without open or use by dates were removed and discarded. Dietary staff was in serviced on labeling and dating. The ovens were cleaned, and staff were	3/28/24

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F 812	Continued From page 47 evidenced by the following: On 3/4/24 at 09:25 AM, the surveyor in the presence of the U.S. FOIA (b) (6)) observed the following during the kitchen tour: 1. During the kitchen inspection, the surveyor observed on the inside of the 3 door refrigerator, individual 2 ounce (oz) condiment cups with parmesan cheese without open or use by labels. The surveyor also observed a gallon of whole milk as well as a gallon of fat-free milk and a 1/2 gallon of 2% milk container, all opened without open or use by dates. The U.S. FOIA explained that the facility goes by the expiration dates printed on the large containers of parmesan cheese and the use by dates on the milk containers to evaluate their freshness. The U.S. FOIA agreed that all products when opened should have an open and use by date clearly documented by the kitchen staff. 2. During the kitchen inspection, the surveyor observed, inside of the standing dual ovens, black-colored baked on debris on both ovens. The U.S. FOIA stated the ovens are cleaned weekly but could not state why the debris was present at this time of observation or when the ovens were cleaned last. 3. During the kitchen inspection, the surveyor observed in a preparation area, 14 open spice containers, with written dates on bottles. The U.S. FOIA could not differentiate if the written dates were received, open or use by dates. Above the spice containers, the surveyor observed multiple wiring, and plastic tubing all with grey colored dust like debris. The U.S. FOIA stated the maintenance department is responsible for	F 812	in serviced on the procedure for cleaning the ovens. A weekly cleaning schedule is posted in the kitchen. The 14 spice containers were discarded and replaced to include proper dating and the area above the spice containers was cleaned. The windows and screens were cleaned, and a cleaning schedule was made for maintenance to be cleaned monthly or as needed. The 2L container of yellow colored liquid, 1 gallon of soy sauce, gravy aid and Worcestershire were discarded and replaced with new items to include correct dating. Dietary staff was in serviced on labeling and dating. The dry storage area was corrected to include proper dating of canned goods and dry goods with proper dating. The fan was cleaned and will be cleaned weekly and/or as needed. DA #1 was in serviced Dietary department Dress code which included proper coverage of hair with hairnet. The mislabeled scrambled eggs were discarded, and kitchen staff reminded of the importance of writing the correct date. The walk-in refrigerator was cleaned (fans, light fixture, and ceiling) and the walk-in freezer was cleared of ice to ceiling,floor, and fans.	

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F 812	Continued From page 48 cleaning that area but could not determine when the area was cleaned last. 4. During the kitchen inspection, the surveyor observed all windows along the wall that appeared to be soiled with yellow color debris. The window screens were observed with dust-like debris. The [redacted] stated the maintenance department also is responsible for cleaning that area but could not determine when the area was cleaned last. 5. During the kitchen inspection, the surveyor observed on the shelf under the chef preparatory table, a 2 liter container with a yellow colored liquid without an open or use by label (no date), an opened 1 gallon bottle of soy sauce, 1 gallon bottle of gravy aid, and 1 gallon Worcestershire sauce all dated. The [redacted] could not explain whether the dates documented were open, use by or delivered dates. The [redacted] stated the yellow colored liquid was cooking oil that was poured from a larger container; no labeling observed on either container (larger container and 2 liter container). 6. During the kitchen inspection, the surveyor observed in the dry storage room, multiple canned goods without delivered/received dates. The surveyor further observed an open bag of tricolor and spiral pasta, no open or discard dates observed. On the top shelf the surveyor observed a circulating fan with a brownish colored caked on debris. The [redacted] stated that all delivered items should have a received date, the opened bags of pasta should be labeled with an open and use by date. The [redacted] informed the surveyor that the maintenance department was responsible for the cleaning of the fan but could	F 812	All Dietary food supplies received were dated upon delivery. All Dietary staff were re-educated on policies in maintaining proper kitchen sanitation practices; storing, labeling, and discarding potentially hazardous foods in a manner to prevent food borne illness. Identification: All residents have the potential to be affected by the deficient practice. Systemic Changes: A comprehensive monthly sanitation audit will be done by RDN or CDM to cover areas of personnel, food production, equipment, dry storage, refrigerator & freezer, chemical storage, pot and pan sink, dishwasher, and dishwashing area. In servicing will continue for all staff and new hires monthly x 3 months and quarterly thereafter Dietary supervisor/cook will do weekly kitchen environmental rounds. Reports will be submitted to FSD/Designee for review and implementation of corrective action for any findingsmonthly x 3 months and quarterly thereafter	

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F 812	Continued From page 49 not determine when the area was cleaned last. 7. During the kitchen inspection, the surveyor observed Dietary Aide #1 (DA#1) with a hat and hairnet on, but sides of his hair sticking out. The U.S. FOIA [redacted] agreed that DA#1 should fully cover his hair. 8. During the kitchen inspection, the surveyor observed a small bowl of cooked scrambled eggs with a label dated: 2/3/24 inside a 3 door standing refrigerator. The U.S. FOIA [redacted] stated she thought the date should have read 3/2/24, not 2/3/24. On the bottom shelf of the refrigerator, the surveyor observed one opened container of liquid eggs without an open/use by date. 9. During the kitchen inspection, the surveyor inspected the walk-in refrigerator and observed the fans, light fixtures, and parts of the ceiling with dust-like debris. In the walk-in freezer, the surveyor observed ice on ceiling, floor, and fans. The U.S. FOIA [redacted] explained that the maintenance department was responsible for maintaining the area but could not determine when the area was cleaned last. On 3/5/24 at 10:15 AM, the U.S. FOIA [redacted] provided the surveyor with multiple facility policies including Labeling and Dating, Dietary Department Dress Code, and Cleaning Instructions: Refrigerators. All policies were reviewed in December 2023. The Labeling at Dating policy states under procedures, 1. "All food received in the building, dry, dairy, refrigerated or frozen, must have a "received date"." 2. "Received date and expiration date must be visible." 5. "All foods prepared in the kitchen must be dated with a "use by" date and discarded in three days." 8.	F 812	Monitoring: A QAPI will be done FSD/Designee to ensure proper kitchen sanitation practices is maintain, storing, labeling, and discarding potentially hazardous foods, dating food supplies upon delivery monthly x 3months and quarterly thereafter. The report will be submitted to the administrator and will be discussed during the quarterly meeting.	

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F 812	Continued From page 50 "Opened bulk - mayo, syrup, mustard, ketchup follow manufacturers expiration date. Once opened, must be dated with "open date", and refrigerated." On 3/11/24 at 1:30 PM, the survey team met with the U.S. FOIA (b) (6) and U.S. FOIA (b) (6)) to review concerns. The U.S. FOIA (b) and U.S. FOIA had no comments regarding the kitchen.	F 812		
F 880 SS=E	NJAC 8:39-17.2(g) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		3/28/24

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F 880	Continued From page 51 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 52 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to follow appropriate infection control practices to decrease the possibility of spreading infection during medication administration and failed to ensure that the sharps container (SC) that were filled with contaminated sharps/needles were disposed properly, for 3 of 3 units reviewed for infection control practices. This deficient practice was evidence by the following: 1. On 3/7/23 at 10:06 AM, the surveyor observed Licensed Practical Nurse # 2(LPN#2) perform a [NJ Exec Order] treatment to Resident #1. LPN #2 went to wash her hands at the sink in the resident's room after entering the resident's room. LPN #2 turned on the faucet, wet her hands with water from the sink, applied soap, lathered her hands for 16 seconds outside the running water prior to rinsing, dried her hands with a paper towel from the dispenser on the wall and used another paper towel to turn off the faucet. On 3/7/24 at 10:11 AM, LPN #2 after cleansing the resident's [NJ Ex Order 26.4b1], removed her gloves and went to wash her hands at the sink. LPN #2 turned on the faucet, wet her hands with water from the sink, applied soap, lathered her hands for 10 seconds outside the running water prior to rinsing, dried her hands with a paper towel from	F 880	Specific Corrective Action: 1. LPN #1 AND LPN #2 were in-service on the Handwashing Policy and LPN#1 and 2 were observed by DON on Handwashing competency validation observation. 2. LPN #1 was in-service by DON/Designee in cleaning the pitcher with soap and water before filling up new water from the water dispenser. 3. Excess full sharp containers on the 3rd and 4th floor storage area were removed and boxed by Housekeeping Director using the hazard waste container. Housekeeping Director called the contracted hazard waste company to picked up the medical waste including all sharp container. 4. All staff were in service by DON/Designee to call the maintenance department to pick up all sharp containers when full. Identification: All residents have the potential to be affected by the deficient practice. Systemic Changes:	

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F 880	Continued From page 53 the dispenser on the wall and used another paper towel to turn off the faucet. On 3/7/24 at 10:16 AM, LPN #2 removed her gloves, sanitized her hands with alcohol based hand rub (ABHR) and went to the treatment cart to get another dressing for the [NJ Exec Order] treatment. LPN #2 retrieved the treatment cart key, opened the cart, obtained the [NJ Exec Order 26.4b] and returned to the resident's room. LPN #2 went in room, closed the door for privacy, and applied gloves to apply treatment and NJ Exec Order 26.4b1. LPN #2 did not sanitize her hands prior to applying gloves. On 3/7/24 at 10:20 AM LPN#2 applied [NJ Exec Order 26.4b] to [NJ Exec Order] removed her gloves and went to wash her hands at the sink. LPN #2 turned on the faucet, wet her hands with water from the sink, applied soap, lathered her hands for 8 seconds outside the running water prior to rinsing, dried her hands with a paper towel from the dispenser on the wall and used another paper towel to turn off the faucet. On 3/7/24 at 10:25 AM, the surveyor interviewed LPN #2 after the wound treatment observation about hand hygiene. The surveyor informed LPN#2 of the hand hygiene concerns observed during the [NJ Exec Order] treatment. LPN #2 stated hand hygiene should be at least for 20 seconds lathering outside the stream of running water. LPN #2 did not realize she did not sanitize her hands upon re-entering the room during wound treatment. LPN # 2 acknowledged hand hygiene should have been performed when re-entering room, and prior to procedure. On 3/7/24 at 12:00 PM, the U.S. FOIA (b) (6)	F 880	DON/Designee will do monthly in service on Handwashing Policy monthly x 3 months and quarterly thereafter One nurse on every shift will be observed for Handwashing competency observation validation by DON/Designee weekly x3months and quarterly thereafter. Medication water pitcher will be sent to dietary for sanitizing daily by 11-7 shift charge nurse on every floor. All nurses in every shift were in-serviced The medication water pitcher will be clean with soap and water before replenishing the water every shift by Licensed staff on duty in each shift. All nurses in every shift were in-serviced The Housekeeping Director will check the soiled utility room daily to ensure that sharp containers boxes are not overflowing. The Housekeeping Director will inform the Maintenance Department to call the hazard waste company for pick up if the sharp container boxes are full. Monitoring: DON/Designee will do monthly QAPI on the cleaning and sanitizing of the medication cart pitcher 3 months and quarterly thereafter. Report will be submitted to the Administartor to discuss during quarterly meeting.	

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F 880	Continued From page 54 U.S. FOIA (b) provided the facility's hand hygiene policy. The U.S. FOIA stated hand hygiene should be performed at least 20 seconds, lathering hands outside the stream of running water. A review of the facility's policy titled "Hand Washing" with a revised date of 5/13/2023, under Policy it read: " ...In order to prevent transmission of infectious diseases, all personnel working in the facility are required to wash their hands before and after resident contact, before and after performing any procedure ..." Under Process, Hand hygiene techniques it read: "1...Wet hands with warm (not hot) water, apply soap to hands, and rub hands vigorously outside the stream of water for 20 seconds, covering all surfaces of the hands and fingers ..." On 3/11/24 at 3:17 PM, the surveyor met with the U.S. FOIA (b) (6) and LPN #2 about the above concerns. There was no additional information provided by the facility. 2. On 3/8/24 at 8:06 AM, the State Surveyor observed the start of medication pass with the Licensed Practical Nurse (LPN#1) on the 3rd floor. a. LPN#1 proceeded to wash her hands appropriately but used the paper towel (lying by the sink against the backsplash area) used to previously dry her hands to wipe the water that had splattered around the sink. LPN#1 then took a new paper towel from the unprotected pile of paper towels and continued drying her hands, wiped around the sink, and proceeded to dry her hands again with the same contaminated paper towel.	F 880	DON/Designee will do monthly observation on hand hygiene competency observation and validation to all staff monthly x3 months and quarterly thereafter. The report will be submitted to the Administrator and will be discuss during the quarterly meeting. The Housekeeping Director will do a monthly QAPI on sharp container storage to ensure that the sharp containers are picked up timely by the hazard waste company monthly x3 months and quarterly thereafter. The report will be submitted to the Administrator and will be discussed during the quarterly meeting.	

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F 880	Continued From page 55	F 880		

b. LPN#1 proceeded to pick up a pitcher filled with water that LPN#1 explained was from the previous shift. LPN#1 spilled out the water from the pitcher and without cleaning the pitcher filled the pitcher with new water from the water dispenser and placed it on the medication cart, without rewashing her hands.

c. LPN#1 removed an open saline solution, that was not dated found on top of a cart. LPN#1 explained that she would have to discard this open bottle of saline as she did not know when it was opened or what it was used for. LPN#1 handled this contaminated bottle of saline solution and proceeded to handle medication, administer medication without washing or sanitizing her hands.

On 3/8/24 at 12:00 PM, the State Surveyor discussed the breeches in infection control during the medication passage with the [redacted] and [redacted] The [redacted] explained that the pitchers should be cleaned daily prior to refilling with water and that LPN#1 should have known to wash her hands after touching the contaminated saline solution prior to beginning medication passage. There was no further information provided.

3. On 3/11/24 at 12:41 PM, the surveyor toured the soiled utility room in the 3rd and 4th floor nursing unit with the facility's [redacted].

On the 3rd floor Soiled Utility Room (SUR) the surveyor observed several SC piled up in a bio-hazard bag that were not sealed and overflowing. The SC bins were observed to be filled with contaminated needles.

On 3/11/24 at 12:45 PM, in the 4th floor soiled

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F 880	Continued From page 56 utility room, the surveyor observed several SC stored in a bio-hazard bag that were unsealed and overflowing. The SC bins were observed to be filled with contaminated needles. The surveyor interviewed the U.S. FOIA (who stated that it was the Maintenance Department's responsibility to dispose the SC bins. The surveyor interviewed the maintenance staff member who stated that he was not aware that it was part of his responsibility to dispose of filled SC since he started working for the facility in NJ Ex Order 26.4(b)(1) and was the only employee of the maintenance department. The maintenance staff member added that he was not informed by any staff to empty the SC bins inside the soiled utility room. A review of the facility's policy and procedure titled, "Waste Management" under "III. Discard contaminated sharps immediately or as soon as feasible in sharps containers." "6. Disposal of full sharps containers the responsibility of Environmental Services personnel." On 3/11/24 at 3:30 PM, the survey team discussed the above concern with the facility's U.S. FOIA (b) and U.S. FOIA (No further information was provided.	F 880		
F 882 SS=F	N.J.A.C. 8:39-19.4 Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)	F 882		4/30/24

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	315378	A. BUILDING _____ B. WING _____	C 03/12/2024

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F 882	Continued From page 57 (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on facility staff interviews and review of other pertinent facility documentation, it was determined that the facility failed to ensure that the designated U.S. FOIA (b) (6)) had completed specialized training in infection prevention and control and was qualified by certification and experience for 1 of 1 staff member reviewed in accordance with Center for Medicare and Medicaid Services (CMS) and New Jersey State guidelines. This deficient practice was evidenced by the following: Reference: State of New Jersey Department of Health Executive Directive No 20-026-1 dated October 20, 2020, revealed the following: ii. Required Core Practices for Infection Prevention and Control: Facilities are required to have one or more	F 882	Specific Corrective Action: Facility hired an LPN that who completed the Infection Preventionist Training Course by CDC and will be in charge as IPCP. The LPN has been an employee of the facility since NJ Exec Order 26.4b1. Please see attached training plan proof of completion and certification Facility is looking to have a contract with a qualified Infectious Disease Practitioner Consultant to provide on-site management of the Infection Control Prevention and Infection Control Program. Identification: All residents have the potential to be	

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F 882	Continued From page 58 individuals with training in infection prevention and control employed or contracted on a full-time basis or part-time basis to provide on-site management of the Infection Prevention and Control (IPC) program. The requirements of this Directive may be fulfilled by: a. An individual certified by the Certification Board of Infection Control and Epidemiology or meets the requirements under N.J.A.C. 8:39-20.2; or b. A Physician who has completed an infectious disease fellowship; or c. A healthcare professional licensed and in good standing by the State of New Jersey, with five (5) or more years of Infection Control experience. iv. Facilities with 100 or more beds or on-site hemodialysis services must: 1. Hire a full-time employee in the infection prevention role, with no other responsibilities and must attest to the hiring no later than August 10, 2021. During an interview, in the presence of the facility's U.S. FOIA (b) (6)) on 3/11/2024 at 10:31 AM, the surveyor interviewed the Licensed Practical Nurse #2 (LPN#2), who served the role as the facility's U.S. F LPN #2 stated that her status to date was a per-diem employee. LPN #2 also stated that she was still in-training and have not yet completed the certification. LPN #2 explained that her work hours every week can be 40 hours or less. LPN #2 added that at times she would work on the unit to administer medications in a clinical role and does wound	F 882	affected by this deficient practice. Systemic Changes: HR will do an audit to ensure that the facility will have a qualified Infection Control Preventionist on staff monthly x 3 months and quarterly thereafter Marketing Director will continue to reach out to doctor's office specilaized in Infectious Disease for a contract as consultant. Monitoring: Administrator will do a weekly review on all qualified Infection Control Preventionist application and Infectious Disease Practices that will be interested to manage the Infection Prevention and Control Program until the facility will be able to hire the qualified candidates.	

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F 882	Continued From page 59 rounds with the wound team. At 3/11/34 3:30 PM, the U.S. FOIA (b) (6) and U.S. FOIA clarified that LPN #2 did not complete any type of infection control training or certification to date. The survey team met with the U.S. FOIA (b) U.S. FOIA and LPN #2 at 3/11/2024 at 3:30 PM and discussed that LPN #2 did not meet the qualifications to be the U.S. F LPN #2 did not have the NJ Exec Order 26.4b1 of experience as an U.S. F and it was not her only designated job title. NJAC 8:39-20.2	F 882		

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S 000	Initial Comments THE FACILITY WAS 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: REPEAT DEFICIENCY Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. This deficient practice was evidenced by the following. Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General	S 560	Specific Corrective Action 1. The facility scheduled agency staff to supplement staffing needs based on census to meet the required direct care staff to resident ratios: 7-3 shift 1:8, 3-11 shift 1:10, 11-7 shift 1:14 2. Admission Director will send a daily census notification to the staffing coordinator to ensure that facility has meet the required staffing for the current residents census	3/28/24

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

Electronically Signed | 03/28/24

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S 560	Continued From page 1 Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher.	S 560	3. Admission Director will consult DON, staffing coordinator for any prospective admission to ensure that there will be enough staff to cover the required staffing ratios for 3 shifts before admission will be approved. 5. The facility is actively recruiting certified nursing assistant and Nursing assistant for the C.N.A class by placing a online ad and newspaper, schools, community work force agency and working directly with recruitment agency to cover the staffing requirements 6. The facility has instituted a sign-on bonus, employee referral program . 7. Facility is sponsoring to pay the tuition for nursing assistant class. 8. The facility has instituted different incentive bonus programs for current staff to assist with the covering staffing requirements. 9. Facility had increased the hiring rate for year 2024 to attract qualified candidates 10. Facility acquired a contract with a staffing agency to supplement staffing needs Identification	

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S 560	Continued From page 2 (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the 1-week period beginning 2/25/24 and ending 3/2/24 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements for 7 of 7 day shifts. The facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: 1. For the week of staffing prior to survey from 2/25/2024 to 3/2/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -2/25/24 had 6 CNAs for 64 residents on the day shift, required at least 8 CNAs. -2/26/24 had 6 CNAs for 64 residents on the day shift, required at least 8 CNAs. -2/27/24 had 5 CNAs for 63 residents on the day shift, required at least 8 CNAs. -2/28/24 had 6 CNAs for 62 residents on the day shift, required at least 8 CNAs. -2/29/24 had 6 CNAs for 60 residents on the day shift, required at least 7 CNAs. -3/1/24 had 6 CNAs for 60 residents on the day shift, required at least 7 CNAs.	S 560	All residents have the potential to be affected by this deficient practice. Systemic Changes 1. Provide a comprehensive orientation program and structured preceptorship. DON/Designee will monitor daily the progress of the newly hires and obtain feedback daily from the new employee. 2. Human Resources Coordinator will do a monthly monitoring and tracking for the retention of newly hired CNA/NA monthly 3. Human Resources Coordinator will do a monthly monitoring and tracking of CNA/NA termination and resignation. 4. The Director of Nursing will work with the Staffing Coordinator in reviewing the Nursing/Certified Nursing Assistant Monthly Schedule to ensure appropriate staffing is in place. 5. The facility offers per diem flexible schedule Monitoring 1. Human Resource Coordinator will do a QAPI on retention of newly hired CNA to ensure that Nursing department will have enough CNA to cover state required staffing to meet the resident's needs monthly x3 months and quarterly thereafter. Reports will be submitted to the	

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S 560	Continued From page 3 -3/2/24 had 5 CNAs for 60 residents on the day shift, required at least 7 CNAs. Complaint #: NJ00169688 2. For the week of Complaint staffing from 11/12/2023 to 11/18/2023, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -11/12/23 had 5 CNAs for 66 residents on the day shift, required at least 8 CNAs. -11/13/23 had 6 CNAs for 66 residents on the day shift, required at least 8 CNAs. On 3/12/23 at 12:24 PM , the surveyor discussed the lack of required staff with the Director of Nursing and Licensed Nursing Home Administrator who did not provide any further information.	S 560	QAPI committee monthly and discussed during the Quality Assurance quarterly meeting. 2. Human Resource Coordinator will do a QAPI on termination and resignation of CNA to ensure that Nursing department will have enough CNA to cover state required staffing to meet the resident's needs monthlyx3 months and quarterly thereafter. Reports will be submitted to QAPI committee and will be discussed during the Quality Assurance quarterly meeting. 3. Director of Nursing/Designee will do a monthly QAPI on Nursing Daily Staffing Schedule to ensure that staffing ratios in all 3 shifts are maintained to meet the resident's needs monthly x 3 months and quarterly thereafter. Reports will be submitted to the QAPI Committee monthly and discussed during Quality Assurance quarterly meeting.	
S1030	8:39-11.2(c) Mandatory Resident Assessment and Care Plans (c) Each resident shall be examined by a physician or advanced practice nurse within five days before, or 48 hours after, admission. This REQUIREMENT is not met as evidenced by: Based on interview, and record review it was determined that the facility failed to have residents evaluated, history and [NJ Ex Order 26.4(b)] ([NJ Ex Ord])	S1030	Specific Corrective Action:	3/28/24

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S1030	Continued From page 4 performed within 48 hrs. of admission by the physician in accordance with New Jersey State requirements. This deficient practice was noted for 4 of 4 residents reviewed for new admission requirements, Resident #217, #218, #18 and #58 This deficient practice was evidenced by the following: 1. On 3/7/24 at 10:02 AM, the surveyor reviewed the Electronic Medical Record (E-Mar) for Resident #217, who was documented as admitted to the facility on NJ Exec Order 26. Review of the Face Sheet (a one-page summary about the patient) (FS) reflected Resident #217 was admitted with diagnosis that included but were not limited to NJ Exec Order 26.4b1 Review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order documented that Resident #217 was admitted to the facility on NJ Exec Order 2 from a "NJ Exec Order 26.4b1 ." Review of the NJ Exec Order 2 Progress Note Text documented by nursing that Resident #217 was admitted to the facility, NJ Exec Order 26.4b1 Review of Facility Progress Notes and the paper chart NJ Exec Order 26 to NJ Exec Order did not present any NJ Exec Order 26.4b1 performed by the Physician. The physician did open a note in the E-Mar on NJ Exec Orde, typing a single letter and left the note in draft status.	S1030	Resident #217 NJ Exec Order 26.4b1 was completed on NJ Exec Order 26.4b1. Resident #218 NJ Exec Order 26.4b1 was completed on NJ ENJ Exec Order 26.4b1. Resident 58 Copy of paper NJ Exec Order 26.4b1 l dated NJ Exec Order 26.4b1 was placed on the physical chart. Resident #18 NJ Exec Order 26.4b1 was completed on NJ ENJ Exec Order 26.4b1 All Physicians were in-service regarding Medical Service Documentation Policy that residents must be evaluated, Hostory and Physicals performed in 48 hours admission. Identification: All residents have the potential to be affected by this deficient practice. Systemic Changes: 11-7 unit nurses will do a monthly audit to ensure that all H&P for new admission and re-admission was completed within 48 hours, physician's monthly orders were signed timely, and all progress notes were done once every 30days. Audit reports will be submitted to the DON/Designee for review.	

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S1030	Continued From page 5 2. On 3/7/24 at 10:08 AM, the surveyor reviewed the Electronic Medical Record (E-Mar) for Resident #218, who was documented as admitted to the facility on [redacted]. Review of the FS reflected Resident #218 was admitted with diagnosis that included but were not limited to [redacted]. Review of the Admission MDS, dated [redacted] documented that Resident #218 was admitted to the facility on [redacted] from a "[redacted]" Review of the [redacted] Progress Note Text documented by nursing that Resident #218 was admitted to the facility, [redacted]." Review of Facility Progress Notes and the paper chart [redacted] to [redacted] did not present any [redacted] performed by the Physician. The physician did open a note in the E-Mar on [redacted], typing a single letter and left the note in draft status. On 3/07/24 at 12:00 PM, the surveyor team conducted a phone interview with Physician #1, who stated "I have the all the patient notes with me." Physician #1 further explained that he writes on paper and takes it with him. Physician #1 acknowledged he is very backed up on typing the written notes and that he types a letter and leaves the notes in draft as a reminder to complete the notes. On 3/07/24 at 12:15 PM, the survey team	S1030	Administrator will addressed with the physicians all documentations that were not done or completed timely based on the audit review done by Nursing staff monthly x 12 months Monitoring: A QAPI will be done by DON/Designee to ensure that all H&P for new admission and re-admission was completed within 48 hours, physician's monthly orders were signed timely, and all progress notes were once every 30 days monthly x3 months and quarterly thereafter. Reports will be submitted to the Administrator and will be discussed during the quarterly meeting.	

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S1030	Continued From page 6 interviewed the Licensed Nursing Home Administrator (LHNA) who stated that physician documentation is an ongoing problem and has been discussed with the physicians. On 3/8/24 at 11:40 AM, the Director of Nursing (DON) provided a copy of the facility policy titled, "Medical Service Documentation Policy" with a reviewed date of 5/23/23. Under the procedure section of the policy it states, 1. Every resident shall have admission/re-admission or within 48 hours. On 3/12/24 at 12:30 PM, the survey team met with the LNHA and DON. The LNHA stated they have spoke with the facility physicians and the resident documentation will be completed correctly and on time. 3. On 3/7/24 at 10:41 AM, the surveyor reviewed Resident #18's hybrid medical records. Review of Resident #18's Admission Record (AR) reflected that Resident #18 was admitted to the facility with medical diagnoses that included but were not limited to NJ Exec Order 26.4b1 [redacted]. Review of the Comprehensive MDS dated [redacted] reflects that Resident #18 was admitted to the facility on [redacted] from a NJ Exec Order 26.4b1 [redacted] The Comprehensive MDS dated [redacted] reflects that Resident #18 has a Brief Interview for Mental Status (BIMS) of [redacted] out of 15, establishing an NJ Exec Order 26.4b1 [redacted].	S1030		

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S1030	Continued From page 7 Review of the Medical Progress Notes (PN) written by Physician #1, from [NJ Exec Order 26.4] [NJ Exec Orde] were held in "DRAFT" by Physician #1 documenting a letter (Z, C, A) to keep the place. No initial [NJ Exec Order 26.4b1] were performed by Physician #1 only a "z" Draft on 2/9/24. No other information was evidenced in the Medical PN.	S1030		

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{E 000}	Initial Comments	{E 000}		
{F 000}	Corrected INITIAL COMMENTS An onsite revisit was conducted on 05/14/2024 to verify the facility's Plan of Correction regarding the 3/12/2024 Recertification survey. Census: 67 Sample Size: 3 The facility was found to be not in compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities, specifically F689.	{F 000}		
{F 689} SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: An onsite revisit was conducted on 5/14/24 to verify the facility's plan of correction (POC) with a completion date of 3/28/24. The facility's POC indicated that the Director of Nursing (DON)/Designee will do a root cause analysis review on all incident and accidents reported after the completion of the incident/accident investigation to ensure that care plan (CP) will have an appropriate intervention	{F 689}	Specific Corrective Action a. [redacted] was in-serviced by Administrator to ensure that the incident report is available at all times during her absence. b. The care plan for resident#3 was updated in the electronic medical record's care plan section after the IDCP team's review	6/7/24

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

Electronically Signed | 06/07/2024

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
	315378	A. BUILDING _____ B. WING _____	R-C 05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & HEALTH CARE CENTER	129 MORRIS TURNPIKE NEWTON, NJ 07860

(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 689}	Continued From page 1 monthly. Based on interview, record review, and review of the POC, it was determined that the facility failed to ensure the residents who had a [NJ Exec Order 26.4b1], were accurately investigated for [NJ Exec O][NJ Exec Order 26.4b1] This deficient practice was identified for 1 of 3 residents reviewed for [NJ Exec O] Resident #3. 1. On 5/14/24 at 10:35 AM, the surveyor observed Resident #3 in the hallway outside of their room in a wheelchair. The surveyor observed the resident's NJ Exec Order 26.4b1 with [NJ Exec Order 26.4b1] and call light within reach. A review of the Admission Record for Resident #3 revealed that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Exec Order 26.4b1 . A review of Resident #3's NJ Exec Order 26.4b1 / Minimum Data Set ([NJ Exec Orde]/MDS), an assessment tool used to facilitate the management of care [NJ Exec Orde]/MDS dated [NJ Exec Order 26.4b1], reflected that Resident #3 has a BIMS score of [NJ Ex] out of 15, indicating [NJ Exec Order 26.4b1] . A review of the history of [NJ Exec O] for Resident #3 revealed that they had [NJ Exec Order 2] on [NJNJ Exec Orde] with [NJ Ex] reported. The facility was unable to provide a [NJ Ex] investigation report, including A review of the form titled, "Resident Incident Tracking Form and QA (Quality Assurance) Checklist" which summarized the detailed	{F 689}	c. All License nurse were in-service by the DON on the Fall policy and procedure and resident prevention program Identification All residents have the potential to be affected by the deficient practice Systemic Changes Summary of the incident report will be completed by the DON/Designee after a fall incident that will include information such as resident's profile, Actual incident, Investigation, connclusion base on root cause analysis,fall prevention and care plan updates Summary of incident reports will be discussed with the IDCP team weekly DON/Designee will audit all incident/Accident report weekly to ensure that incident/accident report is complete and accurate. Monitoring DON/Designee will do a monthly QAPI all incident/accident reports x 3 months and quarterly thereafter to ensure that incident/accident report is complete and accurate. Report will be submitted to the administrator and will be discussed during the quarterly meeting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 689}		{F 689}		

Continued From page 2

information of the [NJ Exec Order 26.4b1] on [NJ Exec Order 2] that included the NJ Exec Order 26.4b1.

A review of the resident's CP revealed that the CP was not updated to ensure that an appropriate intervention was added after the [NJ Exec Order 26.4b1] on [NJ Exec Order 2] to prevent [NJ Exec Order 26.4b1].

On 5/14/24 at 11:50 AM, the surveyor requested from the facility's U.S. FOIA (b) (6) for further information on the RITF and QAC form that was indicated in their POC to current prior deficiency.

On 5/14/24 at 2:07 PM, the survey team informed the [U.S. FOIA (b)] of the above concerns for Resident #3. The [U.S. FOIA (b)] stated it was the responsibility of the [U.S. FOIA] to conduct a review of all [NJ Ex] investigations and oversee fall committee meetings with the interdisciplinary team. The [U.S. FOIA (b)] acknowledged it was her responsibility to oversee that protocols for reviewing residents who had [NJ Exec Order 26.4b1] reported were being completed. The [U.S. FOIA (b)] acknowledged that there were no documentation completed which included the RITF and QAC after the fall incident of Resident #3.

A review of the facility's policy and procedure provided by the [U.S. FOIA (b)] titled, "FALLS, RESIDENT: PREVENTION PROGRAM" with an updated date of 4/23/24, under Policy read: " ...Referrals to the Fall Committee will be made when the resident has fallen. The fall Committee will meet weekly to discuss need for further evaluation and interventions for referred residents ..." Under Procedure it read, " ...3. The licensed nurse shall complete the Fall Risk Assessment Form. In addition, if any one of the following criteria is present, the resident will be re-assessed for falls:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315378	A. BUILDING _____ B. WING _____	R-C 05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & HEALTH CARE CENTER	**129 MORRIS TURNPIKE NEWTON, NJ 07860**

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{F 689}	Continued From page 3 a. The resident has fallen ...Resident Fall Referrals to Fall Committee: 1. The Falls Committee Chairperson or designee, will coordinate all Fall Referrals to be reviewed at the Fall Committee meeting within one week of the generation of the paperwork ...2. Upon review of the referral, information will be presented to the Fall Committee by the chairperson or designee ...4. The Fall Committee Chairperson or designee will report at the QA meeting: prevalence by unit, total prevalence, number of residents reviewed, patterns, etc. ..." A review of the facility's policy and procedure provided by the [U.S. FOIA (b)] titled, "Incident/Accident, Procedure for Reporting Resident" with an update date of 4/23/24, under Procedure read: "14. All 'fall' reports will be reviewed and a resident fall report, consolidating all dates will be prepared by In-Service Department on a monthly basis. The incident will be scrutinized for pattering and utilized as tools for preventative measures. The report will be presented at the quarterly Safety meeting ...15. Patterning issues relative to incidents will be reviewed on an as-needed basis at the weekly Falls Committee meeting." A review of the facility's policy and procedure provided by the [U.S. FOIA (b)] titled, "Care Plans, Comprehensive Person-Centered", under Procedure read: " ...13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change ...14. The Interdisciplinary Team and/or Respective Discipline must review and update the care plan: a. When there has been a significant change in the resident's condition; b. When the desired outcome is not met ..."	{F 689}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315378	A. BUILDING _____ B. WING _____	R-C 05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & HEALTH CARE CENTER	**129 MORRIS TURNPIKE NEWTON, NJ 07860**

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{F 689}	Continued From page 4 NJAC 8:39-27.1(a); 31.4(a); 33.1(d)	{F 689}		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315378	A. Building B. Wing	5/14/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & HEALTH CARE CENTER	129 MORRIS TURNPIKE NEWTON, NJ 07860

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 F0711 Reg. # 483.30(b)(1)-(3) LSC	Correction Completed 03/28/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
3/12/2024	☐ 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
315378 Y1	A. Building B. Wing Y2	5/14/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & HEALTH CARE CENTER	129 MORRIS TURNPIKE NEWTON, NJ 07860

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0658	Correction	ID Prefix F0686	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed
LSC	03/28/2024	LSC	03/28/2024	LSC	03/28/2024
ID Prefix F0695	Correction	ID Prefix F0711	Correction	ID Prefix F0755	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.30(b)(1)-(3)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	03/28/2024	LSC	03/28/2024	LSC	03/28/2024
ID Prefix F0759	Correction	ID Prefix F0761	Correction	ID Prefix F0805	Correction
Reg. # 483.45(f)(1)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(d)(3)	Completed
LSC	03/28/2024	LSC	03/28/2024	LSC	03/28/2024
ID Prefix F0812	Correction	ID Prefix F0880	Correction	ID Prefix F0882	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.80(b)(1)-(4)	Completed
LSC	03/28/2024	LSC	03/28/2024	LSC	04/30/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/12/2024	☐ YES ☐ NO

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061905	A. BUILDING: _____ B. WING _____	R-C 05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & HEALTH CARE CEN	129 MORRIS TURNPIKE NEWTON, NJ 07860

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{S 000}	Initial Comments THE FACILITY WAS 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 observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes.	{S 560}	Specific Corrective Action 1. Continued recruitment for certified nursing assistants by placing and ad, networking, advertising in national and local sites with different incentive programs. 2. Continouosly review salary for certified nursing assistants to ensure the facility salary offer is comparable with other facilitied in the area 3. Contract with agency who provides	6/7/24

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

Electronically Signed | 06/07/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{S 560}	Continued From page 1 Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be	{S 560}	permanent placements 4. Contract with agency for relief staffing 5. Admission Director will consult with DON and staffing coordiantor for any prospective admission to ensure that there will be enough staff to cover the required staffing ratios for 3 shifts before admission will be approved 6. Facility actively recruiting for a nursing assistants for a C.N.A. class outside the facility. Facility will pay for the class tuition. Identification All residents have the potential to be affected by the deficient practice Systemic changes 1. Provide comprehensive orientation program and structured preceptorship. DON/Designee will monitor daily the progress of the newly hire and obtain feedback daily from the new employee 2. Human Resources Coordiantor will do a monthly monitoring and for the retention of a newly hired CNA/NA via monthly interviews about their experience 3. Human Resources Coordinator will do a monthly monitoring and tracking of CNA/NA termination and resignation through exit interviews 4. The facility offers flexible per diem schedule that will accommodate the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061905	A. BUILDING: _____ B. WING _____	R-C 05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{S 560}	Continued From page 2 rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two-week period beginning 4/28/2024 and ending 5/11/2024 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements for 5 of 14 day shifts. The facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows: -04/30/24 had 7 CNAs for 64 residents on the day shift, required at least 8 CNAs. -05/02/24 had 7 CNAs for 64 residents on the day shift, required at least 8 CNAs. -05/03/24 had 7 CNAs for 65 residents on the day shift, required at least 8 CNAs. -05/08/24 had 7 CNAs for 66 residents on the day shift, required at least 8 CNAs. -05/11/24 had 7 CNAs for 66 residents on the day shift, required at least 8 CNAs. On 5/15/24 at 10:20 AM, the surveyor informed the Licensed Nursing Home Administrator and the Director of Nursing about the concerns for	{S 560}	employee's needs 5. DON will work with staffing coordinator to ensure that appropriate staffing is in place Monitoring 1. Human Resources Coordinator will do a QAPI on retention of a newly hired CNA to ensure that Nursing department will have enough CNA to cover the sate required staffing to meet the resident's needs monthly x 3 months and quarterly thereafter . Reports will be submitted to the administrator and will be discussed during the quarterly meeting 2. Human resources Coordinator will do a QAPI in termination and resignation on of CNA to enssure that Nursing department will have enough staff to cover state reuired staffing to meet the resident's needs monthly x 3 months and quarterly thereafter. Report will be ssubmitted to the Administrator and will be discussed during the quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{S 560}	Continued From page 3 CNA to resident ratios.	{S 560}		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061905 Y1	A. Building B. Wing Y2	5/14/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & HEALTH CARE CENTER	129 MORRIS TURNPIKE NEWTON, NJ 07860

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S1030 Reg. # 8:39-11.2(c) LSC	Correction Completed 03/28/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 3/12/2024	☐ 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
061905 Y1	A. Building B. Wing Y2	5/14/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & HEALTH CARE CENTER	129 MORRIS TURNPIKE NEWTON, NJ 07860

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S1030 Reg. # 8:39-11.2(c) LSC	Correction Completed 03/28/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 3/12/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ YES ☐ NO

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315378	A. Building B. Wing	6/26/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & HEALTH CARE CENTER	129 MORRIS TURNPIKE NEWTON, NJ 07860

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 F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 06/07/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
3/12/2024	☐ 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 (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061905		6/26/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & HEALTH CARE CENTER	129 MORRIS TURNPIKE NEWTON, NJ 07860

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 06/07/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 3/12/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ **YES** ☐ **NO**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315378	A. BUILDING **01** B. WING _____	**03/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & HEALTH CARE CENTER	**129 MORRIS TURNPIKE** **NEWTON, NJ 07860**

(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 3/4/24, 3/5/24 and 3/6/24, was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy The facility is a 4-story building that was built in 60's, It is composed of Type II unprotected construction. The facility is divided into 7- smoke zones. The facility utilizes an exterior 150 KW diesel generator. The maintenance staff member did not know the percent of the building that the generator powers. The facility currently does not have a Maintenance Director since approximately December 2023 as per the Maintenance staff member. The facility utilizes a diesel fire pump located in a pump house by a pond that provides water from the pond to support the fire sprinkler system. The laundry department is located in a seperate building not attached to the facility. The facility has 128 certified beds. At the time of the survey the census was 61. The current layout of the facility:	K 000		

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

Electronically Signed | 04/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315378	A. BUILDING **01** B. WING _____	**03/06/2024**

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K 000	Continued From page 1 1st floor no residents (staff offices) 2nd floor LTC 3rd floor LTC 4th floor Rehab The owner was interviewed on 3/4/24 at 11:15 AM in reference to a "water and sewer services agreement between the county of Sussex and 129 Morris Turnpike realty LLC" in reference to: "failure to pay its outstanding sewer bill for 2023". The owner indicated the issue was in litigation with lawyers from both sides.	K 000		
K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered	K 161		3/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315378	A. BUILDING **01** B. WING _____	**03/06/2024**

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K 161	Continued From page 2 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview on 3/5/24, in the presence of the U.S. FOIA (b) (6)), It was determined that the facility failed to provide acceptable construction standards in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.1.6.1, Table 19.1.6.1, 19.1.6.2. through 19.1.6.7, 19.3.1 and 8.6. This deficient practice was evidenced by the following: At 11:22 AM the surveyor and U.S. FOIA (observed in the floor #1 boiler room that an approximately 4' x 2' drop ceiling tile was missing exposing unprotected steel beam and concrete decking. The U.S. FOIA (b) (6) was asked to provide a building construction type on a document, the U.S. FOIA (b) (6) indicated her corporate office was notified and verbally indicated to her that the facility was brick and cement construction.	K 161	Specific Corrective Action: The Maintenance Department installed a missing ceiling located next to the boiler room on 3/10/2024. The Maintenance Consultant has toured the building and took picture to show that the exposed beams in the Boiler room is in fact covered with fire rated protection. Please see attached Pictures. After reviewing the building plans and the approval from DCA it was discovered that this is a Type II 2.2.2 noncombustible Fully Sprinkled building. To comply with NFPA 101 Fire Rating the structure rating is as follows. Columns supporting Roof 1 hour	

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	315378	A. BUILDING **01** B. WING _____	**03/06/2024**

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K 161	Continued From page 3 The physical observation of the exposed unprotected beam indicates the building construction is type II unprotected construction. The U.S. FOIA (b) (6) confirmed during the building observation that the exposed boiler room ceiling was concrete decking and exposed unprotected Ibeam construction indicating the building was Type II unprotected construction and only allows maximum 3 stories with fire sprinkler system. The current building is 4-stories. The U.S. FOIA (b) (6) confirmed that the observed beam was missing any fire rated coating and the beam was left unprotected. The U.S. FOIA (b) (6) was informed of the findings at the Life Safety Code exit conference on 3/6/24. No further construction documentation was provided. NJAC 8:39-31.2(e)	K 161	Beans supporting Roof 1 hour Floor Construction 2 hour Roof Construction 1 hour Identification: All residents have the potential to be affected by the deficient practice. Systemic Changes: The Ceiling tile and expose beams checklist is created for an audit which will be done monthly to ensure all beams fire coating is in place and ceiling tile has their integrity. Monitoring: QAPI will be conducted on all ceiling tiles by the building Life Safety Consultant/Designee to ensure that there are no beams exposed; the tiles are all in place and in compliance monthly x3 months and quarterly thereafter. The report will be submitted to the Administrator and discussed at a quarterly meeting.	
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the	K 222		3/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 222	Continued From page 4 use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.	K 222		

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K 222	Continued From page 5 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/4/24, in the presence of the U.S. FOIA (b) (6)), a). it was determined that the facility failed to provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. b). B). it was determined that the facility failed to ensure that egress doors equipped with a delayed 15-second egress feature were labeled with a sign that read, "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." This deficient practice was evidenced for 2 of 8 egress doors observed by the following in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. This deficient practice was identified for 1 of 2	K 222	Specific Corrective Action: The front sliding door was installed in a way that the door manual locking would not be able to be lock at any time due to the intentional miss alignment of the frame, the facility consultant has further installed a face plate to block the lock from being used to lock this door rendering the lock inoperable. The sliding door if pushed in an emergency will pop out of the frame and open. There is a sign in place with instruction to push in an emergency. After consulting with the Alarm company and contracted electronic company that work on our doors it was revealed that all doors have both Delayed egress and also is wired to the fire alarm system that will	

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K 222	Continued From page 6 sets of sliding doors, 2 of 8 exit/egress doors and was evidenced by the following. a). At 1:40 PM, the surveyor and [redacted] observed at the main entrance, that the inner set of sliding doors had a lockset that engaged a hook-type deadbolt. The device on the doors could restrict emergency use of the exit. The current evacuation plan indicated that the front doors were designated an exit/egress route. The sliding doors had signs indicating push to open in an emergency, but with the thumb-latch locks engaged this procedure would not open the doors as stated on the signs. At the time of the observation, the surveyor interviewed the [redacted] who stated that the lockset (hook type deadbolt) would restrict use of the exit from the egress-side in the event of an emergency. b). At 1:12 PM. the surveyor and [redacted] observed 2 of 8 exit/egress doors. The doors were equipped with a delayed 15-second egress feature, but were not labeled with a sign that read, "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." The door locations were as follows: Floor #1 by 133 and 142 corridor Floor #3 across from 334 (dining-activity lounge) The [redacted] was informed of the findings at the Life Safety Code exit conference on 3/6/24. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section - 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. NFPA 101:2012 Edition, Section - 7.2.1.6.1.1(3)C	K 222	release upon the activation of the fire/sprinkler alarm, and all doors has a keypad and all staff has the codes to open doors. the life safety consultant has now returned the signs to exit door Number 1 by room 133 and 142 corridor and Door number 3 by 334. Identification: All residents have the potential to be affected by the deficient practice. Systemic Changes: 1. Maintenance staff will do an audit monthly to ensure the proper operations for exits doors and delay egress. The report will be submitted to the Environmental Service Consultant for review. Monitoring: A QAPI will be conducted by the Environmental Staff Service Consultant/Designee to ensure the proper operations for exits doors and delay egress monthly x3 months and quarterly thereafter. The report will be submitted to the Administration to be discussed at quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/6/24, in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to provide and maintain a level walking surface, free of all obstructions or impediments to full instant use in the case of fire or other emergency in accordance with NFPA 101, 2012 Edition, Section 19.2, 19.2.1, 19.2.7, 7.7, 7.7.1, 7.7.3.2, 7.1.6, 7.1.6.2, 7.1.6.3, 7.1.10, 7.1.10.1. This deficient condition was evidenced for 1 of 7 observed exit discharges by the following findings: At 12:42 PM, the surveyor and U.S. FOIA [redacted] observed outside the stairwell B-exit that when the U.S. FOIA [redacted] opened the exit/egress door a wooden ramp was observed with over grown brush on the surface. The approximately 4' x 4' wooden ramp also had a slippery substance on the surface leading to the public way, failing to provide a firm level walking surface, free of all obstructions or impediments to full instant use in the case of fire or other emergency. The U.S. FOIA [redacted] stated and confirmed that the area	K 271	Specific Corrective Action: The stairwell B exit wooden Ramp was power wash and all grown vegetations were cleared and removed from the path of this 4x4 ramp leaving a clear and level surface to the walkway. Identification: All residents have the potential to be affected by the deficient practice. Systemic Changes: The Maintenance staff will have a weekly check and walkthrough in all egress pathways to ensure the wooded ramp are safe to walk and 4x4 ramp is clear of any vegetation with level surface to the walkway. Monitoring: Environmental Service Consultant/Designee will do QAPI to ensure that all egress ramp or walkway	3/27/24

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K 271	Continued From page 8 failed to provide a level walking/travel surface to the public way. The exit/egress route was confirmed on the facility evacuation route provided by the US FOIA (b)(6) The U.S. FOIA (b) (6) was informed of the finding at the Life Safety Code exit conference on 3/6/24. NJAC 8:39-31.2(e) NFPA 101:2012 - 7.7, 19.2.7	K 271	are safe, clear of vegetation with level surface walkway monthly. The report will be submitted to the Administration and will be discussed at the quarterly meeting.	
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interviews conducted on 3/4/24, in the presence of facility Maintenance Staff Member (MSM), it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. The deficient practice affected 2 of 6 occupied access areas and corridors observed and was evidenced by the following: 1). At 11:16 AM, the surveyor, in the presence of the U.S. FOIA (b) observed in the floor #3 day room that 3 wall light switches shut off all 12 light fixtures in the occupied room.	K 281	Specific Corrective Action. The Facility contracted [redacted] to run separate electrical circuit from the Emergency generator panel to floors 2 - and 3 - Day room they remove 3 of the 12 light fixtures from the manual light switches and connect them directly to the emergency generator circuit this prevent this light from ever being able to be turned off and they will stay lite even in an emergency where power is lost to the whole building and the generator is activated.	3/28/24

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HOMESTEAD REHABILITATION & HEALTH CARE CENTER	**129 MORRIS TURNPIKE** **NEWTON, NJ 07860**

(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 281	Continued From page 9 2). At 11:47 AM, the surveyor, in the presence of the MSM, observed in the floor #2 day room that 3 wall light switches shut off all 12 light fixtures in the occupied room. The areas were not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention. The [redacted] confirmed the finding's at the time of observations. The [redacted] was informed of these findings at the Life Safety Code survey exit conference on 3/6/24. NFPA 101-2012 edition Life Safety Code: 7.8 Illumination of Means of Egress: 7.8.1.3* (2) NJAC 8:39-31.2(e)	K 281	Identification: All residents have the potential to be affected by the deficient practice. Systemic Changes: The Maintenance staff will do a weekly audit on all emergency lights to ensure they are not able to be manually turned off and that the fixtures are functioning correctly. Monitoring: A QAPI will be done by the Environmental Service Consultant/Designee to ensure that all emergency lights are not able to be manually turned off and that the fixtures are functioning correctly monthly x3 months and quarterly thereafter. The report will be submitted to the Administrator and will be discussed at the quarterly meeting. For the next 3 quarters and light checks will be done monthly thereafter.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting	K 321		4/9/24

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K 321	Continued From page 10 partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/4/24, in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, labeled and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practice was identified in 1 of 9 kitchen exit/egress doors observed and was evidenced by the following: At 12:48 AM, the surveyor and U.S. FOIA [redacted] observed that the gray kitchen door #154 would not close	K 321	Specific Corrective Action: Door #154 - The Environmental Service Consultant will make repairs to the door to ensure it close and latched correctly and will ensure the contractor contact the manufacture to get correct rating if rating is unable to be obtain the consultant will order new 1 hour Fire rated Door and replace. Identification: All residents have the potential to be affected by the deficient practice.	

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K 321	Continued From page 11 and latch into its frame and the door was not labeled to confirm its fire resistant rating. The U.S. FOIA (b) (6) confirmed the findings during the observation. The U.S. FOIA (b) (6) was informed of the findings at the Life Safety exit conference on 3/6/24. NJAC 8:39-31.2 (e) Life Safety Code 101-2012 edition	K 321	Systemic Changes: The Maintenance staff will do a monthly audit to ensure all fore doors are in full operation and all fire rating doors label are in place. Monitoring: A QAPI will be conducted by an Environmental Service Consultant/Designee to ensure all fire door are in good working conditions monthly x3 months and quarterly thereafter. Reports will be submitted to the Administrator and will be discussed at the quarterly meeting.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as	K 324		4/20/24

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K 324	Continued From page 12 hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/5/24, in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed A). to ensure that 2 of 4 exhaust hood grease baffles were in the proper position to protect against grease and fire from entering above the exhaust hood system as per NFPA 96. B). to ensure that 1 of 1 kitchen ansul system inspection tags were inspected monthly in accordance with NFPA 96 and NFPA 10. C). to ensure the ansul fire suppression system was inspected from the facility vendor on a semi-annual basis for 2 of 2 reports as per NFPA 96. This deficient practice was evidenced by the following: Reference: NFPA 96 19.3.2.5.3* (10) Procedures for the use, Inspection, Testing, and Maintenance of the cooking equipment are in accordance with Chapter 11 of NFPA 96 and the Manufacturers instructions and are followed. A). At 10:46 AM, the surveyor observed in the kitchen that 2 of 4 kitchen hood grease baffles were not properly installed over the main commercial cooking stove in the following locations:	K 324	Specific Corrective Action: The Facility has ordered from the hood cleaning company new sets of Grease Baffles, the maintenance staff will be checking the Ansul pull station on monthly basis and sign off on it, the contracted fire suppression inspection company whom the facility contracted to maintain these equipment was contracted and inform that the facility expect that the kitchen suppression system must be inspected date to date to reflect a simi annual inspection. Identification: All residents have the potential to be affected by the deficient practice. Systemic Changes: Maintenance staff will check the hood to ensure that it properly covered, and the hood will be inspected and clean quarterly. The Maintenance staff will check the	

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K 324	Continued From page 13 1. The grease baffle from the left-side #2 was bent and was not properly set in the track. 2. The grease baffle from the left-side #3 was observed not in the track, the hood exhaust fan was pulling the baffle into the upper hood area offering no protection from that grease baffle. An interview was conducted with the U.S. FOIA (b) who acknowledged that 2 of 4 grease baffles over the cooking area, must be installed correctly to prevent a grease fire from entering the hood above the grease baffles. The Grease baffles are the first layer of protection in a commercial kitchen's grease management and exhaust ventilation system. Their purpose is to prevent flames and flammable debris from entering the exhaust duct and capture grease-laden vapors produced from cooking equipment. If this grease were not captured, it would build up in the ventilation system and become a significant fire hazard. B). 10:51 AM, the surveyor observed in the kitchen, that the ansul activation pull station was provided with a monthly inspecion tag that was blank. The ansul system was inspected by the facility vendor on April 2023. The U.S. FOIA (confirmed the finding during the observation. C). On 3/5/24 the kitchen fire suppression inspection reports were provided by the U.S. FOIA (b) (6) and were dated 3/6/24 and 4/28/23. The inspection reports are required to be performed on a semi-annual schedule. The	K 324	Ansul pull station each and sign off on it monthly. The Maintenance staff will check the inspection compliance schedule to follow and is now required to call vendor 10 days prior to the date of any inspection then to report to the Administration if the vendor do not show up on the schedule due date so to escalate the issue and have the inspection completed. Monitoring: A QAPI will be done by Environmental Service Consultant/Designee to ensure that all inspection are done timely monthly x12 months. Reports will be given to the Administration and will be discussed at the quarterly meeting.	

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K 324	Continued From page 14 reports were almost 4-months out of compliance from being on the required semi-annual schedule. The U.S. FOIA (b) (6) confirmed the kitchen fire suppression system must be conducted on a semi-annual basis. The U.S. FOIA (b) (6) was notified of the finding's at the life safety code exit conference on 3/6/23. NJAC 8:39-31.2(e) NFPA 96, 19.3.2.5.3*(10)	K 324		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review on 3/4/24 and 3/5/24, in the presence of the US FOIA (b)(6) it was determined that the facility failed to ensure: a.) that their fire alarm system was inspected on a semi-annual basis in accordance with NFPA 70 and 72. b.) smoke detection sensitivity testing was not completed of the facility smoke detectors in accordance with NFPA 72 (2010 edition) section 14.4.5.3.2. The deficient practice was identified for 2 of 2	K 345	Specific Corrective Action: The Facility Fire alarm contacted the system vendor and scheduled the Simi annual inspection of the fire alarm system and the required 2-year sensitivity test to come out on April 8,2024, for first inspection and 2nd inspection will be October of 2024. Identification:	4/8/24

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K 345	Continued From page 15 inspection reports and was evidenced by the following: a.) On 3/5/24 at approximately 09:50 AM, the surveyor reviewed all documentation from the fire alarm vendor. The document indicated date of inspection's: 5/12/23 and 5/18/22 only and were not performed on a semi-annual basis in accordance with NFPA 70 and 72. The fire alarm system has sealed lead acid batteries and requires a semi-annual inspection. The U.S. FOIA (could not confirm it the fire alarm system was inspected on a semi-annual basis.. b.) On 3/5/24 the surveyor and U.S. FOIA (confirmed that no fire alarm smoke detector sensitivity report was provided in the Life Safety Code Inspection book. The last semi-annual fire alarm inspection report's were dated: 5/12/23, and did not indicate when the last smoke detector sensitivity test was conducted in accordance with NFPA 72 (2010 edition) section 14.4.5.3.2. The U.S. FOIA (b) (6) and U.S. FOIA (were interviewed during the document review, where they stated currently, that no smoke detector sensitivity report was performed and they could not provide any documentation on when it was last conducted. The U.S. FOIA (b) (6) was informed of the findings at the Life Safety Code Exit conference on 3/5/24. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 70, 72	K 345	All residents have the potential to be affected by the deficient practice. Systemic Changes: The facility has created an inspection checklist with a calendar to be used by the maintenance staff each month to ensure that all required Alarm inspection is done. The Maintenance staff is given a compliance schedule to follow and is required to call the vendor 10 days prior to the due date of any inspection. Maintenance staff will inform Administrator if the chedule inspection is not completed. Maintenance staff will contact vendor to reschedule the inspection as soon as possible. Monitoring: A QAPI will be conducted by Environmental Service Consultant/Designee to ensure the Fire Alarm System is fully operational, and inspection is completed semi-annual and smoke detector sensitivity testing is completed in accordance with NFPA 70 and 72 guidelines monthly x3 months quarterly thereafter. The report will be submitted to the Administrator and will be discussed during the quarterly meeting.	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101	K 351		4/6/24

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K 351	Continued From page 16 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/14/24, the facility failed to a.) provide complete sprinkler coverage as required by Centers for Medicare/Medicaid Services regulation § 483.90(a) physical environment, and b.) to install the sprinkler system in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.3.5, 4.6.12 and 9.7, NFPA 13, 2012 Edition, Section 6.2.7.1, 8.1, 8.1.1, 8.5.2.1, 8.5.5, 8.5.5.2 8.15.7, 8.15.7.1 and 8.15.7.5. The lack of sprinkler coverage could delay or prevent the extinguishment of a fire in these areas. This deficient practice was identified in 1 of 1 interior areas and was evidenced by the following: On 3/4/24 at 8:55 AM, the surveyor observed in the facility's	K 351	Specific Corrective Action: The Sprinkler servicing company was contracted and is now scheduled to install sprinkler heads in the 16x12 space between double doors to ensure adequate coverage. Identification: All residents have the potential to be affected by the deficient practice. Systemic Changes: Maintenance staff will do a monthly inspection to ensure the entire building	

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K 351	Continued From page 17 interior vestibule approximately 16' x 12' between to sets of doors that no fire sprinkler heads were observed. The area had a wooden bench for visitors to sit on. An interview was conducted with the [redacted] at the time of the observation, who confirmed the interior vestibule approximately 16' x 12' was not provided with any fire sprinkler protection. The [redacted] was informed of the findings at the Life Safety Code exit conference on 3/6/24. NJAC 8:39-31.2(e)	K 351	has complete sprinkler coverage and that no space is without sprinkler coverage. Monitoring: A QAPI will be done Environmental Service Consultant/Designee to ensure the entire building has complete sprinkler coverage and that no space is without sprinkler coverage monthly x3 months and quarterly thereafter. The report will be submitted to the Administrator and will be discussed at the quarterly meeting.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 353		4/8/24

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K 353	Continued From page 18 Based on observation and interview on 3/4/24 3/5/24 and 3/6/24, in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to a.) maintain all parts of their automatic sprinkler system in optimal condition as per section 5.2.1.1.1 of National Fire Prevention Association (NFPA) 25, b.) to maintain the sprinkler system by ensuring that the ceiling was smoke resistant and fire rated as evidenced by the following: in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1, c.) ensure the diesel fire pump churn test inspection report was fully documentated by the operator as per NFPA 20: fire pump requirements and NFPA 25 and the diesel fire pump was maintained in optimal condition. These deficient practices was identified for and evidenced by the following: A-1), On 3/5/24 at 11:28 AM, the surveyor and U.S. FOIA (observed in the facility kitchen that 5 of 14 fire sprinkler heads had a heavy green coating of oxidation in the pot and dish cleaning section of the kitchen. A-2). On 3/5/24 at 12:25 PM, the surveyor and U.S. FOIA (observed in the floor #2 corridor by resident rooms 229 and 230 that 1 of 8 fire sprinkler heads had a heavy coating of dirt/lint that blocked the view of the frangible bulb on that fire sprinkler head. The U.S. FOIA (confirmed the findings during the observations	K 353	Specific Corrective Action: A-1) & a-2) The Facility contacted the Sprinkler servicing company and get confirmation that they will be onsite on Monday April 1st, 2024, test or replace the 5-sprinkler head in the kitchen Dish/Pot Room and 1 sprinkler head in Room 229/230 bathroom. B-1) The Physical Therapy Closet the over cut tile was replaced with a tile cut correctly with escutcheon to prevent any openings. B-2) The Maintenance Department has replaced missing ceiling tile in the following location:G12 2X2 ceiling tile. B-3) The Maintenance Department has replaced missing ceiling tile in the following location: G224x24 missing ceiling tile. B-4) The Environmental Service Consultant has cut and replaced ceiling tile by split unit in corridor #2 by room 228. B-5) The Maintenance Department has replaced missing ceiling tile in the following location: #3 utility Room two 2x3 missing ceiling tile. B-6) Room #142 4x2 missing ceiling tile, a roofer was also contracted to help resolve all leaks that could have caused this issue. The Sprinkle servicing company was	

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K 353	Continued From page 19 B-1), On 3/4/24 at 10:49 AM, the surveyor and U.S. FOIA (observed in the Physical Therapy closet that an oversized ceiling tile cut was installed around wires, approximately 6"x6". B-2), On 3/4/24 at 10:55 AM, the surveyor and U.S. FOIA (observed vacant resident room G-12 that a 2' x 2' ceiling tile was missing. The U.S. FOIA (indicated the tile was removed due to the roof leaking. B-3), On 3/4/24 at 11:10 AM, the surveyor and U.S. FOIA (observed in resident room G-2 that a 24" x 24" ceiling tile was missing in the bathroom due to a roof leak. B-4), On 3/4/24 at 12:10 PM, the surveyor and U.S. FOIA (observed in the floor #2 corridor by resident rooms 228 and 230 that a split unit was installed and the ceiling tile around the pipe and wires was over cut leaving a gap around that area approximately 4" in size. B-5), On 3/4/24 at 12:10 PM, the surveyor and U.S. FOIA (observed in the floor #3 utility room that two 2' x 4' ceiling tiles were missing. B-6), On 3/4/24 at 12:55 PM, the surveyor and U.S. FOIA (observed in room identified as #142 was missing five 4' x 2' and two 2' x 2' ceiling tiles. The U.S. FOIA (confirmed the findings above during the observations. C.) The U.S. FOIA (b) provided the fire pump documentation for the testing of the diesel fire	K 353	called and is scheduled to be onsite Monday April 1st, 2024, to identify where the pump collect water, to make the repairs of Fuel pump leak, replace coolant system hoses and clamp, the thermostat and gasket, replace fan belt and coolant tank.A Weekly pump exercise will be done, and documentation kept. Identification: All residents have the potential to be affected by the deficient practice. Systemic Changes: The maintenance staff will do a weekly check of all ceiling tiles for stains and integrity to ensure they are all in place and there are not missing tiles the maintenance staff is also educated on how to cut tiles so they will fit whatever areas without gaps. The maintenance staff was educated on what to look for in his inspection tours of the building when checking the condition of the sprinkler heads. A checklist has been provided to maintenance staff to identify potential issues. The maintenance has been educated on how to do the weekly Fire Pump 30 min run test. Monitoring: QAPI will be conducted by Environmental Service Consultant/Designee to ensure	

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K 353	Continued From page 20 pump dated: 6/7/23. The facility vendor work order # 1020795056 indicated under job details that minor routine inspection on the fire pump was performed. The results of the inspection on the report indicated: failed due 1), Fuel pump leaking fuel 2), Entire cooling system needs new hoses, clamps, thermostat and gaskets including fan belts and the coolant tank is rusted through in many spots. 3), Need factory molded rubber hoses "critical condition". It was noted that the system was left in automatic operation mode. The U.S. FOIA (indicated he did not perform a weekly inspection and/or run the diesel generator since he started in [redacted] The facility could not provide any documentation indicating the diesel fire pump 30 minute weekly no-flow (churn) test was performed as per NFPA 25. The pump house located approximately 200' from the facility by a water suppling pond that was observed and the intake from the pond to the fire pump house could not be located as the pond was murky and dirty with over grown vegetation. The U.S. FOIA (was unsure of the operation of the fire pump and indicated the pump was not operated and/or tested since the Maintenance Director left in NJ Ex Order 26.4(b)(1) and could not provide any further documentation. *Penstocks, Flumes, Rivers or Lakes Water supply sources such as penstocks, flumes, rivers, and lakes are acceptable water supplies when used in combination with listed fire pumps.	K 353	that all parts of the automatic sprinkler system are maintain in an optimal condition; maintaining the sprinkler system by ensuring that the tile was smoke resistant, and fire rated monthly x3 months and quarterly thereafter. The report will be submitted to the Administrator and discussed at a quarterly meeting. A QAPI will be done by Environmental Service Consultant/Designee that diesel fire pump churn test inspection was completed and documented; diesel fire pump to is maintained in optimal condition monthly x3 months and quarterly thereafter. The report will be submitted to the Administration and will be discussed at the quarterly meeting.	

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K 353	Continued From page 21 However, these sources must be arranged to avoid mud and sediment and other foreign material in the system piping. Such sources must, therefore, be provided with an approved double removable screens or approved strainers installed on the water intake piping. A major concern while selecting a naturally occurring water source is their reliability and ability to meet the system demand throughout the year, accounting for seasonal fluctuations, as well as low water levels and ice conditions. Therefore, the Authority Having Jurisdiction should be consulted before deciding to use a naturally occurring water source as the water supply for a sprinkler system. The U.S. FOIA (b) (6) indicated she was aware of the fire pump issues and could not provide any further reports and/or documentation details. The U.S. FOIA (b) (6) was informed of the finding's at the Life Safety Code exit conference on 3/6/24. NJAC 8:39 - 31.1(c), 31.2(e) NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 20, Fire Pump Requirements. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems with property owners.	K 353		
K 355 SS=F	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.	K 355		3/13/24

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K 355	Continued From page 22 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview conducted on 3/6/24 in the presence of the U.S. FOIA (b) (6)), it was determined that the facility did not provide portable fire extinguishers in accordance with NFPA 101:9.7.4.1 and NFPA 10 Chapter 7-Inspection, Maintenance, and Recharging of Portable Fire Extinguishers as evidence by: The surveyor and U.S. FOIA (observed that the following fire extinguisher's were missing monthly inspections as follows: 1), 3 of 16 Fire extinguishers inspected had no monthly inspection signatures. (Room:106, 112, First floor middle hallway exit) 2), 12 of 16 Fire extinguishers inspected had signatures for the month of March only. (Room: Lobby, Balance Center, 214,231,333,315, 3rd floor near Elevator A,334, G5, Therapy room, G18). 3), 1 of 16 Fire extinguishers inspected had prior years inspection tags (Soiled linen room/156). The U.S. FOIA (confirmed the findings at the time of observations. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 3/6/24. NJAC 8:39-31.2 (c) (e) NFPA 10: 7.2.1.2*- Fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a	K 355	Specific Corrective Action: All Fire extinguishers were inspected and dated. The maintenance staff has been in-serviced that all fire extinguishers must be checked, inspected, and dated monthly. Identification: All residents have the potential to be affected by the deficient practice. Systemic Changes: A detailed check list of all fire extinguishers and their location has been created for the maintenance staff to ensure all fire extinguishers on the list are checked, inspected, and dated at the time of inspection monthly. Report will be submitted to Environmental Service Consultant/Designee monthly. Monitoring: A QAPI will be done by Environmental Service Consultant/Designee to ensure that fire extinguishers are checked, inspected, and dated at the time of inspection monthly x12 months. The report will be submitted to the Administrator and discussed at the quarterly meeting.	

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K 355	Continued From page 23 minimum of 30-day intervals. NFPA 10: 7.2.4.3 - Where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. NFPA 10: 7.3.1.1 All Fire Extinguishers. NFPA 10: 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification.	K 355		
K 374 SS=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 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 on 3/4/23, in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection.	K 374	Specific Corrective Action: A Contractor was hired to replace the missing fire door in zone 1 first floor -B wing zone 2 first Floor - A wing Zone 10 first Floor- Kitchen.	3/27/24

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K 374	Continued From page 24 This deficient practice was identified for 2 of 5 smoke barrier door sets observed and was evidenced by the following: At 10:28 AM, the surveyor reviewed documentation provided by the U.S. FOIA (b) (6) indicating the first floor fire safety plan equipment & evacuation route. The plan indicates two sets of smoke doors and 3 zones: Zone 1 first floor -B wing Zone 2 first floor- A wing Zone 10 first floor- Kitchen 1). The surveyor and U.S. FOIA (observed that the set of smoke doors to the B-wing was missing 1 of 2 doors. The U.S. FOIA (was not sure why the door was missing and/or removed and he confirmed the set of smoke doors were on the fire safety plan provided by the U.S. FOIA (b) (6) 2). The surveyor and U.S. FOIA (observed that the set of smoke doors to the A-wing located as the primary exit on the fire safety plan were not observed. The U.S. FOIA (indicated he was not sure why the doors were missing and/or removed and he confirmed the set of smoke doors were on the fire safety plan provided by the U.S. FOIA (b) (6) The U.S. FOIA (b) (6) was informed of the findings at the Life Safety Code exit conference on 3/6/24. NJAC 8:39-31.1(c), 31.2(e) NFPA 101-2012- 19.3.7.6, 19.3.7.8, 19.3.7.9	K 374	Identification: All residents have the potential to be affected by the deficient practice. Systemic Changes: Maintenance staff will do monthly audit to ensure that all smoke barrier doors to resist transfer of smoke when completely closed for fire protection. Report will be submitted to Environmental Service Consultant for review. Monitoring: A QAPI will be conducted by the Environmental Service Consultant/ Designee to ensure audit to ensure that all smoke barrier doors resist transfer of smoke when completly closed for fire protection each monthly x3 months and quarterly thereafter. The report will be submitted to the Administrator and will be discussed at a quarterly meeting.	
K 521 SS=F	HVAC CFR(s): NFPA 101	K 521		3/27/24

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K 521	Continued From page 25 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/4/24, in the presence of the U.S. FOIA (b) (6) , a). it was determined that the facility failed to ensure resident bathroom ventilation systems were adequately maintained and operating in optimal condition, in accordance with the National Fire Protection Association (NFPA) 90 A. b). it was determined that the facility failed to ensure that the heating system was in optimal working condition as evidenced by the following: a). At 11:55 AM, during a tour of the building, the surveyor with the U.S. FOI toured the facility and observed that the ventilation systems did not function when the U.S. FO applied a piece of single-ply toilet tissue paper across the upper wall grills to confirm ventilation. When tested, the tissue did not hold in place. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation. The resident room bathrooms with no ventilation were the entire facility as per the U.S. FOIA (b) He stated currently the facility ventilation system in resident room bathrooms were not functioning and the facility did not have a ventilation inspection log or operating check list to provide.	K 521	Specific Corrective Action a. The facility contacted a contractor to check and repair the ventilation system, a broken fan belt was found and replaced to correct the ventilation issue. b. The plumbing company received the parts to fix the heating system and bring it to compliance. Identification All residents have the potential to be affected by the deficient practice. Systemic Changes As part of the maintenance Preventative Maintenance Program the Maintenance staff will check the environmental temperature daily and log the temperature reading; The Maintenance staff is provided with a hv/ac and ventilation check list as guide to ensure that the heating system is fully operational. Report will be submitted to the Environmental Service consultant and call if there is an immediate concern.	

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K 521	Continued From page 26 An interview was conducted with the U.S. FOIA during the observations, and he confirmed the findings. The U.S. FOIA stated the rooftop may have a bad motor and/or a broken fan belt. He stated currently the facility ventilation system in resident rooms was not functioning and the facility did not have a ventilation inspection log or operating check list to provide. b). At 12:15 PM, the surveyor and U.S. FOIA observed that the heating system temperature could not be regulated, currently the heat could not be shut off to the entire facility. The U.S. FOIA indicated a plumber was called in to repair the system a few weeks back and that a part was on order, but he was not sure why it was taking so long to be delivered. The U.S. FOIA (b) (6) was informed of the findings at the Life Safety Code exit conference on 3/6/24. NFPA 90 A Standard for the installation of ventilating systems NFPA 101-2012 -19.5.2.1 section 9.2.1 and 9.2.2 NJAC 8:39-31.2(e)	K 521	Monitoring: QAPI will be conducted by Environmental Service Consultant/Designee to ensure that the heating system is in optimal working condition monthly x 3months and quarterly thereafter. The report will be submitted to the administrator and will be discussed at the quarterly meeting.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and	K 761		3/28/24

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K 761	Continued From page 27 testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: . Based on observation and interview on 3/5/24, in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that the fire doors were inspected annually by an individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. This deficient practice was evidenced for 9 of 9 doors observed by the following: At 09:00 AM document review indicated that the fire door assemblies were not inspected and tested annually in accordance with NFPA 80 Standard for fire doors. The U.S. FOIA [redacted] was interviewed at the time of the document review and he confirmed the fire doors were not inspected annually and could not provide a log indicating so. The U.S. FOIA [redacted] indicated he was not aware of this requirement. The U.S. FOIA (b) (6) was informed of the findings at the Life Safety Code exit conference on 3/6/24. NJAC 8:39-31.1(c), 31.2(e) NFPA 80 .	K 761	Specific Corrective Action The Environmental Service Consultant inspected all fire doors to ensure doors will close and latch; doors were checked for floor sweeps, door hinges, locking/ latching mechanism functionalities. Maintenance staff were educated on door inspection to ensure the door closes and latch; doors were checked for floor sweeps, door hinges, locking/ latching mechanism functionalities. Identification All residents have the potential to be affected by the deficient practice. Systemic Changes Maintenance staff will do a door inspection to ensure doors will close and latch; doors were checked for floor sweeps, door hinges, locking/ latching mechanism functionalities monthly. Reports will be submitted to the Environmental Service Consultant for review. Monitoring	

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K 761	Continued From page 28	K 761	A QAPI will be conducted by the Environmental Service Consultant/Designee to ensure doors will close and latch; doors were checked for floor sweeps, door hinges, locking/ latching mechanism functionalities monthly x 3months and quarterly thereafter. The report will be submitted to the administrator and will be discussed at the quarterly meeting.	
K 911 SS=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 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 and interview on 3/4/24, in the presence of the U.S. FOIA (b) (6) [redacted], the facility did not ensure guarding of live parts of electrical equipment and controls with unlocked panels in resident accessible areas in accordance with NFPA 101, 2012 Edition, Section 19.5.1,19.5.1.1, 9.1, 9.1.2, NFPA 99 2012 Edition, Section 6.3.2.1, 15.5.1.2 and NFPA 70 2011 Edition, Section 110.26, 110.27 and 110.16. This deficient practice of electrical panels not guarded against accidental contact by approved enclosures and unlocked panels in resident accessible areas for 3 of 11 open electrical panels observed.	K 911	Specific Corrective Action: The Maintenance department have now locked electrical panel pp-3, Em and DP 4 was all locked and electrical room was locked as well, keys are now kept in maintenance office. Identification: All residents have the potential to be affected by the deficient practice. Systemic Changes:	3/29/24

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K 911	Continued From page 29 1). At 11:03 AM, the surveyor and U.S. FOIA (b) observed an open electrical wall panels marked PP-3 by the nurse station was open to the corridor. 2). At 11:27 AM, the surveyor and U.S. FOIA (b) observed that the floor #4 electrical room across from the G-24 was unlocked and observed to have open electrical panels marked: EM and DP-4. The observations were confirmed by the U.S. FOIA (during the tour of the facility. The U.S. FOIA (b) (6) was informed of the findings at the Life Safety Code exit conference on 3/6/24. NJAC 8:39-31.2(e) NFPA 70, 99	K 911	The Maintenance staff will do a weekly audit to check all electrical panels to ensure they are guarded and locked. Report will be submitted to the Environmental Service Consultant. Monitoring: A QAPI will be done by Environmental Service Consultant/Designee to ensure that all electrical panels are checked to be guarded and locked monthly 12 months. The report will be submitted to the Administrtor and will be discussed at the quarterly meeting.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per	K 914		3/28/24

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K 914	Continued From page 30 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and documentation review on 3/5/24, in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), it was determined that the facility failed to functionally test electrical receptacles in residents' rooms that had non-hospital grade outlets annually for grounding, polarity, and blade tension in accordance with NFPA 99. This deficient practice was identified for 50 of 65 resident rooms observed, and was evidenced by the following: During record review on 3/5/24, the surveyor while reviewing documentation provided by the U.S. FOIA (b) (6) which included the facility's electrical inspection report from the facility's vendor in 2023, which did not indicate that the rooms with non-hospital grade electrical outlets were annually inspected. During a building tour on 3/4/24 from approximately 9:30 AM to 12:45 PM, the surveyor confirmed the outlets were non-hospital grade except for the most recent floor-4 renovation that upgraded the resident rooms to hospital grade outlets in G-1 resident room through G-26. The floor #3 and #4 resident room outlets were non-hospital grade outlets and the U.S. FOIA (could not provide a log indicating the required testing for grounding, polarity, and blade tension in accordance with NFPA 99.	K 914	Specific Corrective Action The Facility hired an electrical contractor who inspected the entire facility and tested all resident rooms outlet and found them all to be in compliance , and was given a letter that showed that inspection was done, the facility now requires the electrical contractor to give a detail account of the rooms he checked in addition an annual check list was created and an outlet tester was purchase so to have the maintenance staff check each outlet to ensure polarity and ground faults . Identification All residents have the potential to be affected by the deficient practice. Systemic Changes The Maintenance staff has been trained in how to use an outlet tester and test each outlet at least once a year and any findings will be recorded on a monthly log sheet. Report will be submitted to the Environmental Service Consultant for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315378	A. BUILDING **01** B. WING _____	**03/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & HEALTH CARE CENTER	**129 MORRIS TURNPIKE** **NEWTON, NJ 07860**

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K 914	Continued From page 31 In an interview during the observations, the U.S. FOIA (b) (6) indicated he was unaware of this requirement. The U.S. FOIA (b) (6) was informed of the findings at the Life Safety Code exit conference on 3/6/24. NJAC 8:39-31.2(e) NFPA 99	K 914	Monitoring A QAPI will be done by Environmental Service Consultant/Designee to ensure that all electrical receptacles in resident□s room that had non- hospital grade outlets are functionally tested annually for grounding, polarity, and blade tension in accordance with NFPA99 monthly x3 months and quarterly thereafter. The report will be submitted to the administrator and will be discussed at the quarterly meeting.	
K 921 SS=E	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests,	K 921		3/26/24

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	315378	A. BUILDING **01** B. WING _____	**03/06/2024**

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K 921	Continued From page 32 repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observations, interview, and documentation review on 3/4/24, in the presence of the U.S. FOIA (b) (6)), it was determined that the facility a). failed to ensure that PCREE (patient care-related electrical equipment) were maintained in accordance with NFPA 99-testing and maintenance requirements PCREE as per NFPA 99-99:10.5.3 and b). failed to ensure the plug to resident room beds was not modified or altered in accordance with NFPA 99 and was evidenced by the following: a). The deficient practice was evidenced for two of two PCREE area observations and was evidenced by the following: 1). At 11:46 AM, the surveyor observed in resident room NJ Ex O that a resident NJ Ex Order 26.4 and the NJ Ex Order 26.4(b)(1) was against the resident room curtains. The curtains were blocking the NJ Ex Order 26.4(b)(1), not allowing the NJ Ex Order 26.4(b)(1) to have NJ Ex Order 26.4(b)(1) and NJ Ex Ord properly. 2). At 11:58 AM, the surveyor observed in resident room NJ Ex O at bed #1, that a resident NJ Ex Order 26.4(b)(1) was NJ Ex and the NJ Ex Order 26.4(b)(1) was observed to have a NJ Ex Order 26.4(b)(1) blocking NJ Ex Order 26.4, not allowing the NJ Ex Order 26.4(b)(1) to have	K 921	Specific Corrective Action 1.&2. All Nursing staff were in-serviced to ensure that oxygen concentrator intake vent is not blocked to allow the concentrator to have clear access and work properly. 2 b). Maintenance staff replaced the modified plugs of 7 bed power cord with hobble commercial hard wire plugs the following rooms are NJ Ex Order 26.4b1 Identification All residents have the potential to be affected by the deficient practice. Systemic Changes Nursing staff will check all rooms with concentrator every shift to ensure the air flow is adequate and there is no obstruction to the inlet. The maintenance worker was in service to remove any electrical equipment with frayed wire and to not modify connections. A weekly check of all electrical equipment in resident room is now a part of the	

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	315378	A. BUILDING **01** B. WING _____	**03/06/2024**

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K 921	Continued From page 33 NJ Ex Order 26.4(b)(1) and NJ Ex Ord properly. An interview was conducted during the observations with the U.S. FOIA (b) where he stated that the NJ Ex Order 26.4(b)(1) were put into use by the nurses and he would inform them of the observation's of being to close, blocking the NJ Ex Order 26.4(b)(1) of the unit, not allowing the NJ Ex Order 26.4(b)(1) to have NJ Ex Order 26.4(b)(1). b). While touring the facility from approximately 09:21 AM, to 12:45 PM, the surveyor and U.S. FOIA (observed modified and altered plugs to resident room electric beds in the following resident rooms: NJ Ex Order 26.4(b)(1) The U.S. FOIA (indicated he was not sure when or why the original plugs were replaced and he stated they should not be like that in the facility, no policy and procedure was produced for resident room electric beds and maintenance log. The U.S. FOIA (b) (6) was informed of the finding's at the Life Safety Code exit conference on 3/6/24. NJAC 8:39-31.2(e) NFPA 99-99:10.5.3 NFPA 99- 5.1.3.3.3.3 ventilation for motor-driven equipment	K 921	facility preventative maintenance program. Monitoring A QAPI will be done by the DON/Designee to ensure that oxygen concentrator intake vent is not blocked to allow the concentrator to have clear access and work properly monthly. The report will be submitted to the administrator and will be discussed during the quarterly meeting. A QAPI will be done by Environmental Service Consultant/Designee to ensure that all plugs to resident room beds were not modified or altered with NFPA 99 monthly x 3 months and quarterly thereafter. The report will be submitted to the Administrator and discussed during the quarterly meeting.	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and	K 923		3/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 923	Continued From page 34 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, interview ad record review, in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to store cylinders of compressed oxygen in a manner that would protect the cylinders against	K 923	Specific Corrective Action The oxygen cylinder in Floor#3 in the closet that was observed freestanding and unprotected was stored in a safe secured	

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K 923	Continued From page 35 tipping, rupture and damage in accordance with NFPA 99. This deficient practice was identified for 1 of 8 portable oxygen cylinders observed and was evidenced by the following: At 11:52 AM, the surveyor observed on floor #3 in the oxygen storage closet that 1 of 8 portable oxygen cylinders were freestanding and stored unprotected against tipping, rupture and damage.The portable oxygen cylinder was at approximately 800 PSI when observed. An interview was conducted with the U.S. FOIA (b) who stated that the cylinder observed, must be secured from tipping, rupture and damage at all times in the facility. The U.S. FOIA (b) (6) was informed of the finding at the life safety code exit conference on 3/6/24. NJAC 8:39-31.2(e) NFPA 99	K 923	manner. The facility consultant has in-service how to store cylinders of compressed oxygen in a manner that would protect the cylinders against tipping, rupture, and damage in accordance with NFPA 99 Identification All residents have the potential to be affected by the deficient practice. Systemic Changes The maintenance staff will do a weekly audit to ensure that all compressed oxygen cylinders are stored in a secure, safe manner and that the oxygen cylinder is protected against tipping, rupture, and damage. Monitoring A QAPI will be conducted by the Maintenance team to ensure audit to ensure that all compressed oxygen cylinders are stored in a secure, safe manner and that the oxygen cylinder is protected against tipping, rupture, and damage.	

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
315378 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/14/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & HEALTH CARE CENTER	129 MORRIS TURNPIKE NEWTON, NJ 07860

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 K0161	03/10/2024	LSC K0222	03/25/2024	LSC K0271	03/27/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0281	03/28/2024	LSC K0321	04/09/2024	LSC K0324	03/24/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0345	04/08/2024	LSC K0351	04/06/2024	LSC K0353	04/08/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0355	03/13/2024	LSC K0374	03/27/2024	LSC K0521	03/27/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0761	03/28/2024	LSC K0911	03/29/2024	LSC K0914	03/28/2024

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
315378 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/14/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & HEALTH CARE CENTER	129 MORRIS TURNPIKE NEWTON, NJ 07860

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction		
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed		
LSC K0921	03/26/2024	LSC K0923	03/26/2024		

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?
3/6/2024	☐ YES ☐ NO