STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315390	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANFORD PARK CARE	600 LINCOLN PARK EAST CRANFORD, NJ 07016

(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: NJ 167761, NJ 170615, NJ 171733 STANDARD SURVEY: 3/18/24-3/27/24 CENSUS: 64 SAMPLE SIZE: 16+3 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 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the	F 637		4/1/24

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

Electronically Signed | 04/18/2024

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F 637	Continued From page 1 care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility provided documents, it was determined that the facility failed to ensure that a NJ Ex Order 26.4b1 ([redacted]) was completed for Resident #24. This deficient practice was identified for one (1) of 19 residents reviewed, and was evidenced by the following: According to the MDS (minimum data set) 3.0 RAI (Resident Assessment Instrument) Manual included that the [redacted] is a comprehensive assessment for a resident must be completed when the IDT (interdisciplinary team) has determined that a resident meets the [redacted] guidelines for either NJ Ex Order 26.4b1 or [redacted] A "NJ Ex Order 26.4b1" is a [redacted] or NJ Ex Order 26.4b1 in a resident's status that: 1. Will not normally NJ Ex Order 26.4b1 without intervention by staff or by implementing standard NJ Ex Order 26.4b1 interventions, the [redacted] is not considered "NJ Ex Order 26.4b1"; 2. Impacts more than one area of the resident's NJ Ex Order 26.4b1; and 3. Requires interdisciplinary review and/or revision of the care plan. On 3/21/24 at 11:03 AM, the surveyor observed Resident #24 in the dining area (also known as the activity room) laying in NJ Ex Order 26.4b1 ([redacted] with NJ Ex Order 26.4b1 and the NJ Ex Order 26.4b1. The surveyor reviewed the hybrid (combination of paper and electronic) medical records of	F 637	F 637 Comprehensive Assessment after Significant Change Plan of Correction ¿ Corrective action for the resident affected by the deficient practice. " The affected resident continues to reside in the facility. " The resident was not adversely affected by the deficient practice. ¿ Corrective action taken for those residents having the potential to be affected by the deficient practice " . All residents in the facility who develop a significant change have the potential to be affected by the deficient practices. ¿ Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur: " The DON/Designee educated the US FOIA (b)(6) that a Significant Change in Status Assessment (SCSA) should be completed once the IDT had identified two areas of improvement or decline. This assessment should define the two areas of improvement or decline.	

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F 637	Continued From page 2 Resident #24 as follows: According to the Admission Record (admission summary), Resident #10 was admitted to the facility with a diagnosis that included but was not limited to NJ Ex Order 26.4b1 ([redacted]). The resident's comprehensive MDS (cMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of [redacted] revealed in Section [redacted] Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which reflected that the resident's cognition was [redacted]. The cMDS Section [redacted] Status revealed that the resident had a [redacted] of [redacted] in the last month or a [redacted] of [redacted] in the [redacted]. Section [redacted] showed that Resident #24 had [redacted] that was a [redacted].	F 637	¿ How will corrective actions be monitored to ensure the deficient practice will not re occur: " The Director of Nursing /designee will conduct a weekly audit of residents who were observed to have had a significant change or two areas of decline or improvement. " The Director of Nursing /designee will conduct a weekly audit on the identified residents who were noted to have had two areas of decline or improvement to check that a Significant Change in Status Assessment was completed by the MDS Coordinator. " The audit will be conducted weekly x 4 weeks, then monthly x 3 months. " All findings will be presented during the monthly QAPI committee meeting for review.	

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F 637	Continued From page 3	F 637		

The quarterly MDS (qMDS) with an ARD of NJ Ex Order 26.4 included that Resident #24 had no NJ Ex Order 26.4b1 and the NJ Ex Or was NJ Ex Order 2

Further review of the MDS revealed that the NJ Ex Order 26.4b1 cMDS was noted with two areas of changes in resident's assessment status as evidence of NJ Ex Order 26.4b1 and presence of NJ Ex O which was not present in the qMDS dated NJ Ex Order 26.

A review of the NJ Ex Order 26 Summary revealed on NJ Ex Order 26.4b1 the resident's NJ Ex Order 2 was NJ Ex Order 26.4b1 NJ Ex Ord with warning notes that included the following:
NJ Ex Order 2 change [comparison NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Or, NJ Ex Order 26.4b1]
NJ Ex Order 2 change [comparison NJ Ex Order 26.4b1 NJ Ex Order 26.4b1, NJ Ex Or, NJ Ex Order 26.4b1]

A review of the IDCP (Interdisciplinary)/CARE Conference Note with an effective date of NJ Ex Order 26.4b1 included NJ Ex Order 26.4b1 that was electronically signed by the NJ Ex Order 26.4b on NJ Ex Order 26.4b1 that the resident was triggered for a significant NJ Ex Order 26.4b1 x 1 (one) month NJ Ex Ord.

A review of the NJ Ex Order 26.4b1 Chart Details (a NJ Ex Order 26.4b1 visit notes) dated NJ Ex Order 26.4b1 included that Resident #24 had a NJ Ex O to the NJ Ex [redacted].

On 3/25/24 at 11:46 AM, the survey team met with the US FOIA (b)(6)). The US FOIA (b)(6) informed the surveyors that the facility had no specific policy regarding MDS, the facility follows the RAI Manual. The US FOIA (b)(6) stated that if there will be two or more NJ Ex Order 26.4b1 either NJ Ex Order 26.4b1 or NJ Ex Order 26 in the resident's NJ Ex Order 2, that will be the

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F 637	Continued From page 4 criteria that the MDS assessment for [NJ Ex Order 2] will be done. On that same date and time, the surveyor asked the [US FOIA (b)(6)] why the resident's cMDS on ARD [NJ Ex Order 26.4b1] was not an [NJ Ex Order 2] considering the above changes and [NJ Ex Order 26.] in the resident's status in comparison to qMDS on [NJ Ex Order 26.2]. The [US FOIA (b)(6)] stated that it was "probably" a mistake, and acknowledged that the [NJ Ex Order 26.4b1] cMDS should be a [NJ Ex Order 2]. On 3/25/24 at 12:27 PM, the survey team met with the US FOIA (b)(6) [redacted]. The surveyor notified the facility management of the above findings and concerns. On 3/26/24 at 02:15 PM, the survey team met with the US FOIA (b)(6) [redacted]. The facility management did not respond to the above findings and concerns.	F 637		
F 640 SS=E	NJAC 8:39-11.2(i) Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment.	F 640		4/1/24

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F 640	Continued From page 5	F 640		

(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved

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F 640	Continued From page 6 by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on the interview and record review, it was determined that the facility failed to complete and submit electronically the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care of all residents, within 14 days of completing the resident's assessment and in accordance with the Center's for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual. This deficient practice was identified for 7 of 19 residents (Resident #41, 9, 53, 3, 50, 66, and #10) and reviewed for resident assessment. According to the Long-Term Care RAI 3.0 User's Manual Version 1.18.11, updated October 2023, the MDS is a comprehensive tool and a federally mandated process for clinical assessment of all residents. It must be completed and transmitted to the Quality Measure System. The facility must electronically transmit the MDS within 14 days of the assessment being completed. This deficient practice was evidenced by the following: On 3/19/24, at 9:30 AM, the surveyor reviewed the facility task that includes residents' MDS assessments, which was triggered under the survey facility task as "MDS record over 120 days old." 1. Resident #41 was observed to have a Quarterly MDS (QMDS) with an Assessment Reference Date (ARD) on [redacted], which was due to be transmitted to CMS no later than	F 640	F 640 Encoding/Transmitting Resident Assessments Plan of Correction ¿ Corrective action for the residents affected by the deficient practice. " Residents #41, # 9, # 53, # 3, # 50, and #10 continue to reside in the facility. ¿ Corrective action taken for those residents having the potential to be affected by the deficient practice. 1. All residents have the potential to be affected by this deficient practice. 2. The MDS assessments for all other residents were audited for completeness, accuracy, and timely submission to CMS. 3. No other residents were observed to have been affected by this deficient practice. ¿ Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur: " The Director of Nursing/designee educated the [redacted] that	

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F 640	Continued From page 7 NJ Ex Order 26.4. However, the QMDS was not submitted to CMS until NJ Ex Order 2. 2. Resident #9 was observed to have a QMDS with an ARD on NJ Ex Order 2, which was due to be transmitted to CMS no later than NJ Ex Order 26.4. However, the QMDS was not submitted to CMS until NJ Ex Order 2. A review of QMDS with an ARD on NJ Ex Order 26.4 was due to be transmitted to CMS by NJ Ex Order 26.4b1. The QMDS was not submitted to CMS until NJ Ex Order 26.4. 3. Resident #53 was observed to have Annual MDS (AMDS) with an ARD on NJ Ex Order 26.4, which was due to be transmitted to CMS no later than NJ Ex Order 26. However, the AMDS was not submitted to CMS until NJ Ex Order 2. A review of QMDS with an ARD on NJ Ex Order 26.4b1 was due to be transmitted to CMS by NJ Ex Order 26.4b1. The QMDS was not submitted to CMS until NJ Ex Order 26.4. 4. Resident #3 was observed to have AMDS with an ARD on NJ Ex Order 26.4, which was due to be transmitted to CMS no later than NJ Ex Order 26.4. However, the AMDS was not submitted to CMS until NJ Ex Order 2. 5. Resident #50 was observed to have QMDS with an ARD on NJ Ex Order 26.4, which was due to be transmitted to CMS no later than NJ Ex Order 26.4. However, the QMDS was not submitted to CMS until NJ Ex Order 2. 6. Resident #66 was observed to have QMDS with an ARD on NJ Ex Order 26.4, which was due to be transmitted to CMS no later than NJ Ex Order 26.4. However, the QMDS was not submitted to CMS	F 640	completed residents MDS assessments should be submitted to CMS within 14 days of its completion. " The Director of Nursing/designee educated the US FOIA (b)(6) to make a weekly check list for residents whose MDS assessments were completed. The checklist will contain a column for the name of the resident whose MDS assessments were completed, a column for the type of MDS assessment being completed, a column for the Assessment Reference Date (ARD), a column for the expected transmittal due date (14 days after completion of the assessment) and a column for the actual date that the completed MDS assessments were transmitted to CMS. This checklist will guide the MDS coordinator to transmit the completed MDS assessment on or before the expected date of submission to be in compliance with MDS regulations. ¿ How will corrective actions be monitored to ensure the alleged deficient practice will not re occur: 1. The Director of Nursing /designee will conduct a weekly audit to check the dates of completion of 3 residents whose MDS assessments were completed in the past 15 days. 2. The Director of Nursing /designee will conduct a weekly audit of 3 residents whose MDS assessments were completed in the past 15 days to check	

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F 640	Continued From page 8 until [NJ Ex Order 2]. 7. Resident #10 was observed to have AMDS with an ARD on [NJ Ex Order 26.4], which was due to be transmitted to CMS no later than [NJ Ex Order 26.4]. However, the AMDS was not submitted to CMS until [NJ Ex Order 2]. A review of QMDS with an ARD on [NJ Ex Order 26.4b] was due to be transmitted to CMS by [NJ Ex Order 26.4b]. The QMDS was not submitted to CMS until [NJ Ex Order 26.4]. A review of the MDSC's undated "Final Validation Report" for Residents #41, 9, 53, 3, 50, 66, and #10 revealed that "The submission date is more than 14 days after [NJ Ex Order 26.4] on this new assessment." On 3/25/24 at 11:46 AM, the survey team met with the [US FOIA (b)(6)]. The [US FOIA (b)(6)] informed the surveyors that the facility has no specific policy regarding MDS and follows the RAI Manual. The [US FOIA (b)(6)] stated that submissions were late because the discipline needed to complete their assessment. On 3/25/24 at 12:27 PM, the survey team met with the [US FOIA (b)(6)] The surveyor notified the facility management of the above findings and concerns. On 3/26/24 at 02:15 PM, the survey team met with the [US FOIA (b)(6)]. The facility management did not respond to the above findings and concerns.	F 640	that the MDS assessments were submitted to CMS within 14 days of completion. 3. The audit will be conducted weekly x 4 weeks, then monthly x 3 months. 4. All findings will be presented during the monthly QAPI committee meeting for review.	

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F 640	Continued From page 9	F 640		
F 641 SS=E	NJAC 8:39 - 11.1 Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on the interview and record review, it was determined that the facility failed to code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care of all residents, accurately for 5 of 19 residents reviewed (Resident # 69, # 9, # 57, #63, and # 24). The deficient practice was evidenced by the following: 1. The surveyor reviewed Resident # 69's records. The resident was discharged from the facility and according to the Discharge Return Anticipated MDS, an assessment tool used to facilitate the management of care, dated [NJ Ex Order 26.4], the resident was assessed as being discharged to the hospital. A review of Resident # 69's progress notes dated [NJ Ex Order 26.4] revealed the resident had actually been discharged [NJ Ex Order 26.4] NJ Ex Order 26.4b1 On 3/25/24 at 11:49 AM, the surveyor interviewed the US FOIA (b)(6)), who stated that the MDS under section [NJ], which is she completes, for Resident #69 should have indicated discharge to [NJ Ex Order] and that it was an	F 641	F 641 Accuracy of Assessments Plan of Correction ¿ Corrective action for the residents affected by the deficient practice. " Residents # 9, # 57, # 63,# 69 and # 24 continue to reside in the facility. " The PHQ-9 assessment interview was completed by the US FOIA (b)(6) for Resident # 9 and entry for the [NJ Ex Order 26.4b1] was corrected on March 25, 2024, and submitted on March 26, 2024. " The PHQ-9 assessment interview was completed by the Social Worker for Resident # 57 on March 25 and submitted on resubmitted on March 26, 2024. " The MDS assessment for Resident # 63 was corrected on March 26, 2024, and submitted on the same day. " The MDS assessment for Resident # 24 was corrected on March 25, 2024and submitted on the same day.	4/1/24

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F 641	Continued From page 10 error that it indicated discharge to the hospital. During an interview on 3/25/24 at 12:15 PM, the surveyor brought the above concerns to the attention of the US FOIA (b)(6) and US FOIA (b)(6)). 2. On 03/20/24 at 11:40 AM, the surveyor observed Resident #9 in bed lying NJ Ex Order 26.4b1 , NJ Ex Order 26.4b with NJ Ex Order 26.4b1 , and NJ Ex Order 26.4b1 . The surveyor reviewed Resident #9's hybrid (combination of paper and electronic) medical record as follows: A review of the Admission Record (an admission summary) (AR) documented that Resident #9 was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1). The resident's most recent Quarterly MDS (QMDS) assessment, dated NJ Ex Order 2 , reflected that Resident #9 had a Brief Interview for Mental Status (BIMS) score of NJ out of 15, indicating NJ Ex Order 26.4b1 . Section NJ F Special Treatments, Procedures, and Programs revealed that Resident #9, the NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1), was up to date. There is no record that a NJ Ex Order 26.4b1 was given to Resident #9. The NJ Ex Order 26.4b1 record shows that the resident's NJ Ex O refused the NJ Ex Order 26.4b1	F 641	¿ Corrective action taken for those residents having the potential to be affected by the deficient practice. 1. . All residents in the facility have the potential to be affected by this deficient practice. 2. No other residents were adversely affected by this deficient practice. ¿ Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur: 1. The Director of Nursing/designee educated the US FOIA (b)(6) to ensure that before closing the MDS assessment, all sections and notes are completed by each discipline responsible for that section. 2. The Director of Nursing/designee educated the US FOIA (b)(6) about ensuring that the assessment submitted must accurately reflect the resident's status based on data found in the EHR. 3. The administrator educated the US FOIA (b)(6) regarding the completion of PHQ 9 for all residents when an MDS assessment is initiated.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 11 NJ Ex Order 26.4b1 on NJ Ex Order 2. A review of QMDS dated 2/1/24, section NJ Resident NJ Ex Order Interview (NJ Ex Order 26), signed by the US FOIA (b)(6) on NJ Ex Order 2, revealed no record of a NJ Ex Order 26 assessment interview done on the ARD of NJ Ex Order 26. A review of QMDS dated NJ Ex Order 2, section NJ NJ Ex Order 26.4b1 Symptoms, signed by the US FOIA (b) on NJ Ex Order 2, revealed no NJ Ex Order 26.4b1 Symptoms assessment interview on the ARD of NJ Ex Order 2. On 3/25/24 at 11:46 AM, the survey team met with the US FOIA (b)(6) The US FOIA (b)(6) stated that the NJ Ex Order 26.4b1 should reflect the accurate status of the resident's NJ Ex Order 26.4b1 history and that the resident had refused the NJ Ex Order 26.4b 3. On 03/21/24 at 10:47 AM, the surveyor observed Resident #57 sitting in bed, NJ Ex Orc and NJ Ex Order 26.4b1 NJ Ex Order 26.4b1. The surveyor reviewed Resident #57's hybrid medical record as follows: A review of the AR documented that Resident #57 was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26.4b1 (NJ). The resident's most recent Admission MDS (AMDS) assessment, dated NJ Ex Order 26.4b1, reflected that Resident #57 had a BIMS score of NJ Ex out of 15, indicating NJ Ex Order 26.4b1. A review of AMDS dated NJ Ex Order 26.4b1, section NJ , signed by the US FOIA (b)(6) on NJ Ex Order 26.4b1, revealed no record of a NJ Ex Order 26.4 assessment	F 641	¿ How will corrective actions be monitored to ensure the alleged deficient practice will not re occur: 1. The Director of Nursing /designee will conduct a weekly audit of MDS submissions of residents to validate that all sections and notes were completed by each discipline before the assessment was closed as complete. 2. The Director of Nursing /designee will conduct a weekly audit of MDS submissions of residents to check that the data on these assessments were correct and accurate based on the resident□s hybrid medical record. 3. The audit will be conducted weekly x 4 weeks, then monthly x 3 months. 4. All findings will be presented during the monthly QAPI committee meeting for review.	

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	315390	A. BUILDING _____ B. WING _____	C 03/27/2024

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F 641	Continued From page 12 interview done on the ARD of NJ Ex Order 26.4b1. A review of AMDS dated NJ Ex Order 26.4b1, section NJ Symptoms, signed by the US FOIA (b)(6) on NJ Ex Order 26.4b1, revealed NJ Exec Order 26.4b1 Symptoms assessment interview on the ARD of NJ Ex Order 26.4b1. On 03/26/24 at 11:11 AM, the surveyor interviewed the US FOIA (b)(6) who worked in the facility for NJ Ex years as a charge nurse and works closely with the US FOIA (b)(6) The US FOIA stated that she tried as much as possible to check the MDS assessment before submitting it. She checked and reviewed the look-back period. The surveyor asked the US FOIA where to find the assessment, such as NJ Ex Order 26 and NJ Ex Order 26.4b1 assessment. The US FOIA showed the surveyor the "Evaluations" tab in the electronic medical record but could not find NJ Ex Order 26 and NJ Ex Order 26.4b1 interview assessment for Resident #9 QMDS dated NJ Ex Order 2 and Res. #57 AMDS dated NJ Ex Order 26.4b1, respectively. On 03/27/24 at 9:50 AM, the surveyor interviewed the US FOIA (b)(6) and stated that the social worker completed MDS assessment sections C, D, E, and Q and that the interview should be conducted on the ARD date, NJ Ex Order 26.4b1. 4. On 3/20/24 at 12:22 PM, the surveyor observed Resident #63 seated in a wheelchair in the dayroom NJ Ex Order 26.4b1 The surveyor reviewed Resident #63's electronic medical record.	F 641		

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F 641	Continued From page 13 A review of Resident #63 AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted]. A review of Resident #63's quarterly MDS, an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident had a BIMS score of [redacted] out of 15, which indicated that Resident #63's [redacted] was [redacted]. Further review of Section [redacted] Special Treatments, Procedures, and Programs indicated that under [redacted] Resident #63's [redacted] was up to date. A review of Resident #63's electronic medical record under the [redacted] tab included the following: [redacted] It did not indicate a date that it was given as complete or a date with historical to indicate that the resident had the [redacted] in the past. On 3/21/24 at 01:50 PM, in the presence of the survey team, the surveyor requested the [redacted] and [redacted] provide information on Resident #63's	F 641		

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NJ Ex Order 26.4b1

On 3/25/24 at 11:25 AM, the US FOIA (b) provided the surveyor a document that included the following:
NJ Ex Order 26.4b1
Resident #63- ... NJ Ex Order 26.4b1 the consent was signed by the NJ Ex Order 26.4b1 not given.

On 3/25/24 at 11:47 AM, in the presence of the survey team, the surveyor interviewed the US FOIA (b)(6) regarding the process for MDS. The US FOIA (b)(6) stated that she inputted the data and that a US FOIA (b)(6) would review the information to make sure it was accurate before the US FOIA (b)(6) submitted the MDS. The surveyor asked the US FOIA (b)(6) where the NJ Ex Order 26.4b1 status was located that she entered into the MDS. The US FOIA (b)(6) stated that she looked in the electronic medical record under the NJ Ex Order 26.4b1 section. She then stated that if the information was not in the electronic medical record that she would ask the resident or the resident representative. The surveyor then asked the US FOIA (b)(6) what "req" meant on on Resident #63's NJ Ex Order 26.4b1 section. The US FOIA (b)(6) stated that it meant request. The surveyor then asked the US FOIA (b)(6) the reason Resident #63's MDS was coded up to date for the NJ Ex Order 26.4b1 when the resident did not receive the NJ Ex Order 26.4b1 The US FOIA (b)(6) stated that she would have to look into it.

On 3/25/24 at 12:31 PM, in the presence of the survey team, the surveyor told the US FOIA (b)(6) the concern that Resident #63 was not offered the NJ Ex Order 26.4b1 prior to surveyor inquiry and that the MDS was coded inaccurately to indicate that Resident #63's NJ Ex Order 26.4b1 was up to date when

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F 641	Continued From page 15 the resident had not received the NJ Ex Order 26.4b1 On 3/26/24 at 9:47 AM, in the presence of the survey team and US FOIA (b)(6) the US FOIA (b) stated that the US FOIA (b)(6) was in-serviced and that she corrected Resident #63's MDS. A review of the printed MDS that the facility provided indicated that the printed view was different from the electronic view. On 3/26/24 at 11:04 AM, the surveyor showed the US FOIA (b)(6) the different codes in the viewable and printed version of the MDS. The US FOIA (b)(6) confirmed that the viewable version in the electronic medical record was a 1 and that indicated a yes for up to date and that the printed version indicated a 1 and that indicated a no for up to date. The US FOIA (b) stated that the correct answer that she inputted was a yes for up to date. On 3/26/24 at 02:16 PM, in the presence of the survey team, the surveyor told the US FOIA (b)(6) the concern that the MDS printout was different then the transmitted version in the electronic medical record. On 3/27/24 at 9:13 AM, the US FOIA (b)(6) provided an email from the company for the electronic medical record. The email dated NJ Ex Order 26.4 included the following: We believe we have identified a defect affect Section NJ Ex Order 26.4b printing as No on the print version of the MDS, and it is currently under review. We will notify you of any updates via email as they become available. Currently, there is no workaround for this problem. However, it is important to note that while the response from the MDS assessment is appearing	F 641		

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correctly.

The facility did not provide any additional information.

5. On 3/21/24 at 11:03 AM, the surveyor observed Resident #24 in the dining area (also known as the activity room) laying in the [redacted] with [redacted] and the [redacted].

The surveyor reviewed the hybrid medical records of Resident #24 as follows:

According to the AR, Resident #10 was admitted to the facility with a diagnosis that included but was not limited to essential [redacted].

The resident's comprehensive MDS (cMDS) with an ARD of [redacted] revealed in Section [redacted] with BIMS score of [redacted] out of 15

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which reflected that the resident's NJ Exec Order 26.4b was NJ Ex Order 26.4b1. Section NJ E Special Treatments, Procedures, and Programs revealed that Resident #24 was offered and declined the NJ Ex Order 26.4b1 NJ Ex Order 26.4b1).

The NJ Exec Order 26.4b1 record in the electronic medical record (eMR) revealed that Resident #24 had the NJ Ex Order 26.4b1 on NJ Ex Order 26.4.

The above NJ Ex Order 26.4b1 was signed as administered in the NJ Ex Order 26.4b1 electronic Medication Administration Record (eMAR).

On 3/25/24 at 11:46 AM, the survey team met with the US FOIA (b)(6) The US FOIA (b)(6) informed the surveyors that the facility had no specific policy regarding MDS, the facility follows the RAI Manual. The US FOIA (b)(6) stated that the NJ Ex Order 26.4b1 on NJ Ex Order 26.4b1 should reflect the accurate status of the resident's NJ Ex Order 26.4b1 history that the resident had received the NJ Ex Order 26.4b1.

On 3/25/24 at 12:27 PM, the survey team met with the US FOIA (b)(6) . The surveyor notified the facility management of the above findings and concerns.

On 3/26/24 at 02:15 PM, the survey team met with the US FOIA (b)(6) . The facility management did not respond to the above findings and concerns.

NJAC 8:39-11.2(e)1

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F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §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 review of the medical record and review of other facility documentation, it was determined that the facility failed to maintain professional standards of clinical practice by failing to assess the [NJ Ex Order 26] for a resident that was at [NJ Ex Order 26.4b1] and had a [NJ Ex O] according to the facility policy for 1 of 2 residents reviewed for [NJ Exec O] (Resident #63). This deficient practice was evidenced by the following: Reference: New Jersey Statues, Annotated Title 45, Chapter. 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 well being, and executing a medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and	F 658	F 658 Services Provided Meet Professional Standards Plan of Correction ¿ Corrective action for the resident affected by the deficient practice. " The affected resident continues to reside in the facility. " The resident was assessed and found not adversely affected by the deficient practice. ¿ Corrective action taken for those residents having the potential to be affected by the deficient practice. " . All residents in the facility have the potential to be affected by this deficient practice. ¿ Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur: " The Director of Nursing/designee	3/29/24

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F 658	Continued From page 19 responsibilities with in the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." A review of Resident #63 Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted]. A review of Resident #63's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that Resident #63's [redacted] was [redacted]. Further review of Section [redacted] indicated that under [redacted] Resident #63 had a [redacted] since admission/entry or reentry or the prior assessment. A review of Resident #63's electronic medical record under the evaluations section indicated	F 658	educated the licensed nursing staff with regards to consistently completing resident□s fall evaluations quarterly and when there is a change of condition observed. " The Director of Nursing/Designee educated all the licensed nursing staff that Fall Evaluations are scheduled Quarterly, and that these evaluations should be completed in a timely manner, before or on the due date and not after. ¿ How will corrective actions be monitored to ensure the alleged deficient practice will not re occur: " The Director of Nursing /designee will conduct a weekly audit to randomly review the clinical records of 5 residents to check that Fall evaluations were completed for these residents.: " The Director of Nursing /designee will conduct a weekly audit to randomly review the clinical records of 5 residents to check that Fall evaluations were completed on or before the due date and not after. " The audit will be conducted weekly x 4weeks, then monthly x 3months. " All findings will be presented during the monthly QAPI committee meeting for review.	

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that the last NJ Ex Order 26.4b1 Evaluation was done on NJ Ex Order 26. There was not another quarterly NJ Ex Order 26.4b1 Evaluation done which would have been due to be done on NJ Ex Order 2. The surveyor was unable to open or view the NJ Ex Order 26. NJ Ex Order 26.4b1 Evaluation.

On 3/21/24 at 11:40 AM, the surveyor interviewed the US FOIA (b)(6) regarding NJ Ex risk assessments (evaluations). The US FOIA stated that the NJ Ex Order 26 was done on admission and then quarterly. She added that the admission nurse did the admission NJ Ex Order 26 and that the night nurse did the quarterly. The US FOIA stated that the NJ Ex Order 26 assessment would be in the electronic medical record.

On 3/21/24 at 12:59 PM, the surveyor interviewed the US FOIA (b)(6) and asked where the NJ Ex Order 26 assessment was located. The US FOIA (b) in the presence of the US FOIA (b)(6) stated that the NJ Ex Order 26 assessment should be under the evaluations section in the electronic medical record.

On 3/21/24 at 01:52 PM, in the presence of the survey team, the surveyor requested the US FOIA (b)(6)) and the US FOIA print Resident #63's NJ Ex Order 26 assessments since the last recertification survey that was in NJ Ex Order 26.4b1. The surveyor told the US FOIA (b)(6) and US FOIA that the surveyor could not open or view the actual NJ Ex Order 26 assessment.

On 3/22/24 at 8:40 AM, the US FOIA (b)(6) provided the surveyor a copy of 2 NJ Ex Order 26 evaluations with effective dates of NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1. The surveyor reviewed the last one which had an effective date of NJ Ex Order 26.4b1 but it did not have a created date on it. The surveyor then reviewed

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Resident #63's electronic Progress Notes that were linked to the [redacted] evaluation. The [redacted] Evaluation had a created date of [redacted]. The [redacted] Evaluation was created after surveyor inquiry.

On 3/22/24 at 9:45 AM, in the presence of another surveyor, the surveyor asked the [redacted] when the [redacted] Evaluation was created. The [redacted] viewed Resident #63's electronic medical record and stated that the [redacted] assigned to the resident created the [redacted] Evaluation yesterday ([redacted]). The surveyor asked the [redacted] if the [redacted] Evaluation should have been done prior to surveyor inquiry. The [redacted] stated that it should have been done prior.

On 3/25/24 at 12:31 PM, in the presence of the survey team, the surveyor told the [redacted] the concern that Resident #63's [redacted] assessment was not done in [redacted] when it was due to be done quarterly.

On 03/26/24 at 9:38 AM, in the presence of the survey team, the surveyor asked the [redacted] and [redacted] if the [redacted] assessment should have been done prior to surveyor inquiry. The [redacted] stated "it was still in the quarter." The facility provided additional printed [redacted] evaluations.

A review of the additional documents indicated a [redacted] assessment that had an effective date of [redacted] and [redacted] (dated after surveyor inquiry). The surveyor reviewed Resident #63's electronic Progress Notes that were linked to the [redacted] assessment. The [redacted] Evaluation had a created date of [redacted] (dated after surveyor inquiry).

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F 658	Continued From page 22 On 3/26/24 at 11:40 AM, in the presence of the survey team, the surveyor asked the [US FOIA (b)] when the additional [NJ Ex Order 26] evaluations with effective date of [NJ Ex Order 26.4b1] and [NJ Ex Order 26.4] were done. The [US FOIA (b)] stated that the they both were created in [NJ Ex Order 26.4b1]. The [US FOIA (b)] added that it was a late entry. The facility did not provide any additional information. A review of the facility provided policy titled "Falls, Resident: Prevention Program" with a revised date of 3/20/24, included the following: Policy: All residents will be assessed for fall risk on admission. All residents will be reassessed at least quarterly in conjunction with their MDS evaluation, or in the event of change in status. Procedure: 1. The licensed nurse will complete a Fall Risk Assessment for each new admission and quarterly in conjunction with their MDS evaluation.	F 658		
F 686 SS=E	N.J.A.C. 8:39-27.1 (a) 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	F 686		4/1/24

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F 686	Continued From page 23 ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to implement an intervention timely that was recommended by the NJ Ex Order 26 physician. This deficient practice was identified for one of one resident (Resident #28) reviewed. This deficient practice was evidenced by the following: On 3/18/24 at 11:02 AM, the surveyor observed the Resident #28 lying in bed on an NJ Ex Order 26.4b1 The resident NJ Ex Order 26.4b1 in a NJ Ex Orde [redacted]. The resident gave permission to speak with the NJ Ex Order 26. who was in the room. The NJ Ex Order 26. stated, "[The resident] came here because of a NJ Ex Order 2 about NJ Ex Order 26.4b1 ago." On 3/18/24 at 11:26 AM, the surveyor interviewed the NJ Ex Order 26.4b1 who stated, "[the resident] was in the hospital in NJ Ex Order 26.4b1 for NJ Ex Order 26.4b1 and has NJ Ex Order 26.4b1 that NJ Ex Order 26.4b1 [redacted]. The resident also had another NJ Ex Order 26.4b1 and had NJ Ex Order 26.4b1 recently in the hospital. [the resident] has a NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, from the hospital from NJ Ex Order 26.4b1." On 3/20/24 at 11:25 AM, observed the resident lying in bed, on an NJ Ex Order 26.4b1. The resident	F 686	F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer Plan of Correction ¿ Corrective action for the resident affected by the deficient practice. " The affected resident continues to reside in the facility. " The recommendation from the NJ Ex Order 26 doctor was clarified, the NJ Ex Order 26.4b1 was ordered and applied. " The resident was assessed by nursing staff and was found to have had NJ Ex Order 26.4b1 resulting from the deficient practice. ¿ Corrective action taken for those residents having the potential to be affected by the deficient practice. " . All residents in the facility with wounds have the potential to be affected by this deficient practice. ¿ Measures/Systemic changes put in place to assure the deficient practice does	

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	315390	A. BUILDING _____ B. WING _____	C 03/27/2024

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F 686	Continued From page 24 stated, "I am NJ Ex Order 26.4b1, I have NJ Ex Order 26.4b1." On 3/20/24 at 11:28 AM, interviewed License Practical Nurse (LPN) #1 from Unit NJ Ex who worked in the facility for seven years. The US FOIA stated, "The resident gets NJ Ex Order 26.4b1 M-W-F between 1-4 PM with NJ Ex Order 26.4b1. The resident gets NJ Exec Order 26. The NJ Ex Order 26.4b1 has not NJ Ex Order 26.4b1 it's NJ Ex Order 2." On 3/21/24 at 12:49 PM, observed the resident lying in bed. The resident stated, "I NJ Ex Order 26.4b1 today and I feel NJ Ex Orde The resident's NJ Ex Order 26.4b1 who was in the room stated, "They mentioned yesterday that the NJ Ex Order 26 team will look into a NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1). The US FOIA (b)(6) spoke to me on Monday and mentioned at this point that they are keeping the NJ Ex Order 26.4b1 for possible application of a NJ Ex Order 26. I spoke to the NJ Ex Order 26 doctor's office on Monday, and they said there's no indication of NJ Ex Order 26.4b and would determine soon for possible NJ Ex Order 26.4b1. I am waiting to hear back when that would be applied." On 3/21/24 at 12:57 PM, interviewed LPN #1, who stated, "The NJ Ex Order 2 treatment order is NJ Ex Order 26.4b1 with NJ Ex Order 26.4b1, doctor [name redacted] and his assistant did NJ Ex Order 26 rounds yesterday. The NJ Ex Order 26 is NJ Ex Order 26.4b1 and the treatment orders are the same. I haven't got any orders yet about the NJ Ex Order 26.4b1." On 3/21/24 at 1:02 PM, interviewe US FOIA (b)(6) who stated, "The resident is being followed by a NJ Ex Order 26.4b1 team. The NJ Ex Order 26 report comes to me every week and I review it. If there's a new	F 686	not re occur: " The Administrator educated the US FOIA (b)(6) to ensure that all recommendations made by the wound team are clear and precise. " The Administrator educated the US FOIA (b)(6) to ensure that any recommendations made by the wound team that are vague should be immediately clarified and corrected to prevent delay in services. ¿ How will corrective actions be monitored to ensure the deficient practice will not re occur: " The Director of Nursing /designee will conduct a weekly audit to review the recommendations of the wound team to ensure that these are precise and clear.: " The Director of Nursing /designee will conduct a weekly audit to ensure that if the wound team recommendations are vague and questionable, these should be clarified as soon as possible so that the recommendations can be carried out and wound treatment can be implemented in a timely manner. " The audit will be conducted weekly x 4weeks, then monthly x 3months. " All findings will be presented during the monthly QAPI committee meeting for review.	

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F 686	Continued From page 25	F 686		

treatment, I am updating the orders for anything new. I haven't seen anything yet for an order of a NJ Ex Order 26.4b1 ."

A record review of the Admission Record in the Electronic Health Record (EHR) reflected the Resident #28 was admitted to the facility with medical diagnoses which included but not limited to: NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1); NJ Ex Order 26.4b1 ; NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 ; NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1); NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1); NJ Ex Order 26.4b1 ; NJ Ex Order 26.4b1 , and NJ Ex Order 26.4b1 ; and NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1).

According to the Minimum Data Set (MDS) an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4b1 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ E out of 15 indicating NJ Ex Order 26.4b1 . The assessment further reflected that the resident had a NJ Ex Order 26.4b1 on admission, NJ Ex Order 26.4b1 ng and on a NJ Ex Order 26.4b1 and required NJ Exec Order 26.4b1 to NJ Exec O assistance with Activities of Daily Living (ADLs).

The resident's care plan initiated on NJ Ex Order 26.4b1 indicated Resident #28 had a NJ Ex Order 26.4b1 on admission related to NJ Ex Order 26.4b1 .

A review of the Order Summary in the resident's EHR reflected NJ Exec Order 26.4b1 Give NJ Ex Order 26.4b1 by mouth one time a day for NJ Ex Order 26.4b1 , ordered on NJ Ex Order 26.4b1 ; NJ Ex Order 26.4b1 Oral Tablet NJ Ex Order 26.4b1 Give 1 capsule via NJ Ex Order 26.4b1 two

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times a day for NJ Ex Order 26.4b1 for NJ Ex Days, ordered NJ Ex Order 26.4; NJ Ex Order 26.4b1 with NJ Ex Order 26.4b1, pack with NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1 daily. NJ Ex Order 26.4b1 to NJ Ex O , NJ Ex Order 26.4b1, monitor for changes. every night shift for NJ Ex Order 26. -Start Date NJ Ex Order 26.4b1.

A review of the NJ Ex Order 26 consult team notes dated on NJ Ex Order 26.4 reflected NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 and NJ Ex Ord ; NJ Ex Order 26. consult notes on NJ Ex Order 26.4 reflected NJ Ex Order 26.4b1 , NJ Ex Ord , NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 at NJ Ex Order 26.4b1 and recommendation for NJ Ex Order 26.4b1 protocol; NJ Ex Order 26. consult notes on NJ Ex Order 26.4 reflected recommendations for NJ Ex Order 26. protocol; NJ Ex Order 26 notes on NJ Ex Order 26.4 recommended NJ Ex Order 26.4b1 for NJ Ex Order 26.4b1; NJ Ex Order 26 consult notes on NJ Ex Order 26.4 reflected NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 and recommend NJ Ex Order 26.4b1; Updated NJ Ex Order 26 consult notes on NJ Ex Order 26.4 after surveyor inquiry reflected treatment orders clean and pack with NJ Ex Order 26. until NJ Ex Order 26.4b1 is available. NJ Ex Order 26. consult notes from NJ Ex Order 26.4 through NJ Ex Order 26.4 (total of NJ Ex O weeks), indicated recommendations for NJ Ex Order 26.4b1 for NJ Ex Order 26.4b1 with no evidence from the facility of an order or treatment clarification.

A review of the NJ Ex Order 26.4b1 3:41 PM LPN #2 documented on the NJ Ex Order 26.4b1 note in the EHR reflected NJ Ex Order 26.4 Score of NJ Ex indicating NJ Ex Order 26.4b1 for NJ Ex Order 26.4b1. A NJ Ex Order 26. score of NJ Ex on NJ Ex Order 26.4 indicating NJ Ex Order 26.4b for NJ Ex Order 26.4b1.

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A review of the NJ Exec Order 26.4b1 Note Text on NJ Ex Order 26.4 at 4:20 PM: "Resident lying in bed NJ Ex Order 26. NJ Ex Orde NJ Ex Order 26.4b1, denied NJ Ex Or or NJ Ex Order 26.4b1, no NJ Ex Order 26.4b1 or NJ Ex Orde noted, NJ Ex Order 26.4b1 and NJ Ex Order 26.4 no NJ Ex Order 26.4b1 Resident's NJ Ex Order 26.4 and NJ Ex Order 26.4b1 visiting. Informed resident, NJ Ex Order 26.4 and NJ Ex Order 26.4b1 that I am going to do NJ Ex Order 26.4b1 to NJ Ex Order 26.4b1 and apply NJ Ex Order 26.4b1, procedure explained, questions answered, resident, NJ Ex Order 26. and NJ Ex Order 26.4b1 agreed. Resident NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 removed, moderate amount of NJ Ex Order 26.4b1 noted, NJ Ex Order 26.4b1 cleaned with NJ Ex O, NJ Ex Order 26.4b1 applied at NJ Ex Or , NJ Exec Order 26.4b1 NJ Ex Ord NJ Ex Order 26.4b1, off load NJ Ex Order 26. no NJ Ex Order 26.4b I informed resident's NJ Ex Order 26. and NJ Ex Order 26.4b1 that state surveyors would like to observe NJ Ex Order 26.4b1 on Monday, and I asked them for their consent, resident's NJ Ex Order 26. and NJ Ex Order 26.4b1 declined."

A review of the NJ Exec Order 26.4b1 Note Text on NJ Ex Order 26.4 at 5:51 PM: "I offered resident's NJ Ex Order 26. and NJ Ex Order 26.4b1 that I can call US FOIA to order NJ Ex Or medication prior to NJ Ex Order 26.4b1, resident's NJ Ex Order 26. and NJ Ex Order 26.4b1 declined, they want to continue PRN (as needed) NJ Ex Or management. Will continue to monitor."

On 3/25/24 at 9:15 AM, the surveyor interviewed the US FOIA (b) regarding what was the plan of the NJ Ex Order 26 team from NJ Ex Order 26.4b1, to current recommendations for NJ Ex Order 26.4b1 protocol written on the NJ Ex Order 26 report, the US FOIA (b) stated, "It was written on the bottom of the report and the NJ Ex Order 26 doctor never communicated to me about his plan for the NJ Ex Order 26.4b1 and there was no order."

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F 686	Continued From page 28	F 686		

On 3/25/24 at 10:45 AM, the surveyor observed the resident sleeping on the bed with NJ Ex Order 26.4b1 and a NJ Ex Order 26.4b1 applied to NJ Ex Order 26.4b1. The resident's NJ Ex Order 26.4b1 and NJ Ex Order 26.4 were in the room and the NJ Exec Order 26.4 stated, "The NJ Ex Order 26.4b1 application was to start the NJ Ex Order 26.4b1, it's now at the point where it's the next step and it was applied last NJ Ex Order 2."

On 3/25/24 at 10:55 AM, the surveyor interviewed LPN #2, who has been working at the facility for NJ Ex Order 26.4b1 stated," The NJ Ex Order 26.4b1 was started last Friday, and I didn't hear anything about the NJ Ex Order 26.4b1 prior to last NJ Ex Order 2."

On 3/25/24 at 11:14 AM, the surveyor called the NJ Ex Order 26 doctor [name redacted] regarding recommendation of NJ Ex Order 26.4b1 protocol from NJ Ex Order 26.4 and call went into voicemail.

On 3/25/24 at 12:02 PM, the surveyor requested permission from the NJ Ex Order 26.4b1 and NJ Ex Order 26 regarding NJ Ex Order 26.4b1 observation and the family refused.

On 3/25/24 at 12:15 PM, the surveyor interviewed the US FOIA (b)(6), [name redacted] from the NJ Ex Order 2 consultation group, with the survey team present, the doctor stated, "I am the one who reviews the NJ Ex Order 26 reports weekly, but I have not seen the resident. The NJ Ex Order 26.4b1 was on back order in NJ Ex Order 26.4b1. Our doctor should have documented it on the NJ Ex Order 26 report. We should have documented better and done a separate treatment because NJ Ex Order 26.4b1 can actually NJ Ex Order 26.4b1 if NJ Ex Order 26 has NJ Ex Order 26.4b1, there's a better NJ Ex Order 26 treatment." The facility did not provide any

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documentation of the NJ Ex Order 26.4b1 being on back order or that the recommendation for NJ Ex Order 26.4b1 was clarified by the facility.

On 3/26/24 at 9:46 AM, the surveyor met with the US FOIA (b)(6)) and the US FOIA (b in the presence of the survey team and discussed the concern regarding the delay in application of the NJ Ex Order 26.4b1 from NJ Ex Order 26.4 through NJ Ex Order 26.4. The surveyor interviewed the US FOIA (b) regarding the NJ Ex Order 26 note on NJ Ex Order 26.4 pertaining to the NJ Ex Order 26.4b1, the US FOIA (b) stated, "I should have questioned and followed up with the doctor to clarify what he meant by NJ Ex Order 26.4b1 protocol."

On 3/26/24 at 10:49 AM, the surveyor interviewed the NJ Ex Order 26 doctor, [name redacted] in the presence of the survey team. The doctor stated, "The standard NJ Ex Order 26.4b1 needs to be applied for NJ Ex Order 26.4b1 protocol. I believe the resident went to the hospital and came back. The NJ Ex Order 26 has NJ Ex Order 26.4b1, NJ Exec Order 26 NJ Ex Order 26, it's improving. It's the facility's protocol to acquire the NJ Ex Ord but that sometimes takes a couple of days. It's not jeopardizing their treatment until they get the NJ Ex Orde Continue the same treatment until the NJ Ex Ord comes was the plan. I spoke to my scribe about documentation, and he told me he put that note in the report. NJ Ex Order 26.4 is the appropriate treatment while waiting for a NJ Ex Orde We can work on the notes better, I agree with you that it should have been communicated to the facility and documented initially that a NJ Ex Ord was recommended and should have been implemented once the NJ Ex Ord was available."

A review of the facility policy and procedure titled Wound Care: Decubitus/Pressure Ulcers with

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F 686	Continued From page 30 revision date of 2/8/24 revealed, "Each resident will have preventative measures instituted to prevent the development of or further deterioration of skin integrity. The wound doctor will recommend treatment based on his assessment during wound rounds." NJAC 8.39-25.2(c); 27.1(e)	F 686		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other pertinent facility documents, it was determined that the facility failed to ensure a.) implementation of interventions designed by the NJ Ex Order 26.4b1 to NJ Ex Order 26.4b1 , and prevent NJ Ex Order 26.4b1, and b.) the interdisciplinary team provided timely revision	F 688	F 688 Increase or Prevent Decrease in ROM/Mobility Plan of Correction ¿ Corrective action for the resident affected by the deficient practice.	3/29/24

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F 688	Continued From page 31 to the care plan (CP). This deficient practice was identified for one (1) of one (1) resident reviewed for NJ Ex Order 26.4b1 , Resident #29 and was evidenced by the following: 1. On 3/25/24 at 10:33 AM, the surveyor observed the resident with NJ Ex Order 26.4b1 , the NJ Ex Order , and NJ Ex Order 26.4b1 were NJ Ex Order 26.4b1 . On 3/26/24 at 9:24 AM, the surveyor and the US FOIA (b)(6)) assigned to the resident, entered the resident's room. The NJ Ex Order 26 NJ Ex Order NJ Ex Order 26.4b1) was observed next to the resident's bedside table. The US FOIA (b stated that she had fed the resident, who at that time NJ Ex Order 26.4b1 . At that time, the US FOIA (b described the resident as NJ Ex Order 26.4b1 required NJ Ex Order 26.4b1 , was NJ Ex Order 26.4b1 , and had a NJ Ex Order 26.4b1 which the resident often NJ Ex Order 26.4b1 At 9:30 AM, the surveyor and the US FOIA (b reviewed the electronic communication record (eCR; brand redacted) together. The eCR was the system the US FOIA (b)(6) used to document tasks associated with activities of daily living (ADL), via touch screen. The eCR did not reflect a task associated with a splint. At that time, the US FOIA (b stated that the documentation of the donning and doffing of the NJ Ex Order was not assigned to her. The US FOIA (b stated that she reported to the medication nurse on duty who then documented on the electronic Medical	F 688	" The affected resident continues to reside in the facility. " The order for NJ Ex Order 2 and other NJ Ex Order 26.4b1 for the resident was clarified. " The care plan for the affected resident was reviewed and revised to reflect the use of the NJ Ex Orde equipment. ¿ Corrective action taken for those residents having the potential to be affected by the alleged deficient practice " . Any resident in the facility who uses splints, braces and other restorative equipment has the potential to be affected by this deficient practice. ¿ Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur: 1. These deficient practices were discussed during the QAPI meeting. To improve and strengthen our policy and procedure, the QAPI committee recommended: a. If the nursing staff observes a resident having a change in condition or a decline because of the change in condition, the resident will be referred to the Rehabilitation Department for screening and assessment.	

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F 688	Continued From page 32 Record (eMR) the donning, doffing and refusals of the medical device [NJ Ex Orde].	F 688	b. The Rehabilitation Department will screen and assess the resident if he/she warrants rehabilitation and/or requires the use of a splint, a brace or other assistive device.	

The surveyor reviewed the hybrid medical record for Resident #29.

A review of Resident #29's Admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with diagnoses which included NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 (NJ Ex Order 26.4b , and NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1).

A review of Resident #29's most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4b1, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ out of 15, which indicated that Resident #29's cognition was NJ Ex Order 26.4b1. Further review of section NJ E NJ Ex Orde Restorative Nursing Program, under section NJ for NJ Ex Orde or NJ Ex Order 26.4b1 was marked NJ Ex Orde. This number indicated the number of days the NJ Exec Order 26.4b1 was performed, in the last NJ calendar days, for the resident.

According to the NJ Ex Order 26.4b1 NJ Exec Order 26 (NJ Ex) and Plan of Treatment (PT) dated NJ Ex Order 26.4 , the resident was seen for the quarterly assessment. The assessment indicated that the resident presented with NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 NJ Ex Order 26.4b1) of the NJ Ex Order 26.4b1, NJ Ex Order and NJ Ex Orde and NJ Ex Order 26.4b1. The patient required NJ Exec O assistance of NJ Ex Order 26.4b1, to NJ Ex Order 26.4b1 onto the NJ Ex Order 26.4b1 NJ Ex) and for NJ Ex Order 26.4b1. The

c. Upon completion of the screening, the rehabilitation department will report their findings or recommendations to the Interdisciplinary Team.

2. If the resident requires a splint, a brace, or a specific assistive device, the rehabilitation department will write a recommendation and forward this to the DON/Designee.

a. The DON/Designee will discuss the recommendation with the nurse assigned to the resident.

b. The nurse will relay recommendation to the MD/NP and get an order for the splint/assistive device as recommended by the rehabilitation department.

c. Once the order is written, the nursing department through the DON/Designee will notify the Rehabilitation Department to order the splint or device and initiate a care plan based on the splint, brace or assistive device written in the resident□s chart.

d. Once the splint, brace or assistive device is available, the Rehabilitation Department will provide training to the nursing staff on how and when to

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 33 resident received services one to three times per week. A review of the NJ Ex Discharge Summary dated NJ Ex Order 2, revealed that on NJ Ex Order 2, the resident was discharged from receiving NJ Ex Order 26.4b1 services. The discharge recommendations included. -safely wear a NJ Ex Order 26.4b1 on NJ Ex Order 26.4b2, up to 8 hours - an NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 , up to 8 hours -will improve ability to safely, and efficiently perform NJ Ex Order 2 tasks with NJ Exec Order 26.4b1 assistance ... A review of the Order Summary Report (OSR), the list of active physician orders (PO) as of NJ Exec Order 2, included an order for NJ Ex Order 26.4b1 (NJ Ex Order 2; NJ Ex Order 26.4b1) - On during day shift. Off during night shift. Check NJ Ex Or NJ Exec Order 2 every shift, every day, and night shift", started on NJ Ex Order 26. Further review of the OSR did not reflect a physician order for the following: - NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 - NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 On 3/26/24 at 11:07 AM, during an interview with the surveyor, the US FOIA (b)(6) US FOIA (b)(6) US FOIA (b)(6) (US FOIA (b)(6)) US FOIA (b)(6) stated she had no access to the eMR and the eCR. She was unable to view what was donned or doffed by the nursing staff and/or refused by the resident.	F 688	apply/remove the splint, brace, or assistive device. 3. The DON/designee educated all licensed nursing staff with regards to the new policy and procedure and steps to take when a resident requires a splint, a brace or any adaptive equipment. ¿ How will corrective actions be monitored to ensure the alleged deficient practice will not re occur: " The Director of Nursing /designee will conduct a weekly audit of 3 residents using a splint, brace or assistive device to ensure that there is a correct order in place and an appropriate care plan was written in the chart reflecting the use of the specific brace, splint or assistive device. " The audit will be conducted weekly x 4 weeks, then monthly x 3 months. " All findings will be presented during the monthly QAPI committee meeting for review.	

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	315390	A. BUILDING _____ B. WING _____	C 03/27/2024

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At that time, the [redacted] stated, "We don't check the eMR", and that it was the responsibility of the [redacted]) to monitor nursing tasks.

At 11:41 AM, the surveyor and the [redacted] entered the resident's room and confirmed the [redacted] was in the room and that the [redacted] was not in the room.

At 11:44 AM, the surveyor and the [redacted] entered the [redacted]-wing dining/day room. The surveyor observed the resident seated in a [redacted], and a [redacted] within the [redacted]. The [redacted] assessed the resident and confirmed the resident had a [redacted] within the [redacted], however the resident was not wearing a [redacted], [redacted] and [redacted].

At 11:58 AM, the [redacted] stated that the evaluating [redacted] was [redacted] and was not in the building at that time. She would reach out to let him know about the missing orders.

At that time, the surveyor, and the [redacted] reviewed the electronic Treatment Administration Record together for the PO of the [redacted] - On during day shift. Off during night shift. Check [redacted] every shift, every day, and night shift", started on [redacted]. The order reflected a check mark for the day shift.

At that time, the [redacted] acknowledged that the order for the [redacted] and [redacted] should have been separated, for clarity of tracking. The [redacted] also confirmed the resident was not wearing the [redacted] and had a [redacted] without an order.

A review of the succeeding quarter, [redacted] and [redacted]

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evaluation dated NJ Ex Order 26.4, under current referral included that Nursing staff had been educated on the continuance of the need to NJ Ex Order 26.4b1 to prevent further NJ Ex Order 26.4b1 ... Nursing is managing patient's NJ Ex Order 26.4b1.

2. A review of the quarterly Interdisciplinary Care Plan (IDCP) Care Conference Note of the last two quarters dated NJ Ex Order 26.4, and NJ Ex Order 26.4 under section NJ Ex Order 26.4b1 Review did not reflect any documentation relating to medical devices from nursing. The record also did not show a tab where NJ Ex Order 26.4b1 services were able to enter information.

On 3/26/24 at 11:07 AM, during an interview with the surveyor, the US FOIA (b)(6), US FOIA (b) stated as part of her responsibilities, she participated in the quarterly IDCP team meetings.
At that time, the US FOIA (b)(6), US FOIA (b) informed the surveyor that once a resident was discharged with medical device recommendations, the CNAs were educated by the evaluating therapist. Followed by an evaluation of the CNA's competency of donning and doffing NJ Ex Order 26.4 or NJ Ex Order 26.4b1. "We then put it on the CP because we want it to carry over".

A review of the Treatment Administration Record (TAR) for NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1, did not reflect refusals of the application of the NJ Exec Orde and did not include the tracking of the donning, doffing of the following:
- NJ Ex Order 26.4b1 NJ Ex Order 26.4b1
- NJ Ex Order 26.4b1, NJ Ex Order 26.4b1

A review of the resident's Care Plan (CP) included a focus that indicated the resident was at risk for NJ Ex Order 26.4b1 dated/revised on

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F 688	Continued From page 36 NJ Ex Order 26.4; the interventions reflected that the resident would demonstrate increased NJ Ex Order 26.4b of the NJ Ex Order 26.4b2 to NJ Ex Order 26.4b1 and NJ Exec Order 26.4b1 dated/revised on NJ Ex Order 26.4. Further review of the CP goals included that the resident would wear the NJ Ex Order 26.4b1 during the PM (nighttime) hours to prevent NJ Ex Order 26.4b1 and increase NJ Ex Order 26.4b1 dated/revised on NJ Ex Order 2. The CP did not include the NJ Exec Order 2 the EES and the NJ Ex Order 26.4b1. On 3/26/24 at 2:16 PM, in the presence of the survey team the US FOIA (b)(6) the US FOIA (b)(6), the US FOIA (b)(6) the US FOIA (b)(6) and US FOIA (b)(6), the surveyor discussed the concern regarding the failure to develop and implement the NJ Ex (; 's recommendations of promoting NJ Ex Order 26.4b1 and preventing NJ Ex Order 26.4b1 from NJ Ex Order 2, including the IDCP team's quarter review of NJ Ex Order 26.4. The concern regarding the failure to ensure revision of the individualized CP was also discussed. On 3/27/24 at 9:33 AM, during a follow- up interview with the surveyor, the US FOIA (b)(6)/US FOIA (b) stated she attended the quarterly IDCP team meetings but did not document on the conference note. She instead verbally communicated with the IDCP team and emailed the NJ Ex Order 26.4b1 team of the plan for the resident. At that time, the surveyor asked the US FOIA (b)(6)/US FOIA (b) why the omissions of the medical device recommendations were not acted upon on NJ Ex Order 2 and at the quarterly meeting on NJ Ex Order 26.4.	F 688		

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At that time, the [redacted] stated that nursing had not verbalize that the medical devices were missing, and the order for the [redacted] from [redacted], was incorrect. She acknowledged the [redacted] recommendations should have been acted upon at the time of the recommendation on [redacted], and the errors including omissions, should have been captured for correction at the quarterly meeting on [redacted].

At that time, the [redacted] stated the communication between nursing and rehabilitation services could be better. "We started a QAPI" (Quality Assurance and Performance Improvement, a data driven and proactive approach to quality improvement) yesterday.

No further information was provided.

A review of the facility provided policy, Restorative Program, Resident: Ambulation Function Maintenance dated 3/22/24, included the following under Procedure.
1. The therapy Department, in collaboration with Nursing initiates the Functional Maintenance Program for Ambulation. The program goal is set in collaboration with Therapy, Nursing, and the individual resident.
2. As per specific recommendation from therapy ...The specific recommendation shall be documented on the resident's plan of care.

A review of the facility provided policy, Care Plan, Rehabilitation Services dated 2/8/24, included Procedure under section 9. Care Plans will be updated in a timely manner and necessary revision made when there are changes in

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F 688	Continued From page 38 condition.	F 688		
F 692 SS=E	NJAC 8:39-11.2 (e)(1)(2), 27.1(a) Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent facility provided documentation, the facility failed to a) follow through with the US FOIA (b)(6) recommendation for one (1) of two (2) residents (Resident #24), b) ensure the Interdisciplinary team (IDT) was aware of the resident's significant NJ Ex Order 26.4b1 according	F 692	F692 Nutrition/Hydration Status Maintenance Plan of Correction ¿ Corrective action for the resident affected by the deficient practice.	3/29/24

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F 692	Continued From page 39 to the standard of clinical practice for one (1) of two (2) residents (Resident #24), and c) ensure that the [NJ Ex Order 26.4b1] was done according to the standard of clinical practice and facility policy for two (2) of two (2) residents, Resident #24 and #57, reviewed for [NJ Ex Order 26.4b1] This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 3/21/24 at 11:03 AM, the surveyor observed	F 692	" The affected residents [NJ Ex Order 26.4b1] [redacted]. " The residents were assessed and found NJ Ex Order 26.4b1 by the alleged deficient practice. " The [NJ Ex Order 26.4b] level of Resident # 24 was checked and came back within [NJ Ex Order 26.4b1]. " Resident # 57 was [NJ Ex Order 26.4b1] and the [NJ Ex Order 2] was inputted in the Electronic Medical Record. ¿ Corrective action taken for those residents having the potential to be affected by the deficient practice. " . Any residents in the facility have the potential to be affected by this deficient practice. ¿ Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur: 1. These deficient practices were discussed during the QAPI meeting. The QAPI committee recommended: a. Nursing staff will weigh residents and forward the weights/reweighs to the dietician who will review these and input the residents□ weights in the Electronic Medical Record. b. That an IDCP weight meeting will be	

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F 692	Continued From page 40 Resident #24 in the dining area (also known as the activity room) laying in the NJ Ex Order 26.4b1 (NJ Ex Order 26.4 with NJ Ex Order 26.4b1 and the NJ Ex Order 26.4b1 . The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #24. According to the Admission Record (admission summary), Resident #10 was admitted to the facility with a diagnosis that included but was not limited to NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1), NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 (NJ Ex Order NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1) NJ Ex Order 26. NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 and NJ Ex Order 26. . The resident's comprehensive Minimum Data Set (cMDS), and assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of NJ Ex Order 26.4b1 revealed in Section NJ Ex Order 26.4b1 Brief Interview for Mental Status (BIMS) score of NJ out of 15 which reflected that the resident's NJ Ex Order 26.4b1 . The cMDS Section NJ NJ Ex Order 26.4b1 Status revealed that the resident had a NJ Ex Order 26.4b1 of NJ Ex O or more in the	F 692	held weekly to discuss residents diet/weight issues and recommendations from the dietician. c. If the dietician, after reviewing the weights, has recommendations related to residents weight and diet, these recommendations will be forwarded to the DON/designee for resolution. d. If the dietician recommends a reweigh, the recommendation will be forwarded to the DON/designee to recheck the resident/s weight/s. e. The DON/designee will ensure that each recommendation will be addressed by the nurse/s assigned to the resident involved by relaying the recommendation to the MD/NP as well completing the requested reweigh. f. All recommendations from the previous week will be discussed during the weight meeting to ensure these recommendations are addressed and resolved. 2. The DON/Designee educated all the licensed nursing staff with regards to the recommendations of the QAPI Committee. ¿ How will corrective actions be monitored to ensure the alleged deficient practice will not re occur: " The Director of Nursing /designee will conduct a weekly audit to ensure that that	

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F 692	Continued From page 41 last month or a [redacted] of [redacted] in the last [redacted]. The personalized care plan showed a focus on [redacted] that was initiated on [redacted] and revised on [redacted] with interventions that included but were not limited to monitor my [redacted] and [redacted]) as avail (available) initiated on [redacted]. A review of the [redacted] Summary revealed that on [redacted] the resident's [redacted] was [redacted] with warning notes that included the following: [redacted] [comparison [redacted], [redacted], [redacted], [redacted]] [redacted] [comparison [redacted], [redacted], [redacted], [redacted]] A review of the IDCP (Interdisciplinary)/Care Conference Note with an effective date of [redacted] included [redacted] Status that was electronically signed by the [redacted] on [redacted] that the resident was [redacted] for a [redacted] x 1 (one) [redacted]) and the [redacted] recommended for [redacted] level. The Clinical Dashboard in the electronic medical record (eMR) for a facility bulletin board showed that on [redacted], the [redacted] created documentation for the resident's recommendation for an [redacted] level. A review of the Order Summary Report (OSR) for [redacted], [redacted] through [redacted], showed that there was no order for an [redacted] level.	F 692	there is a record of the Interdisciplinary Care Team weekly weight meeting. " The Director of Nursing /designee will conduct a weekly audit to review the recommendations received from the dietitian to ensure all were relayed to the MD and carried out. " The Director of Nursing /designee will conduct a weekly audit to review that all reweigh requests from the dietician were completed according to the standard of clinical practice and facility policy and reported back to her. " The audit will be conducted weekly x 4weeks, then monthly x 3 months. " All findings will be presented during the monthly QAPI committee meeting for review.	

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F 692	Continued From page 42 The Results tab in the eMR showed that the last lab done was on NJ Ex Order 26.4b1. The NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 Note in the Progress Notes (PN) showed that Resident #24 was triggered for a NJ Ex Order 26.4b1 x 1 NJ Ex Order 2 (NJ Ex). The PN did not include that the NJ Ex Order 26.4 was planned, attempted, and refused by the resident. Further review of the PN revealed that there was no documentation from the Physician, US FOIA (b)(, and Nurses about the NJ Ex Order 26.4b1 notes of the NJ Ex Order 26.4 about the NJ Ex Order 26.4b1 and the NJ Ex Order 26.4 level that was recommended. In addition, the PN did not include documentation that the resident was offered and declined the NJ Ex Order 26.4 and NJ Ex Order 26.4 level check. On 3/21/24 at 11:14 AM, the surveyor interviewed the US FOIA (b)(6)) in the presence of two surveyors. The US FOIA informed the surveyor that Resident #24 was NJ Ex Order 26.4b1 , at times required assistance from staff with NJ Ex Order 2, NJ Ex Order 26.4b1, and most of the time NJ Ex Order 26.4 was good. The US FOIA stated that the resident was on NJ Ex Order 26.4b1 and the resident NJ Ex Order 26.4b1. On that same date and time, the US FOIA stated that she was not aware of the resident's NJ Ex Order 26.4b1 . She further stated that she was not sure if the NJ Ex Order 2 meeting existed at the facility. At that same time, the surveyor asked the US FOIA what was the facility's process and standard of practice with regard to NJ Ex Order 26.4b1. The US FOIA informed the surveyor that the US FOIA (b)(6) would notify the nurse verbally of the NJ Ex Order 26.4b1 and	F 692		

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recommendations. The [US FOIA] stated that she can also see the [US FOIA (b)(6)] recommendations in the Clinical Dashboard in the eMR for [NJ Ex Order 26.4b1]. She further stated it was the nurse's responsibility to call the physician for the recommendation to obtain an order which included an order for lab if that was the recommendation of the [NJ Ex Order 26.4b1] The [US FOIA] also stated that if the doctor declined the recommendation it was an expectation that the nurse would document it in the PN.

At this time, the surveyor asked the [US FOIA] why the [NJ Ex Order 26.4b1] recommendation of the [US FOIA (b)(6)] for an [NJ Ex Order 26.4] level in the Clinical Dashboard that the [US FOIA] showed was not followed. The surveyor also asked why there was no documentation that the physician was called about the recommendation. The [US FOIA] responded, "I do not know what happened."

On 3/21/24 at 11:45 AM, the surveyor interviewed the [US FOIA (b)(6)] [US FOIA (b)(6)] ([US FOIA], also known as the [US FOIA (b)(6)]). The [US FOIA] informed the surveyor that the facility's process regarding [NJ Ex Order 26.4b1] "generally," the [US FOIA] enters the [NJ Exec Order] in the eMR specifically in the [NJ Ex Order 2] section, and if there was a [NJ Ex Order 26.4b1] plus or minus [NJ Ex Order 2] discrepancy, a [NJ Ex Order 26.4] will be done. The [US FOIA] stated that she also verified and assessed the resident on what happened and why there was [NJ Exec Order 26.4b1] [NJ Ex Order 26.4b1] or [NJ Ex Order 26.4b1]. She further stated that the [US FOIA (b)(6)] of the resident's primary physician will be notified via a [name of an app] (a messaging app that uses the internet to send messages, images, audio, or video) of a list of residents with [NJ Ex Order 26.4b1] that included [NJ Ex Order 26.4b1].

On that same date and time, the [US FOIA] informed the

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surveyor that there was an IDCP [NJ Ex Order 2] meeting where the [US FOIA] [US FOIA (b)(6)]), and [US FOIA (b)(6)]) participated, and discussed [NJ Ex Order 26.4b1]. The [US FOIA] stated that there was no specific date when the IDT met and there was no documentation of the meeting. The [US FOIA] further stated that the nurses would call the doctor and put the orders that included the recommendations for [NJ Ex Order 26.4b1] and supplements as applicable. The surveyor then asked the [US FOIA] if she followed up on her recommendations and if it was documented. The [US FOIA] responded "Yes, I follow up, but I do not document if the recommendations were not followed through," because the [US FOIA] did not want "other people" to be blamed.

At that same time, the surveyor notified the [US FOIA] of the above findings and concerns. The [US FOIA] stated that she knew Resident #24 and that the resident started to trend [NJ Ex Order] with [NJ Ex Order 2]. The [US FOIA] further stated that she [NJ Exec Order 26.4b1] the resident's [NJ Ex O] "today," and increased the [NJ Ex Order 26.4b1]. The surveyor asked the [US FOIA] why her recommendation on [NJ Ex Order 26.4b1] to check for [NJ Ex Order 26.4] level for NJ Ex Order 26.4b1 was not followed, and the [US FOIA] did not respond.

On 3/21/24 at 01:49 PM, the survey team met with the US FOIA (b)(6) [redacted] and the [US FOIA (b)(6)]. The surveyor notified the facility management of the above concerns and findings regarding [NJ Ex Order 26.4b1].

On 3/25/24 at 10:19 AM, the surveyor interviewed the [US FOIA]. The [US FOIA] informed the surveyor that she was not notified of the resident's [NJ Ex Order 26.4b1] [redacted] and the recommendation to check the [NJ Ex Order 26.4] level. The [US FOIA] stated that "usually" when

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the [US FOIA] recommended, the [US FO] and physician approved and they ([US FO] and physician) documented it in the eMR. The [redacted] acknowledged that if it was not documented in the eMR about the NJ Ex Order 26.4b1, it meant that she was not aware.

At that same time, the [US FO] stated that she was not aware of the facility's policy to [NJ Ex Order 26.4] the resident if there was a NJ Ex Order 26.4b1. The surveyor notified the [US FO] of the above findings and concerns.

On 3/25/24 at 10:34 AM, the surveyor interviewed the [US FOIA (I)] in the presence of the [US FOIA] The [US FOIA (I)] stated that it was an expectation if a resident had a [NJ Exec Order] [NJ Exec O] the [US FOIA] would evaluate the resident and provide recommendations, and nursing and physician would be notified. The [US FOIA] will notify the [US FOIA (I)] of the NJ Ex Order 26.4b1 and recommendations as well. The [US FOIA (I)] informed the surveyor that he was not aware of the [NJ Ex Order 26.4b1] of Resident #24 that was documented by the [US FOIA] on [NJ Ex Order 26.4b1] and [NJ Ex Order 26.4b1].

At that same time, the [US FOIA (I)] stated that the last [NJ Ex Order 2] meeting was held late [NJ Exec Order 26.] , and unable to remember the date because it was informal and not documented. He further stated that he did not remember that in the last [NJ Ex Order 2] meeting in NJ Ex Order 26.4b1 the resident's NJ Ex Order 26.4b1 was discussed, which was why he was not aware of the resident's [NJ Ex Order 2] problem.

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2. On 3/21/24 at 10:47 AM, the surveyor observed Resident #57 sitting in bed, NJ Ex Order and NJ Ex Order 26.4b1 NJ Exec Order 26.4b1 the surveyor's inquiry.

The surveyor reviewed Resident #57's hybrid medical record as follows:

A review of the AR documented that Resident #57 was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26.4b1 (NJ). The resident's most recent Admission MDS (AMDS) assessment, dated NJ Ex Order 26.4b1, reflected that Resident #57 had a BIMS score of NJ Ex out of 15, indicating NJ Ex Order 26.4b1. The AMDS Section NJ NJ Ex Order 26.4b1 Status revealed that the resident had a NJ Ex Order 2 of NJ Ex Order 26.4b1.

A review of the Care plan showed a focus on NJ Exec Order 26.4b initiated on NJ Ex Order 26.4b1 and revised on NJ Ex Order 26.4, with interventions that included but were not limited to, monitoring NJ Ex Order 26.4 and reporting any NJ Exec Order 26.4b1 to the IDCP team.

A review of the NJ Ex Order 26 Summary revealed the following:

On NJ Ex Order 2 at 12:55, NJ Ex Order 26.4b1. (NJ Ex Order 26.4)
On NJ Ex Order 2 at 16:57, NJ Ex Order 26.4b1.

The NJ Ex Order 26.4 NJ Ex Order 26.4b1 Note in the PN showed that Resident #57 was NJ Exec Order 26.4b for a NJ Ex Order 26.4b1 x 1 month (NJ Ex Orde). The PN did not include that the NJ Ex Order 26.4 was planned, attempted, and NJ Exec Order 2 by the resident.

On 3/26/24 at 10:33 AM, the surveyor, in the presence of the team, interviewed the US FOIA (b)(6) over the phone. She stated that the resident

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should have been [NJ Ex Order 26.4b] when the discrepancy was noted. The [US FOIA (b)(6)] confirmed that there was no [NJ Ex Order 26.4b1] after [NJ Ex Order 2] with [NJ Ex Order 26.4b1] lost. She added that she would tell Nursing to [NJ Ex Order 26.4b1] the resident. She stated that she informed the [US FOI] regarding the [NJ Ex Order 26.4b1].

On 3/27/24 at 11:23 AM, the surveyor interviewed the [US FOIA] who has been working in the facility [NJ Exec O] . She stated that the [US FOIA (b)(6)] or nursing did not inform her of the resident's [NJ Ex Order 26.4b1]; if she does, she will order [NJ Exec Order 26.4b] and [NJ Ex Order 26.4b1] the resident.

A review of the facility's Weighing the Resident Policy with a revision date of 3/21/24 that was provided by the [US FOI] included that the weights of residents are taken on admission and monitored monthly. If clinically indicated, weights are monitored more often as needed or as the physician orders. The purpose is to record the actual weight of residents and to keep accurate records of weight gain or loss. Included in the procedure: chart weight on the appropriate form in the chart, any increase or decrease of more than five pounds should be called to the Charge Nurse's attention and reweigh. Document weight and notify the dietician as needed.

On 3/26/24 at 02:15 PM, the survey team met with the [US FOIA (b)(6)] The facility management did not respond to the above findings and concerns.

NJAC 8:39-11.2(d)(e)(1)(f), 17.1(c), 17.2(d), 27.1(a)

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F 695 SS=E	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, record review, and review of other pertinent facility documentation, it was determined that the facility failed to a.) maintain the necessary care and maintenance of a NJ Ex Order 26.4b1 equipment and b.) provide a physician's order for NJ Ex Order 26.4b1 care in accordance with professional standards of practice for one of one resident, (Resident #58) reviewed for NJ Ex Order 26.4b1 care. This deficient practice was evidenced by the following: On 3/18/24 at 10:35 AM, the surveyor observed the Resident #58 lying in a NJ Exec Order 26.4b1. A NJ Ex Order 26.4b1 was on the bedside table in a bag and the label on the NJ Ex Order 2 was dated NJ Ex Order 26.4b1. The resident was NJ Ex Order 26.4b1 NJ Ex Orde and NJ Ex Order 26.4b1, NJ Ex Order and NJ Ex Orde The resident stated, "I am here because I have NJ Ex Order 26.4b1 (NJ Ex) and I need to get my NJ Ex Order 26.4b1 better again." On 3/20/24 at 11:03 AM, the surveyor observed the resident in the NJ Ex Order 26.4b1 with no evidence of NJ Ex Order 26.4b1 while	F 695	F695 Respiratory/Tracheostomy Care and Suctioning Plan of Correction ¿ Corrective action for the resident affected by the deficient practice. " The affected resident continues to reside in the facility. " The resident was assessed and was found NJ Ex Order 26.4b1 by the deficient practice. ¿ Corrective action taken for those residents having the potential to be affected by the deficient practice. " . Any resident in the facility who receive respiratory care has the potential to be affected by this deficient practice. ¿ Measures/Systemic changes put in place to assure the alleged deficient	3/29/24

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F 695	Continued From page 49 NJ Ex Order 26 On 3/20/24 at 11:07 AM, the surveyor interviewed the US FOIA (b)(6), who has been working in the facility for [redacted] years. The [redacted] stated,"The resident's NJ Ex Order 26.4b1 was treated when the resident was first admitted. The resident's NJ Ex Order 26.4b1 is good and does not use the [redacted] now, only as needed. We generally change the NJ Ex Order 26. and NJ Ex Order 26.4b1 [redacted] weekly on Sunday nights." On 3/20/24 at 11:15 AM, the surveyor and the [redacted] entered the resident's room. The surveyor observed the NJ Ex Order 26.4b1 in the resident's drawer in NJ Ex Order 26.4b1. The NJ Ex Order 2 was dated NJ Ex Order 26. The [redacted] stated, "I was not here on NJ Exec Order 26 night, so it was not NJ Exec Order 26.4b I will NJ Exec Order 26 it now and get an order." The physician order sheet (POS) reflected no order for NJ Ex Order 2 changes for over NJ Exec Order 26.4b1 The surveyor observed the resident sitting on the bed and the resident stated, "I feel NJ Ex Order 26.4b1 and my NJ Ex Order 26.4b1, I just finished [redacted]" The [redacted] stated ten minutes later, "I checked the resident's NJ Ex Order 26.4b1, and it was [redacted]." On 3/20/24 at 12:06 PM, the Admission Record review in the Electronic Health Record (EHR) reflected medical diagnoses which included but were not limited to NJ Ex Order 26.4b1; NJ Ex Order 26.4b1 [redacted] (NJ Ex Order 26.4b1); NJ Ex Order 26. [redacted] (NJ Ex Ord); NJ Ex Ord [redacted]. A review of the Order Summary revealed:	F 695	practice does not re occur: The DON/Designee educated all the licensed nursing staff with regards to the care, maintenance and changing of respiratory tubing/equipment every Sunday night or as needed when these are visibly soiled or defective. ¿ How will corrective actions be monitored to ensure the alleged deficient practice will not re occur: " The Director of Nursing /designee will conduct a random weekly audit on 3 residents who use respiratory tubing/equipment to ensure that these are properly dated and changed weekly as ordered. " The audit will be conducted weekly x 4 weeks, then monthly x 3 months. " All findings will be presented during the monthly QAPI committee meeting for review.	

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NJ Exec Order 26 NJ Ex Order 26.4b1 every weekly on NJ Exec Order 26 every night shifts every Sunday for NJ Ex Order 26.4b1 ordered NJ Ex Order 26.4 at 12:49 PM, (after surveyor inquiry).

NJ Exec Order 26 NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1) every weekly while NJ Ex Order 26.4 in use as needed for NJ Ex Order 26.4 change every 7 days, ordered NJ Ex Order 26.4 at 12:53 PM, (after surveyor inquiry).

NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1 two times a day for NJ Ex Order 26 The resident should NJ Ex Order 26.4b1 after use of NJ Ex Order 26.4b1 to decrease the risk of NJ Ex Order 26.4b1. ordered NJ Ex Order 2.

NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1) NJ Ex Order 26.4b1 one time a day for NJ Ex Order 26, ordered NJ Ex Order 2.

NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1) NJ two times a day for NJ Ex Order 26, ordered NJ Ex Order 26.4.

NJ Ex Order 26.4b1 every 6 hours as needed for NJ Ex Order 26.4b1, ordered NJ Ex Order 26.4.

NJ Ex Order 26.4b1 give 1 capsule by mouth two times a day for NJ Ex Order 26.4b1 for 3 Days-Start Date NJ Ex Order 26.4b1 and completed NJ Ex Order 26.4.

NJ Ex Order 26.4b1 at night.

Okay to wean off NJ Ex Order 26. during waking hours if NJ Ex Order 26.4b1 every shift for NJ Ex Order 26.4 -start date NJ Ex Order 26.4b1 0700-Discharge date NJ Ex Order 26.4b1.

A review of the resident's Admission/5Day Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated

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NJ Ex Order 26.4 reflected a Brief Interview of Mental Status (BIMS) score of NJ E out of 15 indicating NJ Ex Order 26.4b1.

A review of the NJ Ex Order 26.4 plan of care notes from the primary physician on revealed "NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1)."

A review of the NJ Exec Order 26 US FOIA (b)(6) plan of care notes revealed assessment and plan: " NJ Ex Order 26 - NJ Ex Order 26.4 NJ Ex Order 26 continue with NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 ."

On 3/21/24 at 11:20 AM, the surveyor observed an NJ Ex Order 26.4 sign on the resident's door, an NJ Ex Order 26. near the bedside and NJ Ex Order 26.4b1 dated NJ Ex Order 26.4 . The resident was sitting on the bed and stated, "I NJ Exec Order 26.4b1 , my NJ Ex Order 26.4b1 , I use that NJ Ex Order 26.4b1 for my NJ Ex Order 2 ."

On 3/21/24 at 11:28 AM, the surveyor interviewed the US FOIA (b)(6) who had been working at the facility for NJ years. The US FOIA stated, "A resident with NJ Ex Order 26.4 will have a sign on the door that says NJ Ex Order 26.4 is in use. We NJ Exec Order 26 the NJ Ex Order 2 for NJ Ex Order 26.4 and NJ Ex Order 26.4b1 on NJ Exec Order 26 during the night shifts, NJ Ex Order 26.4b1 goes in a NJ Ex Order 26.4b1 . I know she was on NJ Ex Order 26.4b1 for a few days on admission and was treated. There is no NJ Ex Order 26.4b1 currently, NJ Ex Order 26.4b1 has been NJ Ex Order 26.4b1 ."

A review of the facility policy and procedure titled Oxygen/Nebulizer Administration: Nasal Cannula

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F 695	Continued From page 52 or Mask revision date 3/22/23 revealed, "Mask/cannula and tubing should be dated upon opening. Change weekly or as needed." On 3/21/24 at 01:45 PM, the surveyor and with the presence of the survey team met with the US FOIA (b)(6) and the US FOIA (b)(6) and discussed the above observations and concern with the NJ Ex Order 26.4b1 maintenance and regulations. The US FOIA (b) acknowledged that the NJ Ex Order 2 should have been changed weekly as per the facility's policy. NJAC 8.39-25.2(c)3	F 695		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and 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	F 755		3/29/24

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F 755	Continued From page 53 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 provide pharmaceutical services in accordance with professional standards by ensuring that an expired controlled drug (NJ Ex Order 26.4b1) was removed from active inventory after NJ Ex Order 26.4 and had accurate corresponding documentation for the removal and administration for Resident #39 in one (1) of three (3) medication carts observed during the medication storage inspection. Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse	F 755	F755 Pharmacy Srvcs/Procedures/Pharmacist/Records Plan of Correction ¿ Corrective action for the resident affected by the deficient practice. " The affected resident continues to reside in the facility. " The resident was assessed and was found NJ Ex Order 26.4b1 by the deficient practice. ¿ Corrective action taken for those residents having the potential to be affected by the alleged deficient practice. " . All resident using controlled substances have the potential to be affected by this deficient practice. ¿ Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur:	

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Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."

The deficient practice was evidenced by the following:

On 3/25/24 at 10:32 AM, the surveyor, with the US FOIA (b)(6) observed in the medication cart, in a NJ Exec Order 26.4b1 drug locked box, a NJ Ex Order 26.4b1 labeled for Resident #39 that had one (1) NJ Ex Order 26.4b1 containing NJ Ex Order 26.4b1 [redacted]). The surveyor with the US FOIA reviewed the Individual Patient's Controlled Drug Record (IPCDR) which corresponded that there was one (1) remaining NJ Ex Order 26.4b1.

At that time, the surveyor, with the US FOIA (b) reviewed the label on the NJ Ex Order 26.4b1 for expiration dating. The US FOIA stated that the expiration date on the label of the NJ Ex Order 26.4b1 [redacted] was NJ Ex Order 26.4 [redacted]. The surveyor, with the US FOIA (b) then observed the label on the NJ Ex Order 26.4b1 that had the one (1) NJ Ex Order 26.4b1 which identified "Beyond Use Date: NJ Ex Order 26.4b1." The US FOIA then stated that the NJ Ex Order 26.4b1 should have been removed from the medication cart because it was expired. The US FOIA stated that

1. The alleged deficient practice was discussed during the QAPI meeting. The QAPI committee recommended that:

a. Each controlled substance in the medication cart will have a yellow expiration sticker attached to the medication card or container that reflects the medication□s expiration date.

b. Each declining sheet of a controlled substance in the medication cart will have a yellow expiration sticker that reflects the medication□s expiration date attached to it.

c. During shift-to-shift count of the controlled drugs, both nurses should check the expiration dates written on the yellow stickers in the declining sheet and in the card or container holding the controlled medications.

d. All expired medications should be removed from the cart together with the corresponding declining sheet and endorsed to the DON/designee.

e. Every time a controlled medication is pulled out by a nurse, the declining sheet should be signed and the eMAR should be signed by the nurse immediately after administering the controlled medication to the resident.

2. The DON/Designee educated all the licensed nursing staff with regards to the

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CRANFORD PARK CARE	600 LINCOLN PARK EAST CRANFORD, NJ 07016

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F 755	Continued From page 55 Resident #39 was administered the NJ Ex Order 26.4b1 as needed (PRN) and was used infrequently. Further review of the IPCDR revealed that the NJ Ex Order 26.4b1 was removed from inventory on NJ Ex Order 26.4, NJ Ex Order 26.4, NJ Ex Order 2, NJ Ex Order 2, and NJ Ex Order 26.4. At that time, the US FOIA explained that she would be removing the NJ Ex Order 26.4b1, along with the IPCDR, and would give it to the US FOIA (b)(6) or the US FOIA (b)(6) The US FOIA stated that NJ Ex Order 26.4b1 inventory counts were completed every shift which was every 12 hours (Q12H) and documented on the Tally Sheet. The US FOIA added that expiration dating should be checked during the shift-to-shift count. A review of the NJ Exec Order 26.4b1 Substance Tally Sheet for NJ Ex Order 26.4b1 that was located in the NJ Ex Order 26.4b1 logbook on the medication cart revealed that shift to shift counts were completed. There was no recorded evidence that the NJ Ex Order 26.4b1 was expired and to be removed from inventory. The surveyor reviewed the medical record for Resident #39. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated NJ Ex Order 26.4b1, reflected the resident had a brief interview for mental status (BIMS) score of three (NJE out of 15, indicating that the resident had a NJ Ex Order 26.4b1. A review of the Admission Record revealed diagnoses which included NJ Ex Order 26.4b1 with NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1.	F 755	procedure recommended by the QAPI committee with regards to the checking of expiration of a controlled drug, the signing of the controlled substance declining sheet and the signing of the eMAR immediately after administering the medication to the resident. ¿ How will corrective actions be monitored to ensure the alleged deficient practice will not re occur: " The Director of Nursing /designee will conduct a weekly audit on all the medication carts in the facility to ensure there are no expired medications in storage. " The Director of Nursing /designee will conduct a random weekly audit on 3 residents from different units who have controlled medications ordered for their use. " The Director of Nursing /designee will conduct a random weekly audit on 3 residents from different units to check their declining sheets against the eMAR to ensure that proper documentation was completed upon administration of the controlled medication. " The audit will be conducted weekly x 4 weeks, then monthly x 3 months. " All findings will be presented during the monthly QAPI committee meeting for review.	

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A review of the Order Summary Report (OSR) revealed a physician's order (PO) with a start date of [redacted] for "NJ Ex Order 26.4b1 Administer NJ Ex Order 26.4b1 [redacted]."

A review of the [redacted] and [redacted] electronic medication administration record (EMAR) revealed that there was no documentation that the NJ Ex Order 26.4b1 was administered.

A review of the March EMAR revealed that the NJ Ex Order 26.4b1 was administered on [redacted] at 2:58 AM. There were no other entries for administration noted.

A review of the electronic progress notes (EPN) revealed an entry dated [redacted] at 2:58 AM indicating that the NJ Ex Order 26.4b1 was administered. There were no other EPN entries for [redacted] or [redacted] indicating that the NJ Ex Order 26.4b1 was administered.

On 3/25/24 at 11:58 AM, the surveyor observed Resident #39 in the activity room in a wheelchair NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 [redacted].

On 3/25/24 at 12:14 PM, the surveyor interviewed the [redacted] who stated that the IPCDR should correspond with the EMAR for the dates and times that the NJ Ex Order 26.4b1 was removed from inventory and then administered. The [redacted] explained that when the EMAR was signed for administration of a PRN medication the EPN would automatically be populated with an entry to indicate the reason for administration. Therefore, for every PRN EMAR administration there should be an EPN. The [redacted] then stated that she had administered the PRN NJ Ex Order 26.4b1 in the past

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but thought that was two (2) to three (3) months ago. The [US FOIA] also stated that she felt that Resident #39 had [NJ Ex Order 26.4b1] with [NJ Ex Order 26.4b1] because there were changes in routine medications. The [US FOIA] added that the PRN [NJ Ex Order 26.4b1] was effective when administered.

On 3/25/24 at 12:30 AM, the survey team met with the [US FOIA (b)(6)] and [US FOIA (b)]. The surveyor requested that the [US FOIA (b)] review the resident's EMAR for [NJ Ex Order 26.4], [NJ Ex Order 26.4b1] and [NJ Ex Order 2] to coincide with the documentation on the IPCDR for removals of [NJ Ex Order 26.4b1].

On 3/26/24 at 9:20 AM, the surveyor interviewed the [US FOIA (b)] who acknowledged that there were no entries on the EMAR that corresponded with the IPCDR for the [NJ Ex Order 26.4b1].

On 3/26/24 at 9:37 AM, the survey team met with the [US FOIA (b)(6)] and [US FOIA (b)]. The [US FOIA (b)] stated that the [NJ Ex Order 26.4b1] should have been removed after [NJ Ex Order 26.4] and thought the label was difficult to read the expiration date. In addition, the [US FOIA (b)] stated that the EMARs had not reflected the administration of the [NJ Ex Order 26.4b1] according to the IPCDR. The [US FOIA (b)] verified that the EMAR and EPN should correspond with the IPCDR. In addition, the [US FOIA (b)] stated that he spoke with the nurse regarding the [NJ Ex Order 2] EMAR which reflected an administration date of [NJ Ex Order 2]. The [US FOIA (b)] explained that the nurse had worked on [NJ Ex Order 2] and inadvertently wrote [NJ Ex Order 26] on the IPCDR. The [US FOIA (b)] added he was continuing to speak with the nurses who signed for the removal of the [NJ Ex Order 26.4b1].

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On 3/26/24 at 10:23 AM, the surveyor interviewed the US FOIA (b)(6)) via telephone who stated that he was not the usual US FO for the facility but was able to answer any questions. The US FO stated that a unit inspection was completed every month by the US FO and any expired medications that were found would be reported to nursing for removal. The US FO added that controlled medications were spot checked during the unit inspection. The US FO also stated that a spot check of the IPCDRs and EMARs were completed and that the documentation of a removal of a NJ Ex Order 26.4b1 should match the EMAR whether the NJ Ex Order 26.4b1 was administered or refused.

A review of the Unit Inspection Reports for the unit completed by a US FO dated NJ Ex Order 26.4, NJ Ex Order 26.4, and NJ Ex Order 26.4 revealed that there was no recorded documentation of the expired NJ Ex Order 26.4b1.

A review of the current facility policy for Administration of Medications with a revision date of 2/14/24 provided by the US FOIA (b) reflected "To administer medication safely and efficiently." In addition, the policy reflected "Once resident has been identified: ...Re-read label ..." The policy further reflected to "Make appropriate entry on eMAR and Narcotic Control Sheet, if applicable."

A review of the current facility policy for Medication: Controlled Drug with a revision date of 2/22/24 provided by the US FOIA (b) reflected "When a controlled drug is administered to a resident, in addition to the following the proper procedure for charting medication, the declining inventory sheet must also be signed."

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F 755	Continued From page 59 NJAC 8:39-11.2(b), 29.2 (a)(d), 29.4(g)(k), 29.7(c)	F 755		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings,	F 842		4/1/24

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F 842	Continued From page 60 law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, it was determined the facility failed to follow professional standards and practices to accurately document in the medical record an ordered medication a resident was being administered. The concern was cited for 2 (Residents #57 and #377) of 19 residents reviewed and is evidenced by the	F 842	F842 Resident Records - Identifiable Information Plan of Correction ¿ Corrective action for the resident affected by the deficient practice.	

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F 842	Continued From page 61 following. 483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are (ii) accurately documented. 1. On 3/19/24 at 12:51 PM, the surveyor reviewed the medication orders for resident #377 in the electronic medical record (EMR). The medication orders reflected that resident #377 had a physician's order for and was being administered NJ Ex Order 26.4b1 (NJ Ex Order 26.4 NJ Ex Order 26.4b1 . On 03/20/24 at 9:51 AM, the surveyor reviewed the EMR for resident #377. The review included documentation recorded by the attending physician and associated nurse practitioners reflected as Plan of Care (POC) notes, Physician Progress Notes and NJ Ex Order 26.4b1 Management Notes. The surveyor identified six (6) out of eleven (11) instances where the documentation did not accurately reflect the NJ Ex Order 2 NJ Ex Order 26.4b1) resident #377 was receiving. The Physician's Progress Notes dated NJ Ex Order 26.4b1 , NJ Ex Order 2 NJ Ex Order 26.4 , and NJ Ex Order 26.4 reflected NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1) (NJ Ex Order 26.4b1 . The NJ Ex Order 26.4b1 Management Monthly note entered by an US FO dated NJ Ex Order 26.4b1 reflected NJ Ex Order 26.4b1 . The NJ Ex Order 26.4b1 Management Monthly notes entered by an US FO dated NJ Ex Order 26.4 and NJ Ex Order 26.4 did not reflect any NJ Ex Order 2 order.	F 842	" The affected residents continue to reside in the facility. " The residents were assessed by the nursing staff and were NJ Ex Order 26.4b1 the deficient practice. ¿ Corrective action taken for those residents having the potential to be affected by the deficient practice. " . Any resident in the facility has the potential to be affected by the deficient practice. ¿ Measures/Systemic changes put in place to assure the deficient practice does not re occur: 1. This issue was discussed with the QAPI committee to improve our current policy and practices. The QAPI committee recommended changes to improve our current documentation practices. Below were the steps taken per recommendation by the QAPI Committee: a. The administrator educated the US FOIA (b)(6) and all NPs working in the facility with regards to reviewing each residents orders and medications prior to documenting their findings in the progress notes. b. The administrator educated the US FOIA (b)(6) and all NPs working in	

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F 842	Continued From page 62 The POC note entered by an [redacted] dated [redacted] as a Late Entry reflected [redacted] and [redacted]). The [redacted] Management Monthly notes entered by an [redacted] dated [redacted], [redacted] and [redacted] reflected [redacted]. [redacted] is described as a [redacted] that starts to work in [redacted] to [redacted] minutes and lasts [redacted] to [redacted] hours. [redacted] is described as a [redacted] that starts to work in [redacted] to [redacted] hours and continues working in the body for [redacted] to [redacted] hours. On 3/25/24 at 12:25 PM, the surveyor discussed this concern with facility administration. On 3/26/24 at 9:38 AM the [redacted] provided documentation in the form of a Physician's progress note reflecting that the physician corrected the record to reflect the resident receiving [redacted]. The surveyor asked the administration team if the physician gave any reason for the discrepancies. The [redacted] stated, there was no specific reason other than human error. No further evidentiary information was provided by the facility. 2. On 03/21/24 at 10:47 AM, the surveyor observed Resident #57 sitting in bed, [redacted] and [redacted].	F 842	the facility with regards to writing a new progress note each time they see their residents and not to copy paste progress from previous visits. c. The DON/designee educated all licensed nursing staff to ensure that immunization status is asked during the admission process and if data is available, these are to be added to the resident□s record in Point Click Care. d. The DON/Designee will review the hospital records of newly admitted residents to gather information regarding immunization within 3 days of admission. e. The DON/designee educated all licensed nursing staff to record all immunization provided to the resident in the facility including but not limited to Mantoux Test and record the result of the same test in the resident□s chart upon reading the result. f. If the resident□s immunization record cannot be found in the hospital records, the facility liaison will request records from family members/POA/Guardian to ensure that the resident□s immunization record is complete. ¿ How will corrective actions be monitored to ensure the alleged deficient practice will not re occur: " The Director of Nursing /designee will conduct a weekly audit on all residents admitted during the past 7 days prior to	

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F 842	Continued From page 63 The surveyor reviewed Resident #57's hybrid (combination of paper and electronic) medical record as follows: A review of the AR documented that Resident #57 was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26.4b1 (NJ [redacted]). The resident's most recent Admission MDS (AMDS) assessment, dated NJ Ex Order 26.4b1, reflected that Resident #57 had a Brief Interview for Mental Status (BIMS) score of NJ E out of 15, indicating NJ Ex Order 26.4b1. Section NJ E Special Treatments, Procedures, and Programs revealed that Resident #57, the NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1 [redacted]) was received outside of the facility, and NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 [redacted]), was up to date. A review of Resident #57's electronic medical record under the NJ Ex Order 26.4b1 tab did not show that the NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 dose did not indicate a date given as complete or a date with historical to indicate that the resident had the NJ Ex Order 26.4b1 in the past. On 3/21/24 at 01:50 PM, in the presence of the survey team, the surveyor requested the US FOIA (b)(6) [redacted] and US FOIA (b)(6) [redacted] to provide information on Resident #57's NJ Ex Order 26.4b1 On 3/25/24 at 11:25 AM, the US FOIA (b) [redacted] provided the surveyor with a document stating, " NJ Ex Order 26.4b1 Resident #57 PNA - resident verbalized received NJ Ex Order 26.4 [redacted] in the community but could not remember when. NJ Ex -per NJ Ex Or [redacted] received NJ Ex [redacted] at US FOIA (b)(6) office."	F 842	the audit date to ensure that their immunization records are in their charts. " The Director of Nursing /designee will conduct a random weekly audit on 3 residents from different units to review that the progress notes written by the MD/NP are accurate and not a copy of the previous notes. " The audit will be conducted weekly x 4 weeks, then monthly x 3 months. " All findings will be presented during the monthly QAPI committee meeting for review.	

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F 842	Continued From page 64 On 03/26/24 at 09:55 AM, the [redacted] asked for a copy of the resident's [redacted] record from a family member. He added that the [redacted] tab was updated and that the [redacted] record copy was uploaded to the miscellaneous tab of the electronic record after the surveyor's inquiry.	F 842		
F 851 SS=F	NJAC 8:39-35.2(d)9 Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements.	F 851		4/1/24

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F 851	Continued From page 65 The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to submit their Payroll Based Journal (PBJ) Report to the	F 851	F 851 Payroll Based Journal Plan of Correction	

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F 851	Continued From page 66 Centers for Medicare and Medicaid Services (CMS) within a timely manner. This deficient practice was identified for the PBJ Report submission for Fiscal Year (FY) Quarter 1 2024 (October 1-December 31) and was evidenced by the following: A review of the PBJ Staffing Data Report CASPER Report 1705D reflected a triggered area indicating the facility failed to submit data for the first Fiscal Year Quarter to CMS. The dates of the first quarter included October 1, 2023, through December 31, 2023. On 3/19/24 at 10:00 AM, the US FOIA (b)(6) informed the survey team that the facility used a third party to submit the PBJ Staffing Data Report to CMS. The third party did not provide a CMS validation or any proof of submission to CMS for staffing reported for the FY Quarter 1 2024. On 3/27/24 at 11:15 AM, the surveyor interviewed the US FOIA (b)(6) in the presence of another surveyor, regarding communication of staffing with CMS and he stated, "We submitted everything with this third party, and they communicate with CMS. I don't have any documentation or proof on hand to reflect that CMS received the data for the FY Quarter 1 2024." The survey team explained the concern to the US FOIA (b)(6) that CMS did not have the data. The US FOIA (b)(6) was not able to provide additional proof of documentation indicating the third party communicated to CMS. On 3/27/24 at 12:00 PM, the surveyor requested the policy and procedure from the US FOIA (b)(6) for PBJ submission/communication to CMS.	F 851	¿ Corrective action for the resident affected by the deficient practice. " No resident was directly affected by this deficient practice. ¿ Corrective action taken for those residents having the potential to be affected by the deficient practice. " No resident in the facility has the potential to be affected by the alleged deficient practice. ¿ Measures/Systemic changes put in place to assure the deficient practice does not reoccur: " The administrator educated the US FOIA (b)(6) to double check before submitting PBJ that all Nursing Hours are submitted and accepted with no errors. ¿ How will corrective actions be monitored to ensure the alleged deficient practice will not re occur: " The Administrator /designee will conduct a weekly audit to ensure that all Nursing hours are submitted to the PBJ with no errors.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315390	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANFORD PARK CARE	600 LINCOLN PARK EAST CRANFORD, NJ 07016

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F 851	Continued From page 67 The facility's policy and procedure were received from the [redacted] on 3/27/24 at 12:30 PM, the policy titled PBJ Reporting, with the revised date of 2/8/24 did not indicate the timeframe of submitting data to CMS and who was responsible for submission. NJAC 8:39-41.3(a)	F 851	" " The audit will be conducted weekly x 4 weeks, then monthly x 3 months. " All findings will be presented during the monthly QAPI committee meeting for review.	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 883		4/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 883	Continued From page 68 §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, and review of other pertinent facility documents, it was determined that the facility failed to offer a resident a NJ Ex Order 26.4b1 for 1 of 6 residents reviewed for NJ Ex Order 26.4b1 (Resident #63). The deficient practice was evidenced by the following: The surveyor reviewed Resident #63's medical record.	F 883	F883 Influenza and Pneumococcal Immunizations Plan of Correction ¿ Corrective action for the resident affected by the deficient practice. " The affected residents continue to reside in the facility. " The resident was assessed by the nursing staff and was NJ Ex Order 26.4b1	

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F 883	Continued From page 69 A review of Resident #63 Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted]. A review of Resident #63's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that Resident #63's [redacted] was [redacted]. Further review of Section [redacted] Special Treatments, Procedures, and Programs indicated that under [redacted] Resident #63's [redacted] was up to date. A review of Resident #63's electronic medical record under the [redacted] tab included the following: [redacted]: [redacted] Req. It did not indicate a date that it was given as complete or a date with historical to indicate that the resident had the [redacted] in the past. On 3/21/24 at 11:40 AM, the surveyor interviewed	F 883	[redacted] by the deficient practice. ¿ Corrective action taken for those residents having the potential to be affected by the alleged deficient practice " . All residents in the facility have the potential to be affected by the alleged deficient practices. ¿ Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur: 1. The DON/Designee educated all licensed nursing staff with regards to immunization as follows: a. All consents for immunization will be forwarded to the Infection Control Nurse or DON/designee in the absence of the Infection Control Nurse. b. A list of those who agreed to receive the immunization and those who refused the immunization will be generated. c. Once the list is completed, the Infection Control Nurse will reach out to the pharmacy to inquire about the availability of the vaccine. d. The infection control will then schedule a date for immunization (like a vaccine clinic) during which all who consented will receive the vaccine on the same date as everyone.	

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F 883	Continued From page 70 the US FOIA (b)(6)) regarding NJ Ex Order 26.4b1 . The US FOIA stated that the nurse would request proof of the NJ Ex Order 26.4b1 She added that if the resident did not receive the NJ Ex Order 26.4b1 then she would get an order from the physician and give the NJ Ex Order 26.4b1 On 3/21/24 at 01:50 PM, in the presence of the survey team, the surveyor requested the US FOIA (b)(6)) and US FOIA (b)(6) provide information on Resident #63's NJ Ex Order 26.4b1 On 3/21/24 at 02:08 PM, the surveyor reviewed the hybrid medical record. There was a Resident Consent Form NJ Ex Order 26.4b1 (NJ Ex Or) NJ Ex Order 26.4b1 which included the resident's representative signature under "I consent to receive the NJ Ex Order 26.4b1." There was no date next to the signature. On the top of the form was the resident's representative signature under "I consent to receive the NJ E (NJ Ex Order 26.4b1) NJ Ex Order 26.4 ." There was NJ Ex Order 26 (NJ Ex Order 26.4b1) written on the date line. On 3/22/24 at 10:31 AM, the surveyor reviewed Resident #63's electronic medical record. The Misc (Miscellaneous) section contained a Resident Consent Form NJ Ex Order 26.4b1 (NJ Ex Orde) NJ Ex Order 26.4b1 that included per phone conversation with resident's representative dated NJ Ex Order 26.4b1 "I consent to receive the NJ Ex Order 26.4b1." On 3/25/24 at 11:25 AM, the US FOIA (b) provided the surveyor a document that included the following: NJ Ex Order 26.4b1 Resident #63- ... NJ Ex Ord (NJ Ex Order 26.4b1) NJ Ex Order 26.4 the consent was signed by the NJ Ex Order 26.4b1 , not	F 883	e. Those who refused to receive the vaccine will have a note stating their refusal in their chart. f. All orders for immunization will be written in each of the resident□s chart who agreed to receive the vaccine then administer the vaccine to these residents. g. Once vaccine is administered, the immunization record of that resident will be updated to reflect that the vaccine was administered as ordered. ¿ How will corrective actions be monitored to ensure the alleged deficient practice will not re occur: " The Director of Nursing /designee will conduct a weekly random audit on 5 residents to check if they consented to receive the Pneumonia Vaccine. " The Director of Nursing /designee will conduct a random weekly audit on the same 5 residents who consented to receive the Pneumonia Vaccine to ensure that they received the vaccine when they consented. " The audit will be conducted weekly x 4 weeks, then monthly x 3 months. " All findings will be presented during the monthly QAPI committee meeting for review	

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F 883	Continued From page 71 given. On 3/25/24 at 11:47 AM, in the presence of the survey team, the surveyor interviewed the [US FOIA (b)(6) redacted] regarding what "req" meant on Resident #63's [NJ Ex Order 26.4b1] section. The [US FOIA (b)(6)] stated that it meant request. On 3/25/24 at 12:31 PM, in the presence of the survey team, the surveyor told the [US FOIA (b)(6) redacted] the concern that Resident #63 was not offered and given the [NJ Ex Order 26.4b1 redacted] prior to surveyor inquiry. On 3/26/24 at 9:47 AM, in the presence of the survey team and [US FOIA (b)(6) redacted] the [US FOIA (b) redacted] stated that the [NJ Ex Order 26.4b1 redacted] should have been offered and given. The [US FOIA (b) redacted] stated that he was not sure why it was not given. On 3/26/24 at 10:56 AM, in the presence of the survey team, the surveyor interviewed the [US FO redacted] regarding the process for [NJ Ex Order 26.4b1 redacted]. The [US F redacted] stated that the admitting nurse would find out if the resident was up to date with the [NJ Ex Order 26.4b1 redacted] She added that if not sure of the status then they would check with the physician if the resident would benefit from receiving it and get an order to give it. The facility provided the surveyor a document that indicated Resident #63 received the NJ Ex Order 26.4b1 on [NJ Ex Order 26.4 redacted] which was after surveyor inquiry. The facility did not provide any additional information.	F 883		

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F 883	Continued From page 72 A review of the facility provided policy titled, "Immunization Protocol, Resident" with a revised date of 3/21/2023, included the following: Policy: All residents will be offered the opportunity to be immunized for both influenza and pneumococcal disease. The influenza vaccine will be offered to the resident on an annual basis. The pneumococcal disease vaccine will be offered per physician order. Procedure: Upon admission, all residents will be interviewed as to their current immunization status. This information will be recorded on the resident's "Immunization Record" and in red ink within the Nursing History. The information will be maintained in the resident's medical record. All residents not immunized will be reviewed quarterly at the Infection Control Meeting and will be offered appropriate vaccinations. N.J.A.C. 8:39-19.4(i)	F 883		

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
315390 Y1	A. Building B. Wing Y2	5/3/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANFORD PARK CARE	600 LINCOLN PARK EAST CRANFORD, NJ 07016

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 F0637	Correction	ID Prefix F0640	Correction	ID Prefix F0641	Correction
Reg. # 483.20(b)(2)(ii)	Completed	Reg. # 483.20(f)(1)-(4)	Completed	Reg. # 483.20(g)	Completed
LSC	04/01/2024	LSC	04/01/2024	LSC	04/01/2024
ID Prefix F0658	Correction	ID Prefix F0686	Correction	ID Prefix F0688	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. # 483.25(c)(1)-(3)	Completed
LSC	03/29/2024	LSC	04/01/2024	LSC	03/29/2024
ID Prefix F0692	Correction	ID Prefix F0695	Correction	ID Prefix F0755	Correction
Reg. # 483.25(g)(1)-(3)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	03/29/2024	LSC	03/29/2024	LSC	03/29/2024
ID Prefix F0842	Correction	ID Prefix F0851	Correction	ID Prefix F0883	Correction
Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed	Reg. # 483.70(q)(1)-(5)	Completed	Reg. # 483.80(d)(1)(2)	Completed
LSC	04/01/2024	LSC	04/01/2024	LSC	04/01/2024
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	
3/27/2024	☐ 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
	315390	A. BUILDING **01, 02, 03** B. WING _____	**03/27/2024**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 03/25/2024, 03/26/2024 and 03/27/2024, 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 This Building identified as the "Nursing Home with a basement" (#1) is a 2-story building that was certified in 90's, It is composed of Type V unprotected construction. The Annex is divided into 2- smoke zones (The first and second floors). The exterior 30 KW natural gas generator does approximately 80 % of the facility. The facility has 100 certified beds. At the time of the survey the total facility census was 64. The Nursing Home census was 37. The completed FSES (fire safety evaluation system) dated 10/27/2023 (as a result of the 09/15/2023 survey) indicated that: Cranford Park Rehabilitation & Health Care Center, provider # 31-5390 is comprised of 3-buildings: Nursing Home (two stories and basement); Annex Section (two stories); and C-unit (three stories and basement). *The facility US FOIA (b)(6) was informed that a new FSES needs to be conducted for the 03/27/2024 recertification survey.	K 000		
K 000	INITIAL COMMENTS	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/16/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315390	A. BUILDING **01, 02, 03** B. WING _____	**03/27/2024**

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K 000	Continued From page 1 A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 03/25/2024, 03/26/2024 and 03/27/2024, 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 This Building identified as the "Annex" (#2) is a 2-story building that was certified in 90's. It is composed of Type V unprotected construction. The Annex is divided into 2- smoke zones (first and second floors). The exterior 30 KW natural gas generator covers approximately 80 % of the facility. The facility has 100 certified beds. At the time of the survey the total facility census was 64. The Annex census was 8 Residents. The completed FSES (fire safety evaluation system) dated 10/27/2023 (as of a result of the 09/15/2023 survey) indicated that: Cranford Park Rehabilitation & Health Care Center, provider # 31-5390 is comprised of 3-buildings: Nursing Home (two stories and basement); Annex Section (two stories); and C-unit (three stories and basement). *The facility US FOIA (b)(6) was informed that a new FSES needs to be conducted for the 03/27/2024 recertification survey.	K 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the	K 000		

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 000	Continued From page 2 New Jersey Department of Health, Health Facility Survey and Field Operations on 03/25/2024, 03/26/2024 and 03/27/2024, 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 This Building identified as the "C-Unit with a basement" (#2) is a 3-story building that was certified in 90's, It is composed of Type II Protected construction. The Annex is divided into 2- smoke zones (The first and second floors). The exterior 30 KW natural gas generator covers approximately 80 % of the facility. The facility has 100 certified beds. At the time of the survey the total facility census was 64. The "C-Unit with a basement" census was 22. The completed FSES (fire safety evaluation system) dated 10/27/2023 (as of a result of the 09/15/2023 survey) indicated that: Cranford Park Rehabilitation & Health Care Center, provider # 31-5390 is comprised of 3-buildings: Nursing Home (two stories and basement); Annex Section (two stories); and C-unit (three stories and basement). *The facility US FOIA (b)(6) was informed that a new FSES needs to be conducted for the 03/27/2024 recertification survey.	K 000		
K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height	K 161		5/7/24

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K 161	Continued From page 3 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 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.	K 161		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 161	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 03/25/2024, 03/26/2024 and 03/27/2024, in the presence of the US FOIA (b)(6)) and US FOIA (b)(6) it was determined that the facility failed to comply with the construction requirements of NFPA 101:21012 as evidenced by the following: During a tour of the Annex section of the building on 03/25/2024 from approximately 10:14 AM to 12:00 PM, in the presence of the facility's US FOIA the Surveyor observed that the "Annex Building #2" was a 2-story wood-frame structure, exceeding the 1-story height requirement for wood-frame structures. The condition noted above was confirmed by the facility's US FOIA (b)(6) during the Life Safety Code exit conference on 03/27/2024 at approximately 11:58 AM. The facility's US FOIA (b)(6) was informed to conduct an on-site Fire Evaluation System (FSES) survey for this re-certification. NJAC 8:39-31.2(e)	K 161	Corrective action for the residents affected by the deficient practice. The facility conducted a Fire Safety Evaluation System on 5/7/2024 for compliance with NFPA 101A-20123. The FSES equivalency calculation passed the Fire Safety Evaluation System (FSES). Corrective action taken for those residents having the potential to be affected by the deficient practice Any resident in the facility has the potential to be affected by this deficient practice. Measures/Systemic changes put in place to assure the deficient practice does not re occur. 1. The Administrator/Designee will train staff extensively every quarter on enhanced level of safety concerning the annex section for the evacuating of residents, fire hazards, electrical hazards, sprinkler system and fire alarm section operations. How will corrective actions be monitored to ensure the deficient practice will not re occur: 1.The Administrator/Designee will monitor the building while the corporate physical plant will be monitored monthly. All findings will be presented during the monthly QAPI committee meeting for review.	
K 252 SS=F	Number of Exits - Corridors CFR(s): NFPA 101 Number of Exits - Corridors Every corridor shall provide access to not less than two approved exits in accordance with	K 252		5/7/24

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	315390	A. BUILDING **01, 02, 03** B. WING _____	**03/27/2024**

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K 252	Continued From page 5 Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 03/25/2024 and 03/27/2024, in the presence of the US FOIA (b)(6)), it was determined that the facility failed to provide 2 acceptable exits from each floor or fire section of the building as evidenced by the following: During a tour of the building on 03/25/2024 from 9:27 AM to 12:00 PM, in the presence of the facility's US FOIA the surveyor observed the following conditions: 1. The stairway leading from the 3rd floor of the older section C-Unit (Cranford Hall) of the building was of a winding design. Also, the basement stairway was of a winding design. 2. The 2nd exit/means of egress from the 3rd floor was through an office room leading to a fire escape. Further inspection of the outside fire escape revealed the fire escape leads you to a first floor combustible wooden porch roof. The means of egress (fire escape) does not lead to a Public Way. The condition noted above was confirmed by the facility's US FOIA (b)(6) during the Life Safety Code exit conference on 03/27/2024 at approximately 11:58 AM.	K 252	Corrective action for the residents affected by the deficient practice. The facility conducted a Fire Safety Evaluation System on 5/7/2024 for compliance with NFPA 101A-20123. The FSES equivalency calculation passed the Fire Safety Evaluation System (FSES). Corrective action taken for those residents having the potential to be affected by the deficient practice Any resident in the facility has the potential to be affected by this deficient practice. Measures/Systemic changes put in place to assure the deficient practice does not re occur. 1. The Administrator/Designee will train staff extensively every quarter on enhanced level of safety concerning the annex section for the evacuating of residents, fire hazards, electrical hazards, sprinkler system and fire alarm section operations. How will corrective actions be monitored to ensure the deficient practice will not re occur: 1.The Administrator/Designee will monitor the building while the corporate physical plant will be monitored monthly. All findings will be presented during the monthly QAPI committee meeting for	

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 252	Continued From page 6 The facility's US FOIA (b)(6) was informed to conduct an on-site Fire Evaluation System (FSES) survey for this re-certification. NJAC 8:39-31.2(e)	K 252	review.	
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 03/25/2024 and 03/27/2024, in the presence of the US FOIA (b)(6) it was determined that the facility failed to ensure that vertical openings between floors were enclosed with 1-hour fire-rated construction as evidenced by the following: During a tour of the building on 03/25/2024 from 9:27 AM to 12:45 PM, in the presence of the facility's US FOIA the surveyor observed the stairway connecting the first and second floors in the C Unit were not enclosed with 1-hour fire rated walls on both sides and a fire-rated door at the bottom.	K 311	Corrective action for the residents affected by the deficient practice. The facility conducted a Fire Safety Evaluation System on 5/7/2024 for compliance with NFPA 101A-20123. The FSES equivalency calculation passed the Fire Safety Evaluation System (FSES). Corrective action taken for those residents having the potential to be affected by the deficient practice Any resident in the facility has the potential to be affected by this deficient practice. Measures/Systemic changes put in place to assure the deficient practice does not re occur. 1. The Administrator/Designee will train	5/7/24

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K 311	Continued From page 7 This condition was confirmed by the facility's US FOIA (b)(6), during the Life Safety Code exit conference on 03/27/2024 at approximately 1:01 PM. The facility's US FOIA (b)(6) was informed to conduct an on-site Fire Evaluation System (FSES) survey for this re-certification. NJAC 8:39-31.2(e)	K 311	staff extensively every quarter on enhanced level of safety concerning the annex section for the evacuating of residents, fire hazards, electrical hazards, sprinkler system and fire alarm section operations. How will corrective actions be monitored to ensure the deficient practice will not re occur: 1.The Administrator/Designee will monitor the building while the corporate physical plant will be monitored monthly. All findings will be presented during the monthly QAPI committee meeting for review.	
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 hazardous areas, but shall not be open to the corridor.	K 324		4/1/24

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K 324	Continued From page 8 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 review of facility documentation on 03/25/2024, 03/26/2024 and 03/27/2024, in the presence of facility management it was determined that the facility failed to Hydrostatic test the kitchen range-hood fire suppression system cylinder every 12 years as required in accordance with National Fire Protection Association (NFPA) 96 and NFPA 17A. The deficient practice was evidenced by the following: Reference: NFPA 17A, 7.5 Hydrostatic Testing, - 7.5.1 The following parts of the wet chemical extinguishing system shall be subjected to a hydrostatic pressure test at intervals not exceeding 12 years: (1) Wet Chemical containers. (2) Auxiliary pressure containers. (3) Hose assemblies. On 03/25/2024 (day one of survey) during the survey entrance at approximately 8:48 AM, a request was made to the US FOIA (b)(6) to provide all mandatory inspections that had been conducted from 01/01/2023 through 03/24/2024 for review later. Later on 03/25/2024 at approximately 11:43 AM,	K 324	Response K324 " Corrective action for the residents affected by the deficient practice On April 1, 2024, the facility□s range-hood fire suppression system including the hydrostatic testing for the wet chemical fire suppression system was completed by NJ Ex Order 26.4b1 in the presence of the Maintenance Director. " Corrective action taken for those residents having the potential to be affected by the deficient practice o Any resident in the facility has the potential to be affected by this deficient practice. " Measures/Systemic changes put in place to assure the deficient practice does not re occur: 1. The Administrator educated the US FOIA (b)(6) that the facility□s range hood fire suppression system should be inspected and documented at least every 12 years 2. On 4/1/2024 the suppression system was inspected and maintenance performed as required. " How will corrective actions be	

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K 324	Continued From page 9 a review of the facility's range-hood fire suppression system inspections for the previous 22 months identified the system had three (3) semi-annual inspections on the following dates that read in part: - January 15, 2024, Last hydrostatic test date, 2012. - July 26, 2023, Last hydrostatic test date, 2011. - January 28, 2023, Last hydrostatic test date, 2011. On 03/26/2024 at approximately 9:00 AM, a request was made to the US FOIA to provide a copy of the last semi-annual kitchen fire suppression system inspection for 2022 for review. On 03/27/2024 at approximately 9:10 AM, the facility US FOIA provided a copy of the last semi-annual kitchen fire suppression that read in part, - July 27, 2022, Last hydrostatic test date, 2011. The facility failed to conduct the 12 year Hydrostatic testing for the Wet Chemical fire suppression system as required by code. The US FOIA confirmed the finding and the testing had not been done. The US FOIA (b)(6) was informed of the Life Safety Code deficiency during the survey exit on 03/27/2024 at approximately 12:01 PM. NFPA 101, NFPA 96, 17A. NJAC 8:39-31.2(e)	K 324	monitored to ensure the deficient practice will not re occur: 1. The Administrator and Maintenance Director will monitor the testing of the facility□s range hood suppression system to assure the hydrostatic testing of the kitchen range-hood fire suppression system cylinder will be tested every 12 years as required in accordance with National Fire Protection Association (NFPA) 96 and NFPA 17A. 2. The monitoring will be done annually to assure compliance. All audit findings will be presented during the monthly QAPI committee meeting for review.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance	K 345		3/29/24

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K 345	Continued From page 10 CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on interview and documentation review on 03/25/2024, 03/26/2024 and 03/27/2024 in the presence of the facility management, it was determined that the facility failed to: 1) Ensure smoke detection sensitivity was checked every alternate year of the facility smoke detectors, in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010) Edition Section 14.4.5.3.2. This deficient practice was identified for 1 of 1 fire alarm systems and was evidenced by the following: Reference: 1) Fire Protection Association (NFPA) 72. National Fire Alarm and Signaling Code: - 10.4.3.2.2 Sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 10.4.3.2.3 On 03/25/2024 (day one of survey) during the survey entrance at approximately 8:48 AM, a request was made to the US FOIA (b)(6) [redacted] provide all mandatory inspections that	K 345	Response K345 " Corrective action for the residents affected by the deficient practice On March 27, 2024, NJ Ex Order 26.4b1 conducted smoke detector sensitivity testing of the facility smoke detectors. This testing will be conducted and maintenance provided as needed every even year. " Corrective action taken for those residents having the potential to be affected by the deficient practice o Any resident in the facility has the potential to be affected by this deficient practice. " Measures/Systemic changes put in place to assure the deficient practice does not re occur: 1. The Administrator educated the US FOIA (b)(6) [redacted] that the facility□s smoke detector sensitivity system must be tested and maintained at least every even year.	

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K 345	Continued From page 11 had been conducted from 01/01/2023 through 03/24/2024 for review later. The surveyor also requested the US FOIA to provide a copy of the last smoke detectors sensitivity testing. The surveyor also informed the US FOIA that he might have to call the Fire Alarm and Detection Inspection Vendor and ask to obtain a copy of the last smoke detector sensitivity testing. Later at approximately 12:45 PM on 03/25/2024, the surveyor reviewed the following semi-annual Fire Alarm and Detection system inspections that were provided and read in part: - 05/23/2023, no evidence of smoke detector sensitivity testing performed. - 05/24/2023, no evidence of smoke detector sensitivity testing performed. - 12/08/2024, no evidence of smoke detector sensitivity testing performed. - 12/11/2024, no evidence of smoke detector sensitivity testing performed. This review of the testing reports revealed no reference to a smoke detection sensitivity testing. Later at approximately 1:50 PM, the surveyor made a request to the US FOIA to place a phone call to the Fire Alarm and Detection Inspection Vendor to obtain a copy of the last smoke detector sensitivity testing. On 03/26.2024 (day two of survey) at approximately 9:30 AM, during an interview with the facility's US FOIA the surveyor requested if he had received the last sensitivity testing for the Smoke	K 345	" How will corrective actions be monitored to ensure the deficient practice will not re occur: 1. The Administrator and Maintenance Director will monitor the testing of the facility□s smoke detector sensitivity system at least every even year. 2. The monitoring will be done annually to assure compliance. All audit findings will be presented during the monthly QAPI committee meeting for review.	

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K 345	Continued From page 12 Detectors. The [redacted] could not provide the Smoke Detector sensitivity testing. On 03/27/2024 at approximately 10:00 AM, the surveyor observed two (2) Alarm and Detection Vendor mechanics conducting sensitivity testing of the smoke detectors in the C-Unit building. The [redacted] confirmed the sensitivity testing had not been done. The [redacted] was informed of the Life Safety Code deficiency during the survey exit on 03/27/2024 at approximately 12:01 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345		
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 interview and documentation review on 03/25/2024, 03/26/2024 and 03/27/2024 in the presence of the facility management, it was determined that the facility failed to: 1) Ensure smoke detection sensitivity was checked every alternate year for the facility	K 345	Response K345 " Corrective action for the residents affected by the deficient practice On March 27, 2024, NJ Ex Order 26.4b1 conducted smoke detector sensitivity testing of the facility smoke detectors. This testing will be conducted and	3/29/24

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K 345	Continued From page 13 smoke detectors, in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010) Edition Section 14.4.5.3.2. This deficient practice was identified for 1 of 1 fire alarm systems and was evidenced by the following: Reference: 1) Fire Protection Association (NFPA) 72. National Fire Alarm and Signaling Code: - 10.4.3.2.2 Sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 10.4.3.2.3 On 03/25/2024 (day one of survey) during the survey entrance at approximately 8:48 AM, a request was made to the US FOIA (b)(6)) to provide all mandatory inspections that had been conducted from 01/01/2023 through 03/24/2024 for review later. The surveyor also requested the US FOIA to provide a copy of the last smoke detectors sensitivity testing. The surveyor also informed the US FOIA that he might have to call the Fire Alarm and Detection Inspection Vendor and ask to obtain a copy of the last smoke detector sensitivity testing. Later at approximately 12:45 PM on 03/25/2024, the surveyor reviewed the following semi-annual Fire Alarm and Detection system inspections that were provided and read in part: - 05/23/2023, no evidence of smoke detector sensitivity testing performed. - 05/24/2023, no evidence of smoke detector	K 345	maintenance provided as needed every even year. " Corrective action taken for those residents having the potential to be affected by the deficient practice o Any resident in the facility has the potential to be affected by this deficient practice. " Measures/Systemic changes put in place to assure the deficient practice does not re occur: 1. The Administrator educated the US FOIA (b)(6) that the facility□s smoke detector sensitivity system must be tested and maintained at least every even year. " How will corrective actions be monitored to ensure the deficient practice will not re occur: 1. The Administrator and Maintenance Director will monitor the testing of the facility□s smoke detector sensitivity system at least every even year. 2. The monitoring will be done annually to assure compliance. All audit findings will be presented during the monthly QAPI committee meeting for review.	

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K 345	Continued From page 14 sensitivity testing performed. - 12/08/2024, no evidence of smoke detector sensitivity testing performed. - 12/11/2024, no evidence of smoke detector sensitivity testing performed. This review of the testing reports revealed no reference to a smoke detection sensitivity testing. Later at approximately 1:50 PM, the surveyor made a request to the US FOIA to place a phone call to the Fire Alarm and Detection Inspection Vendor to obtain a copy of the last smoke detector sensitivity testing. On 03/26.2024 (day two of survey) at approximately 9:30 AM, during an interview with the facility's US FOIA the surveyor inquired if he had received the last sensitivity testing for the Smoke Detectors. The US FOIA could not provide the Smoke Detector sensitivity testing. On 03/27/2024 at approximately 10:00 AM, the surveyor observed two (2) Alarm and Detection Vendor mechanics conducting sensitivity testing of the smoke detectors in the C-Unit building. The US FOIA confirmed the sensitivity testing had not been done. The US FOIA (b)(6) was informed of the Life Safety Code deficiency during the survey exit on 03/27/2024 at approximately 12:01 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101	K 345		3/29/24

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K 345	Continued From page 15 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on interview and documentation review on 03/25/2024, 03/26/2024 and 03/27/2024 in the presence of the facility management, it was determined that the facility failed to: 1) Ensure smoke detection sensitivity was checked every alternate year of the facility smoke detectors, in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010) Edition Section 14.4.5.3.2. This deficient practice was identified for 1 of 1 fire alarm systems and was evidenced by the following: Reference: 1) Fire Protection Association (NFPA) 72. National Fire Alarm and Signaling Code: - 10.4.3.2.2 Sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 10.4.3.2.3 On 03/25/2024 (day one of survey) during the survey entrance at approximately 8:48 AM, a request was made to the US FOIA (b)(6) to provide all mandatory inspections that had been conducted from 01/01/2023 through	K 345	Response K345 " Corrective action for the residents affected by the deficient practice On March 27, 2024, NJ Ex Order 26.4b1 conducted smoke detector sensitivity testing of the facility smoke detectors. This testing will be conducted and maintenance provided as needed every even year. " Corrective action taken for those residents having the potential to be affected by the deficient practice o Any resident in the facility has the potential to be affected by this deficient practice. " Measures/Systemic changes put in place to assure the deficient practice does not re occur: 1. The Administrator educated the US FOIA (b)(6) that the facility□s smoke detector sensitivity system must be tested and maintained at least every even year. " How will corrective actions be	

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K 345	Continued From page 16 03/24/2024 for review later. The surveyor also requested the US FOIA to provide a copy of the last smoke detectors sensitivity testing. The surveyor also informed the US FOIA that he might have to call the Fire Alarm and Detection Inspection Vendor and ask to obtain a copy of the last smoke detector sensitivity testing. Later at approximately 12:45 PM on 03/25/2024, the surveyor reviewed the following semi-annual Fire Alarm and Detection system inspections that were provided and read in part: - 05/23/2023, no evidence of smoke detector sensitivity testing performed. - 05/24/2023, no evidence of smoke detector sensitivity testing performed. - 12/08/2024, no evidence of smoke detector sensitivity testing performed. - 12/11/2024, no evidence of smoke detector sensitivity testing performed. This review of the testing reports revealed no reference to a smoke detection sensitivity testing. Later at approximately 1:50 PM, the surveyor made a request to the US FOIA to place a phone call to the Fire Alarm and Detection Inspection Vendor to obtain a copy of the last smoke detector sensitivity testing. On 03/26.2024 (day two of survey) at approximately 9:30 AM, during an interview with the facility's US FOIA the surveyor inquired if he had received the last sensitivity testing for the Smoke Detectors. The US FOIA could not provide the Smoke	K 345	monitored to ensure the deficient practice will not re occur: 1. The Administrator and Maintenance Director will monitor the testing of the facility□s smoke detector sensitivity system at least every even year. 2. The monitoring will be done annually to assure compliance. All audit findings will be presented during the monthly QAPI committee meeting for review.	

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K 345	Continued From page 17 Detector sensitivity testing. On 03/27/2024 at approximately 10:00 AM, the surveyor observed two (2) Alarm and Detection Vendor mechanics conducting sensitivity testing of the smoke detectors in the C-Unit building. The US FOIA confirmed the sensitivity testing had not been done. The US FOIA (b)(6) was informed of the Life Safety Code deficiency during the survey exit on 03/27/2024 at approximately 12:01 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 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)	K 351		4/29/24

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K 351	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 03/25/2024, 03/26/2024 and 03/27/2024, in the presence of facility management it was determined that: The Facility failed to install sprinklers, as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition. The deficient practice is evidenced by the following, On 03/25/2024 (day one of survey) during the survey entrance at approximately 8:48 AM, a request was made to the US FOIA (b)(6) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility as having three (3) buildings: the C-Unit, Annex and Main Nursing that are connected together. There were four (4) exit stairwells in the facility that Resident, Staff and Visitors would use in the event of an emergency to exit the building. Starting at approximately 9:27 AM on 03/25/2024 and continued on 03/26/2024, 03/27/2024 in presence of the facility's US FOIA a tour of the building was conducted. Along the three (3) day tour of the facility the surveyor observed the following location that failed to provide proper fire sprinkler	K 351	Response K351 " Corrective action for the residents affected by the deficient practice On April 16, 2024, NJ Ex Order 26.4b1 was contracted to install a new sprinkler head in the lower level of the stairwell in C unit basement level. This work was completed on 4/29/2024. " Corrective action taken for those residents having the potential to be affected by the deficient practice o Any resident in the facility has the potential to be affected by this deficient practice. " Measures/Systemic changes put in place to assure the deficient practice does not re occur: 1. The Administrator educated the US FOIA (b)(6) that code requires fire sprinkler coverage in stairwells at the top landing, bottom landing and every other floor in between. " How will corrective actions be monitored to ensure the deficient practice will not re occur: 1. The Administrator and Maintenance Director will monitor the sprinkler system to assure that all stairwells are in compliance and have functioning sprinkler coverage on the bottom landing, top landing and every other floor in between. 2. The monitoring will be done annually to assure compliance. All audit findings will be presented during the QAPI	

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K 351	Continued From page 19 coverage: On 03/25/2024 at approximately 9:29 AM, the surveyor observed no evidence of fire sprinkler coverage inside the "C-Unit" basement level approximately twelve feet by eight feet (12' x 8') lower landing. At this time the surveyor asked the US FOIA "Do you see any fire sprinklers on the lower level landing." The US FOIA looked up and around and told the surveyor, "No." Code requires fire sprinkler coverage in stairwells at the top landing , bottom landing and every other floor in between. The facility US FOIA confirmed the findings at the time of the observation. The US FOIA (b)(6) was informed of the Life Safety Code deficiency during the survey exit on 03/27/2024 at approximately 12:01 PM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351	committee meeting for review.	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation on 03/25/2024, 03/26/2024	K 355	Response K355 " Corrective action for the residents	3/29/24

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K 355	Continued From page 20 and 03/27/2024 in the presence of facility management, it was determined that the facility failed to: 1) Perform a six (6) year maintenance for 4 of 26 portable fire extinguishers observed and inspected, 2) Maintain 1 of 26 fire extinguishers in proper working condition, as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and there after at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification.	K 355	affected by the deficient practice On March 29, 2024, the Maintenance Director replaced the fire extinguisher in building #2 (B unit) end floor that had an outdated 6 year maintenance collar with a new fire extinguisher. The Maintenance Director audited the remaining 25 fire extinguishers and found they were within maintenance compliance. " Corrective action taken for those residents having the potential to be affected by the deficient practice o Any resident in the facility has the potential to be affected by this deficient practice. " Measures/Systemic changes put in place to assure the deficient practice does not re occur: 1. The Administrator educated the US FOIA (b)(6) that the facility□s fire extinguishers must be properly maintained and have a 6 year internal examination completed as detailed in the manufacturer□s service manual and documented. " How will corrective actions be monitored to ensure the deficient practice will not re occur: 1. The Administrator and Maintenance Director will monitor and audit the maintenance of the fire extinguishers in the facility on a quarterly basis. 2. The audit will be completed on a monthly basis for six months and then on a quarterly basis after that. All audit findings will be presented during the	

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K 355	Continued From page 21 - 7.3.1.2.1 Six-Year Internal Examination. Every 6 years, stored-pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable internal examination procedures as detailed in the manufacture's service manual and this standard. The findings include the following, On 03/25/2024 (day one of survey) during the survey entrance at approximately 8:48 AM, a request was made to the US FOIA (b)(6) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility has three (3) buildings: the C-Unit building #3, Annex building #2 and Main Nursing building #1. Starting at approximately 9:27 AM on 03/25/2024 and continued on 03/26/2024, 03/27/2024 in presence of the facility's US FOIA a tour of the 3 buildings was conducted. During the three (3) day tour of the facility, the surveyor observed and inspected twenty-six (26) portable fire extinguishers in various locations that were annually inspected January 2024 with the following in the Main Nursing building #1. On 03/26/2024: 1) At approximately 11:14 AM, the surveyor observed in the Nursing Home building #2 (B-Unit) 2nd. floor, one (1) ABC-Type fire extinguisher to the left of Resident room #209 with a (white) six-year (6) Maintenance collar attached to the extinguisher dated 2013.	K 355	monthly QAPI committee meeting for review.	

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K 355	Continued From page 22 The US FOIA confirmed the findings at the times of the observations. The US FOIA (b)(6) was informed of the Life Safety Code deficiency during the survey exit on 03/27/2024 at approximately 12:01 PM. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation on 03/25/2024, 03/26/2024 and 03/27/2024 in the presence of facility management, it was determined that the facility failed to: 1) Perform a six (6) year maintenance for 4 of 26 portable fire extinguishers observed and inspected, and 2) Maintain 1 of 26 fire extinguishers in proper working condition, as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010	K 355	Response K355 " Corrective action for the residents affected by the deficient practice On March 29, 2024, the Maintenace Director replaced the fire extinguisher in building #2 (B unit) end floor that had an outdated 6 year maintenance collar with a new fire extinguisher. The Maintenance Director audited the remaining 25 fire extinguishers and found they were within maintenance compliance. " Corrective action taken for those residents having the potential to be affected by the deficient practice o Any resident in the facility has the potential to be affected by this deficient	3/29/24

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K 355	Continued From page 23 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and there after at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. - 7.3.1.2.1 Six-Year Internal Examination. Every 6 years, stored-pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable internal examination procedures as detailed in the manufacture's service manual and this standard. The findings include the following, On 03/25/2024 (day one of survey) during the survey entrance at approximately 8:48 AM, a request was made to the US FOIA (b)(6) to provide a copy of the facility lay-out which identifies the various rooms and smoke	K 355	practice. " Measures/Systemic changes put in place to assure the deficient practice does not re occur: 1. The Administrator educated the US FOIA (b)(6) that the facility□s fire extinguishers must be properly maintained and have a 6 year internal examination completed as detailed in the manufacturer□s service manual and documented. " How will corrective actions be monitored to ensure the deficient practice will not re occur: 1. The Administrator and Maintenance Director will monitor and audit the maintenance of the fire extinguishers in the facility on a quarterly basis. 2. The audit will be completed on a monthly basis for six months and then on a quarterly basis after that. All audit findings will be presented during the monthly QAPI committee meeting for review.	

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K 355	Continued From page 24 compartments in the facility. A review of the facility provided lay-out identified the facility has three (3) buildings: the C-Unit building #3, Annex building #2 and Main Nursing building #1. Starting at approximately 9:27 AM on 03/25/2024 and continued on 03/26/2024, 03/27/2024 in presence of the facility's US FOIA a tour of the building was conducted. During the three (3) day tour of the facility, the surveyor observed and inspected twenty-six (26) portable fire extinguishers in various locations that were annually inspected January 2024 with the following in the Annex building #2, On 03/26/2024: 1) At approximately 12:27 PM, the surveyor observed in the Annex building, one (1) ABC-Type fire extinguisher to the left of Resident room #209 with a (white) six-year (6) Maintenance collar attached to the extinguisher dated 2013. The US FOIA confirmed the findings at the times of observations. The US FOIA (b)(6) was informed of the Life Safety Code deficiency during the survey exit on 03/27/2024 at approximately 12:01 PM. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with	K 355		3/29/24

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K 355	Continued From page 25 NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation on 03/25/2024, 03/26/2024 and 03/27/2024 in the presence of facility management, it was determined that the facility failed to: 1) Perform a six (6) year maintenance for 4 of 26 portable fire extinguishers observed and inspected, and 2) Maintain 1 of 26 fire extinguishers in proper working condition, as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and there after at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at	K 355	Response K355 " Corrective action for the residents affected by the deficient practice On March 29, 2024, the Maintenance Director audited ALL 26 fire extinguishers and found that 2 of 26 were not within compliance. The extinguisher in the basement level and in the old owners apartment were replaced with a new extinguishers with current inspection stickers. T " Corrective action taken for those residents having the potential to be affected by the deficient practice o Any resident in the facility has the potential to be affected by this deficient practice. " Measures/Systemic changes put in place to assure the deficient practice does not re occur: 1. The Administrator educated the US FOIA (b)(6) that the facility□s fire extinguishers must be properly maintained and have a 6 year internal examination completed as detailed in the manufacturer□s service manual and documented. " How will corrective actions be monitored to ensure the deficient practice will not re occur: 1. The Administrator and Maintenance	

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K 355	Continued From page 26 least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. - 7.3.1.2.1 Six-Year Internal Examination. Every 6 years, stored-pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable internal examination procedures as detailed in the manufacture's service manual and this standard. The findings include the following, On 03/25/2024 (day one of survey) during the survey entrance at approximately 8:48 AM, a request was made to the US FOIA (b)(6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is comprised of three (3) buildings: the C-Unit building #3, Annex building #2 and Main Nursing building #1. Starting at approximately 9:27 AM on 03/25/2024 and continued on 03/26/2024, 03/27/2024 in presence of the facility's US FOIA a tour of the building was conducted. During the three (3) day tour of the facility, the surveyor observed and inspected twenty-six (26) portable fire extinguishers in various locations that were annually inspected January 2024 with the following in C-Unit building #3, On 03/25/2024: 1) At approximately 9:30 AM, the surveyor	K 355	Director will monitor and audit the maintenance of the fire extinguishers in the facility on a quarterly basis. 2. The audit will be completed on a monthly basis for six months and then on a quarterly basis after that. All audit findings will be presented during the monthly QAPI committee meeting for review.	

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	315390	A. BUILDING **01, 02, 03** B. WING _____	**03/27/2024**

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K 355	Continued From page 27 observed in the C-Unit, basement level, one (1) ABC-Type fire extinguisher with a (white) six-year (6) Maintenance collar attached to the extinguisher dated 2013. 2) At approximately 10:03 AM, the surveyor observed in the C-Unit, 3rd. floor (the old owner's apartment), one (1) ABC-Type fire extinguisher with a (white) six-year (6) Maintenance collar attached to the extinguisher dated 2013. 3) At approximately 10:54 AM, the surveyor observed in the C-Unit 1st. floor conference room, one ABC-Type fire extinguisher with the pressure indicating needle in the "RED" discharge zone on the pressure gauge. At this time the surveyor made a request to the [redacted] to exchange the fire extinguisher with a spare fire extinguisher. The [redacted] complied with the request and replaced the fire extinguisher with a spare fire extinguisher. The [redacted] confirmed the findings at the times of observations. The [redacted] was informed of the Life Safety Code deficiency during the survey exit on 03/27/2024 at approximately 12:01 PM. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.	K 521		3/29/24

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K 521	Continued From page 28 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations on 03/25/2024, 03/26/2024 and 03/27/2024 in the presence of facility management, it was determined that the facility failed to provide resident bathrooms with ventilation either by a mechanical exhaust system or a window with an operable area for 4 of 13 Resident bathrooms, as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: On 03/25/2024 (day one of survey) during the survey entrance at approximately 8:48 AM, a request was made to the US FOIA (b)(6) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. The surveyor also asked the US FOIA "How many resident sleeping rooms are in the facility." The US FOIA did not know how many sleeping rooms there were. A review of the facility provided lay-out identified the facility had three (3) buildings: the C-Unit building #3, Annex building #2 and Main Nursing building #1 that are connected together. There were 45 Resident sleeping rooms in the facility. Starting at approximately 9:27 AM on 03/25/2024 and continued on 03/26/2024, 03/27/2024 in	K 521	Response K521 " Corrective action for the residents affected by the deficient practice On March 29, 2024, the Maintenance Director replaced the ventilation fan in the therapy gym was replaced and is fully functional. The windows in room C&, B 212 and B 215 were repaired and now are able to opened the required 4 for proper ventilation. " Corrective action taken for those residents having the potential to be affected by the deficient practice o Any resident in the facility has the potential to be affected by this deficient practice. " Measures/Systemic changes put in place to assure the deficient practice does not re occur: 1. The Administrator educated the US FOIA (b)(6) that all bathrooms must have proper ventilation. Either a fully functional ventilation fan or the ability to open the window 4 inches. . " How will corrective actions be monitored to ensure the deficient practice will not re occur: 1. The Administrator and/or the Maintenance Director will audit the bathroom ventilation throughout the facility	

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K 521	Continued From page 29 presence of the facility's [US FOIA] a tour of the building was conducted. During the three (3) day building tour the surveyor inspected thirteen (13) Resident bathrooms. This inspection identified the following: 1. On 03/25/2024 at approximately 10:39 AM, the surveyor observed inside Resident room #[NJ Ex O] bathroom observed no exhaust system. The surveyor observed that the bathroom window could not open. The window was screwed closed. 1. On 03/26/2024 at approximately 11:17 AM, the surveyor observed inside Resident room [NJ Ex Orde] bathroom had no exhaust system. The surveyor observed that the bathroom window could not open. The window was screwed closed. 2. On 03/26/2024 at approximately 11:17 AM, the surveyor observed inside Resident room #[NJ Ex O] bathroom had no exhaust system. The surveyor asked the [US FOIA] if he could open the window. The [US FOIA] attempted to open the window, the window would not open. 3. On 03/27/2024 at approximately 10:36 AM, the surveyor observed inside the Therapy Gym Resident bathroom, there was no exhaust system and no window. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. The [US FOIA] confirmed the findings at the times of the observations. The [US FOIA (b)(6)] was informed of the Life Safety Code deficiency during the survey exit on	K 521	for proper ventilation on a monthly basis. 2. The audit will be completed weekly for 3 weeks and then monthly. All audit findings will be presented during the monthly QAPI committee meeting for review.	

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K 521	Continued From page 30 03/27/2024 at approximately 12:01 PM. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		
K 521 SS=D	HVAC CFR(s): NFPA 101 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 observations and interview on 03/25/2024, 03/26/2024 and 03/27/2024 in the presence of facility management, it was determined that the facility failed to provide resident bathrooms with ventilation either by a mechanical exhaust system or a window with an operable area for 4 of 13 Resident bathrooms, as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: On 03/25/2024 (day one of survey) during the survey entrance at approximately 8:48 AM, a request was made to the US FOIA (b)(6) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. The surveyor also	K 521	Response K521 " Corrective action for the residents affected by the deficient practice On March 29, 2024, the Maintenance Director removed the screws form the window in room C7,so that the window can now be opened 4" allowing for proper ventilation. " Corrective action taken for those residents having the potential to be affected by the deficient practice o Any resident in the facility has the potential to be affected by this deficient practice. " Measures/Systemic changes put in place to assure the deficient practice does not re occur: 1. The Administrator educated the	3/29/24

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K 521	Continued From page 31 asked the US FOIA "How many Resident sleeping rooms are in the facility." The US FOIA did not know how many sleeping rooms there were. A review of the facility provided lay-out identified the facility as having three (3) buildings: the C-Unit building #3, Annex building #2 and Main Nursing building #1 that are connected together. There were 45 resident sleeping rooms in the facility. Starting at approximately 9:27 AM on 03/25/2024 and continued on 03/26/2024, 03/27/2024 in presence of the facility's [redacted] a tour of the building was conducted. During the three (3) day building tour the surveyor inspected thirteen (13) Resident bathrooms. This inspection identified the following: 1. On 03/25/2024 at approximately 10:39 AM, the surveyor observed inside Resident room #C-7 bathroom observed no exhaust system. The surveyor observed that the bathroom window could not open. The window was screwed closed. At this time the US FOIA told the surveyor that the facility screwed the window closed due to the resident throwing things out of the window. The US FOIA confirmed the findings at the times of the observations. The US FOIA (b)(6) was informed of the Life Safety Code deficiency during the survey exit on 03/27/2024 at approximately 12:01 PM. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521	US FOIA (b)(6) that all bathrooms must have proper ventilation. Either a fully functional ventilation fan or the ability to open the window 4 inches. . " How will corrective actions be monitored to ensure the deficient practice will not re occur: 1. The Administrator and/or the Maintenance Director will audit the bathroom ventilation throughout the facility for proper ventilation on a monthly basis. 2. The audit will be completed weekly for 3 weeks and then monthly. All audit findings will be presented during the monthly QAPI committee meeting for review.	

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K 761	Continued From page 32	K 761		
K 761 SS=E	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 testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observations and review of facility documentation on 03/25/2024, 03/26/2024 and 03/27/2024, in the presence of facility management it was determined that the facility failed to ensure that 1 of 9 exit access stairwell doors tested were capable of maintaining the 1 hour fire rated construction. This is evidenced by the following, Reference: National Fire Protection Association (NFPA) 80 Standard for Fire Doors and Fire Windows. - 80- 2-4.4.3, All single doors and active leaves of pairs of doors shall be provided with an active latch bolt that cannot be held in a retracted position as specified in table 2-4.4.3. On 03/25/2024 (day one of survey) during the	K 761	Response 761 " Corrective action for the residents affected by the deficient practice On March 29, 2024, the maintenance director repaired malfunctioning latch on the identified access door with a properly functioning latch that assures the required 1 hour fire rating. The Maintenance Director also assured that the remaining 8 doors were properly functioning. " Corrective action taken for those residents having the potential to be affected by the deficient practice o Any resident in the facility has the potential to be affected by this deficient practice.	3/29/24

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K 761	Continued From page 33 survey entrance at approximately 8:48 AM, a request was made to the US FOIA (b)(6) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility had three (3) buildings: the C-Unit, Annex and Main Nursing that are connected together. There are four (4) exit stairwells in the facility that Resident, Staff and Visitors would use in the event of an emergency to exit the building. Starting at approximately 9:27 AM on 03/25/2024 and continued on 03/26/2024, 03/27/2024 in presence of the facility's US FOIA a tour of the building was conducted. Along the three (3) day tour of the facility the surveyor observed and performed closure tests of nine (9) exit access (doors leading into stairwells) doors with the following: On 03/26/2024 at approximately 10:56 AM, the surveyor observed that when the US FOIA entered the code to de-energize the magnetic hold close device on the door, the surveyor observed the door could be pushed open. Upon further inspection the surveyor observed the push bar device had no means to positive latch the door into its frame to maintain the one hour fire rated construction of the exit stairwell. This test was repeated two additional times with the same results. The facility US FOIA confirmed the finding at the time of the observation. The US FOIA (b)(6) was informed of the Life Safety Code deficiency during the survey exit on 03/27/2024 at approximately 12:01 PM.	K 761	" Measures/Systemic changes put in place to assure the deficient practice does not re occur: 1. The Administrator educated the US FOIA (b)(6) that all Fire-Rated Doors should have properly functioning latching system to assure appropriate fire resistant levels. 2. The Administrator educated the Maintenance Director that all doors should be tested on a monthly basis. " How will corrective actions be monitored to ensure the deficient practice will not re occur: 1. The Administrator/ Maintenance Director will conduct an audit to ensure all Fire-Rated Doors shall have properly functioning latching / release systems. 2. The monitoring will be done weekly x 4 weeks, then monthly x 3 months. All audit findings will be presented during the monthly QAPI committee meeting for review.	

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K 761	Continued From page 34 Fire Safety Hazard. Life Safety Code 101, 2012 Edition NJAC 8:39- 31.2(e)	K 761		
K 911 SS=D	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 on 03/25/2024, 03/26/2024 and 03/27/2024, in the presence of facility management, it was determined that the facility failed to ensure that 2 of 9 electrical outlets located next to a water source (within 6 feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection as required. This deficient practice was evidenced by the following: Reference: National Fire Protection Association (NFPA) 101, 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70, 210.8 Ground-Fault Circuit-Interrupter Protection for Personal, Ground-fault circuit-interruption for personal shall be provided as required in 210.8	K 911	" Corrective action for the residents affected by the deficient practice On April 1, 2024, In building #1 the maintenance director removed one the outlet in question in the staff dining area as it is not used any longer. this outlet has been appropriately capped. replaced on quad outlet in room 206 with and appropriate GFCI outlet and tested to assure that it de-energized as required by code for electrical outlets outlets as required for outlets that are located next to a water source (within 6 feet).. The Maintenance Director also assured that all of the remaining GFCI outlets in the facility are in compliance and properly functioning. " Corrective action taken for those residents having the potential to be affected by the deficient practice	4/1/24

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K 911	Continued From page 35 (A) through (C). The ground-fault circuit-interrupter shall be installed in readily accessible location. (B) Other than Dwelling Units. All 125-volt, single phase, 15- and 20- ampere receptacles installed in locations specified in 210.8 (B) (1) through (8) shall have ground-fault circuit-interrupter protection for personal. (5) Sinks-- where receptacles are installed within 1.8 M (6 feet) of the outside of a sink. On 03/25/2024 (day one of survey) during the survey entrance at approximately 8:48 AM, a request was made to the US FOIA (b)(6) [redacted] to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility had three (3) buildings: the C-Unit building #3, Annex building #2 and Main Nursing building #1 that are connected together. Starting at approximately 9:27 AM on 03/25/2024 and continued on 03/26/2024, 03/27/2024 in presence of the facility's US FOIA [redacted] a tour of the building was conducted. During the three (3) day tour of the facility, the surveyor observed and tested nine (9) electrical outlets in wet (within 6 feet of a sink) locations with two (2) electrical outlets in the Main Nursing Building #1 that failed to de-energize when tested in the following locations. On 03/26/2024: 1. At approximately 10:36 AM, the surveyor observed, measured and recorded in the Facility Staff Dining area, one (1) Quad electrical outlet located 4' to the left of the sink when tested with a GFCI tester to de-energize, the Quad electrical	K 911	o Any resident in the facility has the potential to be affected by this deficient practice. " Measures/Systemic changes put in place to assure the deficient practice does not re occur: 1. The Administrator educated the US FOIA (b)(6) [redacted] that all outlets less than 6 feet from a water source must be GFCI and tested monthly to assure proper functioning. " How will corrective actions be monitored to ensure the deficient practice will not re occur: 1. The Administrator/ Maintenance Director will conduct an audit to ensure all outlets that are less than 6 feet from a water source are GFCI 2. The Maintenance Director will conduct monthly testing with a GFCI testing to make sure that all of the GFCI outlets de energize as appropriate. 3. The monitoring will be done weekly x 4 weeks, then monthly x 3 months. All audit findings will be presented during the monthly QAPI committee meeting for review	

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K 911	Continued From page 36 outlet did not de-energize as required by code. 2. At approximately 10:58 AM, the surveyor observed, measured and recorded in Resident room #206, one (1) Duplex electrical outlet located 3'- 5" to the right of the sink when tested with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. The US FOIA confirmed the findings at the times of the observations. The US FOIA (b)(6) was informed of the Life Safety Code deficiency during the survey exit on 03/27/2024 at approximately 12:01 PM. Safety Hazard. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		
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 on 03/25/2024, 03/26/2024 and 03/27/2024, in the presence of facility management, it was determined that the facility failed to ensure that 5 of 9 electrical outlets located next to a water source (with-in 6 feet)	K 911	Response K911 " Corrective action for the residents affected by the deficient practice On April 1, 2024, the maintenance director replaced 5 electrical outlets (In C unit	4/1/24

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CRANFORD PARK CARE	**600 LINCOLN PARK EAST** **CRANFORD, NJ 07016**

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K 911	Continued From page 37 were equipped with Ground-Fault Circuit Interrupter (GFCI) protection as required. This deficient practice was evidenced by the following: Reference: National Fire Protection Association (NFPA) 101, 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70, 210.8 Ground-Fault Circuit-Interrupter Protection for Personal, Ground-fault circuit-interruption for personal shall be provided as required in 210.8 (A) through (C). The ground-fault circuit-interrupter shall be installed in readily accessible location. (B) Other than Dwelling Units. All 125-volt, single phase, 15- and 20- ampere receptacles installed in locations specified in 210.8 (B) (1) through (8) shall have ground-fault circuit-interrupter protection for personal. (5) Sinks-- where receptacles are installed within 1.8 M (6 feet) of the outside of a sink. On 03/25/2024 (day one of survey) during the survey entrance at approximately 8:48 AM, a request was made to the US FOIA (b)(6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility was comprised of three (3) buildings:	K 911	building 3rd floor kitchen area, nursing office, resident room C4, resident room C13, Director of nursing office) with properly functioning Ground Fault Circuit Interruption protection outlets as required for outlets that are located next to a water source (within 6 feet).. The Maintenance Director also assured that all of the remaining GFCI outlets in the facility are in compliance and properly functioning. " Corrective action taken for those residents having the potential to be affected by the deficient practice o Any resident in the facility has the potential to be affected by this deficient practice. " Measures/Systemic changes put in place to assure the deficient practice does not re occur: 1. The Administrator educated the US FOIA (b)(6) that all outlets less than 6 feet from a water source must be GFCI and tested monthly to assure proper functioning. " How will corrective actions be monitored to ensure the deficient practice will not re occur: 1. The Administrator/ Maintenance Director will conduct an audit to ensure all outlets that are less than 6 feet from a water source are GFCI. 2. The Maintenance Director will conduct monthly testing with a GFCI testing to make sure that all of the GFCI outlets de energize as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315390	A. BUILDING **01, 02, 03** B. WING _____	**03/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANFORD PARK CARE	**600 LINCOLN PARK EAST** **CRANFORD, NJ 07016**

(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 911	Continued From page 38 the C-Unit building #3, Annex building #2 and Main Nursing building #1 that are connected together. Starting at approximately 9:27 AM on 03/25/2024 and continued on 03/26/2024, 03/27/2024 in presence of the facility's [redacted] a tour of the building was conducted. During the three (3) day tour of the facility, the surveyor observed and tested nine (9) electrical outlets in wet (with-in 6 feet of a sink) locations with five (5) electrical outlets that failed to de-energize when tested in the following location, On 03/25/2024: 1. At approximately 10:11 AM, the surveyor observed, measured and recorded in the "C-Unit building #3" 3rd. floor kitchen area, one (1) Duplex electrical outlet located 12" to the right of the sink when tested with a Ground Fault Circuit Interrupter (GFCI) tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. 2. At approximately 10:17 AM, the surveyor observed, measured and recorded in the "C-Unit building #3" Nursing office, one (1) Quad electrical outlet located 4'- 8" to the right of the sink when tested with a GFCI tester to de-energize, the Quad electrical outlet did not de-energize as required by code. 3. At approximately 10:28 AM, the surveyor observed, measured and recorded in the "C Unit building #3" Resident room C-4, one (1) Quad electrical outlet located 3'- 9" to the right of the sink when tested with a GFCI tester to de-energize, the Quad electrical outlet did not de-energize as required by code.	K 911	3. The monitoring will be done weekly x 4 weeks, then monthly x 3 months. All audit findings will be presented during the monthly QAPI committee meeting for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315390	A. BUILDING **01, 02, 03** B. WING _____	**03/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANFORD PARK CARE	**600 LINCOLN PARK EAST** **CRANFORD, NJ 07016**

(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 911	Continued From page 39 4. At approximately 11:01 AM, the surveyor observed, measured and recorded in the "C-Unit building #3" Resident room C-13, one (1) Ground Fault Circuit Interrupter electrical outlet located 2 feet to the right of the sink when tested with a Ground Fault Circuit Interrupter (GFCI) tester to de-energize, the GFCI electrical outlet did not de-energize as required by code. 5. At approximately 11:11 AM, the surveyor observed, measured and recorded in the "C-Unit building #3" Director of Nursing office, one (1) Quad electrical outlet located 21" to the right of the sink when tested with a GFCI tester to de-energize, the Quad electrical outlet did not de-energize as required by code. The US FOIA confirmed the findings at the times of the observations. The US FOIA (b)(6) was informed of the Life Safety Code deficiency during the survey exit on 03/27/2024 at approximately 12:01 PM. Safety Hazard. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315390	A. Building 02 - ANNEX B. Wing	5/10/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANFORD PARK CARE	600 LINCOLN PARK EAST CRANFORD, NJ 07016

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 Reg. # NFPA 101 LSC K0161	Correction Completed 05/07/2024	ID Prefix Reg. # NFPA 101 LSC K0345	Correction Completed 03/29/2024	ID Prefix Reg. # NFPA 101 LSC K0355	Correction Completed 03/29/2024
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

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	
3/27/2024	☐ 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
315390 Y1	A. Building 03 - C UNIT B. Wing Y2	5/10/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANFORD PARK CARE	600 LINCOLN PARK EAST CRANFORD, NJ 07016

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0252	05/07/2024	LSC K0311	05/07/2024	LSC K0345	03/29/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	04/29/2024	LSC K0355	03/29/2024	LSC K0521	03/29/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0911	04/01/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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FOLLOWUP TO SURVEY COMPLETED ON	
3/27/2024	☐ 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
315390 Y1	A. Building 01 - MAIN NURSING BUILDING B. Wing Y2	5/10/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANFORD PARK CARE	600 LINCOLN PARK EAST CRANFORD, NJ 07016

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ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0324	04/01/2024	LSC K0345	03/29/2024	LSC K0355	03/29/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0521	03/29/2024	LSC K0761	03/29/2024	LSC K0911	04/01/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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