STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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 164192, 164811, 167683, 168689, 172468, 173271, 173785, 173962, 174358, 174754 STANDARD SURVEY: 7/22/24-7/29/24 CENSUS: 171 SAMPLE SIZE: 34+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 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 584		8/27/24

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

Electronically Signed | 08/22/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 584	Continued From page 1 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Complaint # NJ00167683 Based on observation and interview, it was determined that the facility failed to maintain the residents' environment and living areas in a sanitary and homelike manner. This deficient practice was identified for 1 of 5 nursing units observed for the facility environment task.	F 584	1. The dirty areas in the hallway of [redacted] wing were stripped and dirt was removed. The broken tile in the shower room was replaced and it was recaulked. The floor of the shower room was scrubbed. Dirty towel, mask, glove, clothing items, and open brief were removed. 2. All residents in [redacted] hallway could have been affected by this deficient	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 584	Continued From page 2 This deficient practice was evidenced by the following: On 7/22/24 at 10:30 AM, the surveyor observed dark "dirty appearing areas" in hallway on the [NJ Exec O] hallway and doorways. On 7/23/24 at 11:30 AM, the surveyor observed dark "dirty appearing areas" in hallway on the [NJ Exec O] hallway and doorways. On 7/24/24 at 9:49 AM, the surveyor observed dark "dirty appearing areas" in hallway on the [NJ Exec O] hallway and doorways. On 7/22/24 at 11:29 AM, the surveyor interviewed the [US FOIA (b)(6)] who stated the floors are done daily. He also stated the rotunda was done already and that he has not done [NJ Exec Order 26.4b1] yet. He further stated that he's usually the only porter and a floor tech works the weekends only. On 7/24/24 at 1:04 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that the procedure for cleaning the floors included both a wet mop machine and a mop /bucket. The mop machine was used during the night and a was used during the day. She also stated that both were done twice daily. The surveyor showed her a few doorways on the [U.S. FOIA] hallway and she stated "this is from wax". She further stated "We are in the process of stripping and re waxing the floors. This will come up with floor stripper. This is from years of wax on top of wax. It should've been stripped before waxing. The floors have been waxed once in past 3 years." When asked for a policy regarding the floors, she stated she has never seen one.	F 584	practice. 3. Administrator provided education to HSK and Maintenance Directors on the requirements of maintaining a clean Homelike Environment. Facility educator educated C NA□s on maintaining a safe, clean, comfortable, and homelike environment and to properly dispose of garbage and remove soiled clothing after showering a resident. HSK and Maintenance directors conducted facility wide audit on all hallways and shower rooms to ensure they were clean, with no broken tiles or garbage. HSK Director will conduct an audit of hallways and shower rooms weekly x4 for 3 months. 4. Administrator will monitor audit findings during monthly QAPI for 3 months to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 584	Continued From page 3	F 584		

On 7/25/24 at 10:34 AM, the surveyor observed the shower room on the [NJ Exec Order 26.4b1] with items on the floor including a used towel, used gloves, a clothing item and a used mask. There was also noted an NJ Exec Order 26.4b1 on a shower chair.

On 7/25/24 at 10:40 AM, the surveyor interviewed a [U.S. FOIA (b] who was shown the shower room. She stated, "this is not what is supposed to be". She stated that when someone gives a shower, the [U.S. FOIA (b] should clean up after done with shower.

On 7/25/24 at 10:43 AM, the surveyor interviewed an [U.S. FOIA] who was shown the shower room and stated "that's terrible, it's unacceptable." She further stated that when finished with a shower, the [U.S. FOIA (b] should clean up afterward." She stated she was not sure how often the shower room is checked. She further stated that housekeeping cleans the shower room, but she was not sure how often.

On 7/25/24 at 11:00 AM, the surveyor interviewed the U.S. FOIA (b)(6), regarding the dark areas on the floor and the tiles. She stated that it is probably from old. She further stated, "this is clean as its going to get." When asked if she would want to take a shower on that shower stall, she stated "no". She also stated that she tries to check the shower room twice a day. She further stated that maybe it needs new tiles and caulking. A loose tile was noted.

On 7/25/24 at 12:04 PM, the surveyor interviewed the U.S. FOIA (b)(6), regarding the [NJ Exec Order 26.4b1] shower room. He stated he does rounds monthly and walks through weekly to see what he could see. He further stated that he was in that room earlier this week to fix a broken tile near scale. He

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 584	Continued From page 4 also stated he did not see tile in photo. He stated the brown stuff is housekeeping, and that it is not acceptable, and should've been scrubbed. On 7/25/24 at 1:33 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated they are working on the floors and doorways on the weekends. On 7/26/24 at 9:51 AM, the surveyor observed doorways on NJ Exec Order 26.4b1 show "faded" areas where dark "dirty areas" were noted previously. The shower room on the NJ Exec Order 26.4b1 noted with new caulking and broken tile replaced. Dark brown areas still noted in the shower stall. On 7/26/24 at 10:16 AM, the surveyor interviewed the U.S. FOIA (b)(6) regarding NJ Exec Order 26.4b1 shower room. Shown a photo and asked if the work was completed in the shower room. He stated he would check on it. On 7/26/24 at 11:31 AM, the surveyor interviewed the NJ Exec Order 26.4b1 who stated she reminded the staff to keep the shower rooms clean and tidy and housekeeping to clean. The U.S. FOIA (b)(6) stated, "we are finishing up that shower room."	F 584		
F 641 SS=D	N.J.A.C. 8:39-31.4 (a) (f) 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: NJ 00167683 NJ 00172468	F 641	1. The MDS assessment for resident #94 was modified to reflect that the	9/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 641	Continued From page 5 Repeat Deficiency Based on observation, interview, and record review it was determined that the facility failed to ensure the accurate assessment of residents using the Minimum Data Set (MDS) assessment tool. The deficient practice was identified for 3 of 34 residents (#94, 37, 586) reviewed for MDS accuracy and is evidenced by the following. 1. The surveyor observed Resident #94 on 7/23/24 at 11:58 AM, lying in bed with eyes closed. A review of the hybrid medical record revealed the resident was admitted with diagnoses including but not limited to NJ Exec Order 26.4b1 [redacted] NJ Exec Order 26.4 Care Consultant reports from NJ Exec Order 2 documented NJ Exec Order 26.4b1 [redacted] NJ Exec Order 26.4b1 Conditions of the NJ Exec Order 26.4 annual MDS indicated the resident had NJ Exec Order 26.4b1 [redacted]. Section NJ Exec Order 26 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 [redacted]) was unchecked to indicate NJ Exec Order 2 was not present during the assessment reference date of NJ Exec Order 26.4. On 7/24/24 at 11:00 AM, the surveyor interviewed the U.S. FOIA (b)(6) . She stated the NJ Exec Order 26.4b1 quarterly NJ Exec Order 26.4b1 should have reflected that the resident had NJ Exec Order 26 She stated a correction MDS would be done immediately. The corrected MDS was provided	F 641	resident had NJ Exec Order 26 [redacted] The MDS assessment for resident #37 was modified to include a NJ Exec Order 26 [redacted]. The MDS assessment for resident #586 was modified to NJ Exec Order 26.4b1. 2. All residents have the potential to be affected by this deficient practice The Director of MDS audited the most recent comprehensive assessment of all active residents with the diagnosis of cancer, skin impairments such as MASD and pressure injuries, and those with falls to ensure accuracy. As of 8/22/2024, all active residents with the diagnosis of cancer, skin impairments such as MASD and pressure injuries, those with falls are coded in the MDS assessment. 3. The MDS Director and Coordinator were educated on the facility policy Comprehensive Assessment. The Regional Director of MDS or Designee will audit the accuracy of the assessments for falls, cancer diagnoses and skin impairments such as MASD and pressure injuries, of 5 new admissions and 5 long term care residents weekly x 4, then monthly x 3 to ensure compliance. 4. The LNHA or Designee will report the results of the audits in the monthly QAPI meetings x 4 months to ensure compliance and if further action is necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	205 BIRCHWOOD AVE 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
F 641	Continued From page 6 to the surveyor. On 7/24/24 at 2:10 PM, the surveyor discussed the MDS inaccuracy with the U.S. FOIA (b)(6) [redacted]. 2. The surveyor observed resident #37 on 7/23/24 at 11:45 AM, sitting in a chair in room next to the bed with call bell within reach. A review of the hybrid medical record revealed the resident was admitted with NJ Exec Order 26.4b1 [redacted] The care plans included 'NJ Exec Order 26.4b1 [redacted], and 'NJ Exec Order 26.4b1 related to history of NJ Exec Order 26.4b1 [redacted] A consult dated NJ Exec Order 26.4b indicated there were no plans for NJ Exec Order 26, resident NJ Exec Order 26.4b appropriate, but not ready yet. A consult dated NJ Exec Order 26 indicated NJ Exec Order 26.4b1 [redacted] Section I - Active Diagnoses of the NJ Exec Order 26.4 annual MDS indicated the resident did not have NJ Exec Order 26.4b Section NJ Exec Orde - NJ Exec Order 26.4b1 [redacted] was not an active diagnosis during the assessment reference date of NJ Exec Order 26.4b On 7/24/24 at 2:10 PM, the surveyor discussed the MDS inaccuracy with the U.S. FOIA (b)(6) [redacted].	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 641	Continued From page 7 On 07/25/24 at 9:16 AM, the surveyor interviewed the U.S. FOIA (b)(6) . She stated the NJ Exec Order 26 diagnosis should have been coded, indicating the resident had NJ Exec Order 26. She stated she would modify the MDS. 3. A review of the electronic medical record revealed Resident #586 was admitted with diagnoses including but not limited to NJ Exec Order 26.4b1 [redacted]). Progress notes indicated that on NJ Exec Order 26.4 it was noted that the resident was U.S. FOIA (b)(6) . An NJ Exec Orde was completed, and a NJ Exec Order 26.4b1 was noted. A review of facility reported investigation dated NJ Exec Order 26.4 indicated the conclusion was that NJ Exec Order 26.4 was the result of an NJ Exec Order 26.4b1 by the resident. Section J - Health conditions of the NJ Exec Order 26.4 discharge MDS indicated the resident had U.S. FOIA (b)(6) since the prior MDS assessment. Section J1800 was coded 0, indicating U.S. FOIA (b)(6) since the prior assessment. On 7/24/24 at 2:10 PM, the surveyor discussed the MDS inaccuracy with the U.S. FOIA (b)(6) [redacted] On 7/25/24 at 9:20 AM, the surveyor interviewed the U.S. FOIA (b)(6) regarding the conclusion of the investigation that an U.S. FOIA (b)(6) caused the NJ Exec Order 26.4b1 of the MDS. She stated that she will check with her regional about the NJ Exec O and get back to me on their decision. On 7/26/24 at 11:13 AM, the U.S. FOIA (b)(6)	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 641	Continued From page 8 stated that she was modifying the discharge MDS to include the [redacted] N.J.A.C 8:39-11.1	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		9/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 656	Continued From page 9 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to develop a comprehensive care plan to address the U.S. FOIA (b)(6) medication prescribed for 1 of 3 residents (Resident # 115) reviewed for U.S. FOIA (b)(6) t medications and evidence by the following: On 7/22/24 at 12:54 PM, the surveyor observed Resident #115 in room and the resident stated takes an NJ Exec Order 26.4b1 medication. The surveyor reviewed the Electronic Medical Records for Resident # 115 that revealed the following: According to the Admission Record indicated that Resident # 115 was admitted with NJ Exec Order 26.4b1 [redacted] According to the U.S. FOIA (b)(6) Order Summary Sheet, the resident had the following physician's order for by mouth administration of medications:	F 656	1. A care plan addressing the NJ Exec Order 26.4b1 medication was initiated for resident #115. 2. All residents on an anticoagulant medication have the potential to be affected. The DON audited all active residents on an anticoagulant medication to ensure a care plan was developed to address the anticoagulant medication. As of 8/22/2024 all active residents prescribed an anticoagulant has care plan addressing the anticoagulant. 3. Nursing Management staff were educated on the facility Care Plans-Comprehensive Policy. 4. The DON or Designee will conduct an audit of all residents prescribed an anticoagulant weekly x 4, then monthly x 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 656	Continued From page 10 [redacted] mg [redacted] tablet by [redacted] every [redacted] The surveyor reviewed the resident's care plans and observed that there was no care plan to address the care needs for Resident #115 with an NJ Exec Order 26.4b1. On 7/25/24 at 11:03 AM, the surveyor interviewed the NJ Exec Order 26.4b1 who stated that the NJ Exec Order 26.4b1 completes the care plans and that there should be a care plan in place for this resident who receives NJ Exec Order 26.4b1 medication. The [redacted] stated that she was not sure why there was no care plan created. On 7/25/24 at 1:16 PM, the surveyor discussed the above concern with the NJ Exec Order 26.4b1 [redacted]. No additional information was provided. NJAC 8:39-11.2 (e)	F 656	to ensure the perspective care plan is in place. The DON or designee will report the results of the audits in the monthly QAPI meeting x 4 months to ensure compliance and if further action is necessary.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		9/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	205 BIRCHWOOD AVE 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
F 686	Continued From page 11 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Complaint # 173271 Based on interview, record review and review of pertinent facility documentation it was determined that the facility failed to a.) thoroughly assess a NJ Exec Order 26.4b1 that was identified on an admission assessment and, b.) implement a care plan for a resident identified as a NJ Exec Order 26.4b1 . This deficient practice was identified for 1 of 4 residents (Resident #585) reviewed for and was evidenced by the following: . According to the Admission Record, Resident #585 was admitted to the facility with the diagnoses which included but was not limited to; NJ Exec Order 26.4b1 The admission Minimum Data Set (MDS), an assessment tool that facilitates a resident's care dated NJ Exec Order 26.4b reflected that the resident was frequently U.S. FOIA (b)(6) and required NJ Exec Order 26.4b1 with activities of daily living (ADLs). The MDS also reflected that the resident was at risk for U.S. FOIA (b)(6) and had NJ Exec Order 26.4b1 treatments. Review of the U.S. FOIA (b)(6) Notes dated NJ Exec Order 26.4b1 at 23:29 (11:29 PM) indicated that the resident was admitted from the hospital to the facility and was NJ Exec Order 26.4b1	F 686	1. Resident #585 discharged from the facility on NJ Exec Order 26.4b1 2. All resident□s have the potential to be affected by this deficient practice. The DON audited all active residents to ensure residents with skin impairments such as pressure injuries are adequately assessed and described and residents high risk for skin breakdown have an associated care plan. As of 8/22/2024, all active residents with skin impairments are adequately assessed and residents high risk for skin breakdown has an associated care plan. The DON audited all new admission in the past 72hrs to ensure skin assessments were performed and adequately described upon admission and the following day and care plans were initiated on those high risk for skin breakdown. As of 8/22/2024, the new admission in the past 72 hours with skin impairments are adequately described with an associated skin impairment. No further deficient practice noted. 3. All nurses were educated on the facility policy Pressure Injury Prevention and Management and Baseline Care Plans.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	205 BIRCHWOOD AVE 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
F 686	Continued From page 12 Review of the Admission Assessment (AA) dated U.S. FOIA (b)(6)) indicated that the resident had NJ Exec Order 26.4b1 . There was NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1 documented in the medical record. The AA also reflected that the resident was always NJ Exec Order 26.4b1 . The NJ Exec Order 26 scale NJ Exec Order 26.4b1 was completed on the AA dated which revealed the following: The resident scored a U.S. FO on the NJ Exec and if the total score was NJ Exec or lower, the resident should be considered at high risk for NJ Exec Order 26.4b1 . The AA indicated that prevention protocol should be initiated immediately and documented on the care plan. The AA indicated that the following intervention would be implement on the CP: NJ Exec O and NJ Exec Order 26.4b1 apply NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 care, NJ Exec Order 26.4b1 , change bedding as needed, and to monitor NJ Exec Order 26.4b1 status. Review of Resident #585 care plan (CP) revealed that a CP was not implemented for potential for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 interventions were put in place to prevent NJ Exec Order 26.4b1 of the resident's NJ Exec Or Review of the Treatment Administration Record (TAR) dated NJ Exec Order 26.4b1 , the surveyor could not find any documentation any NJ Exec Order 26.4b1 treatments were ordered by the physician. The TAR dated NJ Exec Order 26.4b at 7:00 AM, reflected a physician's order for NJ Exec Order 26.4b1 to be completed under the assessment area in the electronic medical record (EMR). The nurse signed the TAR indicating that the residents	F 686	4. The DON or Designee will conduct an audit on all new admissions to ensure a thorough skin assessment was performed with an appropriate care plan initiated weekly x 4, then monthly x 3. The DON or designee will report the results of the audit in the monthly QAPI meeting x 4 months to ensure compliance and if further action is necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	205 BIRCHWOOD AVE 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
F 686	Continued From page 13 NJ Exec Order 26.4b1 was completed, however there was no documentation on the assessment section of the EMR. On 7/23/24 at 11:20 AM, the surveyor interviewed the facilities U.S. FOIA (b)(6) care nurse who identified herself as a U.S. FOIA (b)(6) The U.S. FOIA (b) explained that her responsibilities included all U.S. FOIA (b)(6) care in the facility and that she performed all treatments in the facility from Monday through Friday. The U.S. FOIA (b)(6) Care nurse stated that when the nurse completed and admission assessment and identified that the resident was at risk for NJ Exec Order 26.4b1, the nurse would be responsible to initiate the care plan with interventions to prevent NJ Exec Order 26.4b1 of the NJ Exec Orde She continued to explain that any NJ Exec O were to be described on the assessment such as NJ Exec Orde and NJ Exec Orde On 7/23/24 at 11:41 AM, the surveyor interviewed the U.S. FOIA (b)(6)), reviewed Resident #585's AA dated 3/22/24 with the surveyor and confirmed that the AA indicated that the resident had NJ Exec Order 26.4b1 The U.S. FOIA (b) stated that the nurse should have been more descriptive on the admission assessment to include the NJ Exec Orde and NJ Exec O of the NJ Exec Order 26.4b1. The U.S. FOIA (b) also confirmed that when the resident was identified as a high risk for NJ Exec Order 26.4b1 on admission, a CP should have been implemented with interventions to prevent U.S. FOIA She confirmed that a CP was not implemented at that time. On 7/24/24 at 11:06 AM, the surveyor interviewed a U.S. FOIA (b)(6) who stated that standard NJ Exec O care practice in the	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 686	Continued From page 14	F 686		

facility included NJ Exec Order 26.4b1 NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 to be applied as needed for protection (do not need a physician's order) and NJ Exec Order 26.4b1 every two hours, and frequent checks. She stated that if a resident was identified as a risk for NJ Exec Order 26.4b1 on admission to the facility a CP should be initiated to include all NJ Exec Order 26.4b1 prevention interventions. She explained that the interdisciplinary team also be notified that a resident was admitted to the facility and was at risk for U.S. FOIA (b)(6). She added that the care team would also be notified if a resident had any NJ Exec Order 26.4b1 so that they could determine a cause and identify the type of issue the resident had. She stated this would help to determine the appropriate interventions that would need to be initiated on the CP.

On 7/24/24 at 11:13 AM, the surveyor interviewed and Certified Nursing Assistant (CNA #1) who has been employed in the facility for . She stated that standard care in the facility wound include application of NJ Exec Order 26.4b1 . She stated that the would only be applied if the resident was at risk for U.S. FOIA (b)(6) . She stated that she did not think that a physician's order was required for this type of care. She stated that the was only applied for protection. She continued to explain that NJ Exec Order 26.4b1 resident required changing more frequently and that the staff were required to the residents every two hours. She stated that she was unsure if the NJ Exec Order 26.4b1 utilized in the facility were NJ Exec Order 26.4b1 .

On 7/24/24 at 11:20 AM, the surveyor interviewed CNA #2 who had been employed in the facility for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 686	Continued From page 15 NJ Exec Order 26. . She stated that if a resident was NJ Exec Order 26.4b1 they were NJ Exec Order 26.4b1, and U.S. FOIA (b)(6) could be applied as needed to protect the resident's NJ Exec O. She stated that if a resident had any NJ Exec Order 26.4b1 it would be reported to the nurse and the nurse would be responsible to order treatments, write a CP and consult the NJ Exec Order 26 care team. On 7/24/24 at 11:24 AM, the surveyor interviewed a NJ Exec Order 26.4b1 who explained that if a resident was admitted with a NJ Exec Order 26.4b1, a detailed description should be documented. "A NJ Exec Order 26.4b1 could be anything". She stated that NJ Exec O assessments were done weekly on the electronic medical record under NJ Exec Or assessments". She stated that a CP with interventions to prevent NJ Exec Order 26.4b1 should be initiated if a resident was identified as a high risk for NJ Exec Order 26.4b1. She explained that all NJ Exec Order 26.4b1 in the facility were NJ Exec Order 26.4b1 and that NJ Exec Order 26.4b1 was applied by the CNAs as a preventative treatment when a resident was NJ Exec Order 26.4b1. On 7/24/24 at 2:08 PM, the NJ Exec Or stated that the NJ Exec Order 26.4b1 should have described the NJ Exec Order 2 in better detail such as NJ Exec Or and NJ Exec O when the nurse completed the admission assessment. She stated that a NJ Exec Order 26.4b1 check was usually conducted on day two and the nurse should have put in a physicians order for the NJ Exec Order 26.4b1 check. On 7/25/24 at 8:30 AM, the surveyor interviewed the U.S. FOIA (b) who explained that when a nurse completed the NJ Exec Order 26.4b1, the nurse needed to go into the assessment section of the	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 686	Continued From page 16 EMR to complete the documentation describing the resident's [NJ Exec Ord]. The [U.S. FOIA (b)] reviewed Resident 585's medical record in the presence of the surveyor and stated that this was not completed as per facility protocol on 03/26/24. On 7/25/24 at 8:30 AM, the surveyor interviewed the [U.S. FOIA (b)] who explained that when a nurse completed the weekly [NJ Exec Ord] checks, the nurse needed to go into the assessment section of the EMR to complete the documentation describing the resident's [NJ Exec O]. The [U.S. FOIA (b)] reviewed Resident 585's medical record in the presence of the surveyor and stated that this was not completed as per facility protocol on 3/26/24. On 7/25/24 at 10:09 AM, the surveyor interviewed the LPN #3 that performed the AA dated [NJ Exec Order 26.4]. LPN #3 stated that when she observed the [NJ Exec Order 26.4b1] on Resident #585's [U.S. FOIA (b)(6)] she should have documented the [NJ Exec Ord] and [NJ Exec O] of the U.S. FOIA (b)(6). She also stated that a CP should have been implemented for potential for [NJ Exec O] [NJ Exec Order 26.4b1] with interventions to prevent [NJ Exec O] [NJ Exec Order 26.4b1] especially since the resident was a high risk for [NJ Exec Order 26.4b1]. On 7/25/24 at 10:31 AM, the surveyor interviewed the U.S. FOIA (b)(6)) who stated that she had been employed in the facility for approximately [NJ Exec Order 26.4b1]. The [U.S. FO] stated that when she performed the [NJ Exec Order 26.4b1] for Resident #585 on [NJ Exec Order 26.4b1], she forgot to complete the [NJ Exec Order 26.4b1]. The [U.S. FOIA] stated that had recollection that the resident had a [U.S. FOIA] U.S. FOIA (b)(6). She stated that she must have overlooked that she was supposed to complete the [NJ Exec Order 26.4b1] in the EMR. She stated that it would have been	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 686	Continued From page 17 important to complete the NJ Exec Order 26.4b1 because it would give a more detailed "picture" of what the NJ Exec Order 26.4b1 looked like. She stated that the resident frequently NJ Exec Order 26.4 to be NJ Exec Order 2 and NJ Exec Order 26.4b1 and that the resident had NJ Exec O interventions. She stated that it would have been important to initiate a Care Plan for the resident to include all preventive NJ Exec O interventions. Review of the facility policy titled, "Pressure Injury Prevention and Management" with a revised date of 11/29/23 that the facility was committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and development of additional pressure ulcers/injuries. -The policy specified that licensed nurses would conduct a pressure risk injury assessment on all residents upon admission/readmission, weekly times four weeks, then quarterly. -Licensed Nurses would conduct a full body skin assessment on all residents upon admission/readmission, weekly and after any newly identified pressure injury and findings would be documented in the medical record. -After completing a thorough assessment, the interdisciplinary team shall develop a relevant care plan that included measurable goals for prevention and management of pressure injuries with appropriate interventions. Care plan interventions would be based on specific factors identified in the risk assessment, skin assessment and any pressure ulcer assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging and wound characteristics).	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 686	Continued From page 18 The facility policy titled, "Baseline Care Plan" with a revised date of 9/18/23 reflected that a baseline care plan would be developed within 48 hours of a resident admission. Interventions shall be initiated that address the resident's current needs including: pressure ulcer risk. NJAC 8:39-27.1 (e)	F 686		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to assess for complications upon residents' return from the U.S. FOIA (b)(6)) center for 2 of 5 residents (Resident #55 and Resident #146) reviewed for NJ Exec Order 26.4b care. The deficient practice was evidenced by the following: 1. On 7/22/24 at 11:07, AM the surveyor observed Resident #55 lying in bed with the television on, wearing glasses, call light within reach. The resident stated, "I go to NJ Exec Order 26.4b1 [redacted]) M-W-F, but I NJ Exec Order 26.4b1 because I don't NJ Exec Order 26.4b1 . I usually get my medication and meal before I leave for NJ Exec Order 26 . I have my NJ Exec Order 26 on	F 698	1. The medical records for resident #55 were reviewed for post NJ Exec Order 26.4b site assessments and the assessments were documented in the EMAR on NJ Exec Order 26.4b1 [redacted] The medical records for resident # 146 were reviewed for post NJ Exec Order 26 site assessment and the assessments were documented in the EMAR on NJ Exec Order 26.4b1 [redacted] 2. All residents receiving hemodialysis services have the potential to be affected	9/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	205 BIRCHWOOD AVE 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
F 698	Continued From page 19 NJ Exec Order 26.4 and the nurses checks on this at times." A review of the medical record revealed the following information: The Resident #55 had a diagnosis of but not limited to NJ Exec Order 26.4b1 [redacted] A review of the order summary in the electronic health record (EHR) revealed orders for NJ Exec Order 26.4b treatment 3 times a week on Mon, Wed, Fri at 10:00am. Pick-up at 9:45am, one time a day every Mon, Wed, Fri; Monitor NJ Exec Order 26 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 Notify provider if NJ Exec Order 26.4b1 [redacted] findings to medical doctor (MD). A review of the Quarterly Minimum Data Sheet (MDS), an assessment tool used to facilitate the management of care, dated U.S. FOIA (b)(6) reflected the Resident #55 had a brief interview for NJ Exec Order 26 status (BIMS) score of NJ Exec Order 26.4b1, indicating the resident had NJ Exec Order 26.4b1 . The RD Care Plan initiated on NJ Exec Order 26 instructed nursing staff to 'NJ Exec Order 26.4b1 [redacted] Refer to MD as needed." On 7/24/24 at 12:15 PM, the surveyor interviewed the NJ Exec Order 26.4b1, who has been working at the facility for NJ Exec Order 26.4b1, who stated,	F 698	by this deficient practice. The DON audited all active residents receiving hemodialysis services to ensure post dialysis assessment of their site were conducted. As of 8/22/2024, all residents receiving hemodialysis treatments have post dialysis site assessment documented. 3. The Dialysis Communication Form was amended to include the post dialysis site assessment. All nurses were educated on the facility Hemodialysis Policy and the amended Dialysis Communication Form. The DON or Designee will audit the Hemodialysis Communication Form for post dialysis site assessment from all active resident□s receiving dialysis services daily x 7, then weekly x 4, then monthly x 3. 4. The DON or designee will report the results of the audit in the monthly QAPI meeting x 4 months to ensure compliance and if further action is necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	205 BIRCHWOOD AVE 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
F 698	Continued From page 20 "Resident #55 was in the hospital a couple of times because resident [redacted] at least [redacted] and was sent out to hospital due to refusing [redacted] This is resident's typical self, and all the doctors are aware. The resident goes to [redacted] A review of the nurses' progress notes for [redacted] assessment when resident was agreeable to go to [redacted], revealed inconsistent nursing assessment done from [redacted]). The missing nursing documentations for [redacted] assessment were: [redacted] 2. On 7/22/24 at 10:20 AM, the surveyor observed Resident #146 lying in bed, appears neat and dressed, call light within reach. The resident stated, "I have an [redacted] on my [redacted] I'm supposed to go today." A review of the medical records for Resident #146 revealed diagnosis but not limited to: [redacted]. The order summary revealed: Continue to monitor [redacted] every shift for bleeding; [redacted] 3 times a week on Tu/Th/Sat; [redacted] for s/s of [redacted] every shift. NO [redacted], Monitoring Report any [redacted] findings to MD; Monitor [redacted] for signs & symptoms of [redacted] every shift every shift ordered [redacted] The Quarterly MDS dated [redacted] revealed a BIMS score of [redacted] indicating [redacted] Care plan dated [redacted] reflected to	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 698	Continued From page 21 monitor [redacted]. A review of the nursing progress notes revealed the resident received [redacted] on [redacted] and then changed to [redacted]. The surveyor reviewed nurses progress notes for [redacted] assessment which revealed inconsistent nursing assessment done from [redacted]. The nursing progress notes revealed missing documentation for post [redacted] assessment for the dates of: [redacted] On 7/24/24 at 2:15 PM, the surveyor interviewed the [redacted]), who has been working in the facility since last [redacted], in the presence of the [redacted] and the survey team regarding the [redacted] Communication Worksheet to clarify pre and post [redacted] evaluations. The worksheet did not include post [redacted] assessments. Requested the [redacted] to provide additional documentation for [redacted] assessments by nursing staff. On 7/25/24 at 8: 45 AM, the [redacted] provided documentation of [redacted] Worksheet for pre assessment of [redacted] access for residents but did not provide documentation for post [redacted] assessments. The [redacted] stated in the presence of another surveyor, "The documentation in this place is really bad. The post [redacted] assessment documentation should be in the nursing progress notes in the computer if the nurses did them."	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 698	Continued From page 22 On 7/25/24 at 11:03 AM, interviewed the RN who stated, "The process is you have to check the U.S. FOIA (b)(6) site every shift for NJ Exec Order 26.4b1 and we also check it before and after NJ Exec Order 26.4b and document in the computer. I don't see any U.S. FOIA (b)(6) NJ Exec Order 26.4b1 assessment documentation for the Resident #55 in the EHR for the last few weeks and Resident #146, I see one time documentation in progress notes for NJ Exec Order 26.4b only." The NJ Exec O acknowledged that there should be documentation every time the resident comes back after NJ Exec Order 26.4b On 7/25/24 at 1:30 PM, the surveyor discussed findings and concern with post NJ Exec Order 26 site nursing assessment, in the presence of the survey team, the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) . No additional documents were provided by the facility. A review of the facility policy and procedure titled "Hemodialysis" with a revision date of 3/2024 revealed, "The nurse will monitor and document the status of the resident's access site(s) upon return from the dialysis treatment to observe for bleeding or other complications."	F 698		
F 711 SS=D	NJAC 8:39-27.1(a); 2.9 Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this	F 711		9/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	205 BIRCHWOOD AVE 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
F 711	Continued From page 23 section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure that the physician signed and dated monthly medication orders. The deficient practice was identified for 5 of 34 residents reviewed (#2, 84, 115, 32 and 33) and occurred over a 3 month period. The deficient practice was evidenced by the following. 1. A review of the hybrid medical record for Resident # 2 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for U.S. FOIA (b)(6) [redacted]. 2. A review of the hybrid medical record for Resident # 84 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for NJ Exec Order 26.4b1 [redacted]. 3. A review of the hybrid medical record for Resident # 115 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for NJ Exec Order 26.4b1	F 711	1. The monthly medication orders for resident□s #2, #84, #115, #32, and #33 were reviewed and signed and dated by the physician. 2. All residents have the potential to be affected by this deficient practice. An audit was conducted by the DON on all active residents to ensure all monthly orders for 7/2024 were reviewed and signed by the physician. As of 8/15/2024, all of 7/2024 monthly orders were reviewed and signed by the physician. An audit was conducted by the DON on all active residents to ensure the monthly orders for 8/2024 requiring the review and signature of the physician were completed. As of 8/22/2024, all the 8/2024 monthly orders requiring review and signature of the physician were reviewed and signed by the physician. 3. All primary physicians were educated on the facility□s policy Physician Services and Medication Orders and how to electronically sign the monthly orders	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 711	Continued From page 24 NJ Exec Orde 4. A review of the hybrid medical record for Resident #32 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for NJ Exec Order 26.4b1. 5. A review of the hybrid medical record for Resident #33 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for NJ Exec Order 26.4b1 . On 7/26/24 at 10:51 AM, the US FOIA (b)(6) US FOIA (b)(6) stated to the surveyor that the physicians should sign their monthly orders electronically. On 7/26/24 at 12:49 PM, the surveyor discussed with the NJ Exec Order 26.4b1 and the U.S. FOIA (b)(6) concerns of physicians not signing their monthly orders. The NJ Exec Orde stated the physicians should be signing orders electronically.	F 711	under the Pending Orders Review. The DON or Designee will review the Pending Orders Review weekly and communicate with healthcare providers monthly orders requiring review and signatures. The DON or Designee will audit the monthly orders of 10 random charts to ensure monthly orders are reviewed and signed within the facility policy weekly x 4, then monthly x 3. 4. The DON or designee will report the results of the audit in the monthly QAPI meeting x 4 months to ensure compliance and if further action is necessary.	
F 755 SS=E	NJAC 8:39-23.2 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.	F 755		9/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 755	Continued From page 25 §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 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 by ensuring the accurate administration of a medication, [redacted], according to the physician's order to meet the needs of the resident. The deficient practice was identified for one (1) of 34 residents, (Resident #55) reviewed for medication management. The deficient practice was evidenced by the following: On 7/22/24 at 11:07 AM, the surveyor observed the Resident #55 in the [redacted] in their room, lying in bed with the television on, wearing	F 755	1. The physician reviewed the [redacted] order for resident #55 and determined the [redacted] is not necessary. The order was discontinued on [redacted]. 2. All resident□s receiving [redacted] has the potential to be affected by this deficient practice. The DON audited all active resident□s prescribed [redacted] to ensure nurses followed the physician orders. As of [redacted], no deficient practice was noted on all active residents prescribed [redacted]	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	205 BIRCHWOOD AVE 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
F 755	Continued From page 26 glasses, and call light within reach. On 7/24/24 at 9:34 AM, the surveyor reviewed the electronic health records (EHR) for Resident #55 which revealed diagnosis that included but not limited to NJ Exec Order 26.4b1 [redacted] A review of the Quarterly Minimum Data Sheet (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected the resident had a brief interview for mental status (BIMS) score of [redacted], indicating the resident had NJ Exec Order 26.4b1 [redacted]. A review of the resident's Order Summary Report reflected a physician's order dated [redacted] for NJ Exec Order 26.4b1 [redacted]) Give [redacted] tablet by mouth at [redacted] for [redacted] NJ Exec Order 26.4b1 The [redacted]) is the first number, it is the [redacted] caused by your NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. A review of the electronic medication administration (eMARS) from NJ Exec Order 26.4b1 [redacted]) revealed [redacted] was administered and not held for parameters of [redacted] as ordered for: [redacted], received 13 dosages [redacted], 3, 4, 5, 9, 12, 13, 14, 15, 16, 17, 18, 19}; [redacted] received 11 dosages [redacted], 13, 15, 16, 18, 20, 21, 22, 23, 25, 30); [redacted] received 15 dosages ([redacted], 5, 7, 8, 9, 10, 14, 17, 18, 19, 20, 21, 22, 26, 28); and on [redacted], received 17 dosages [redacted],, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 15, 16, 19, 21, 23, 24).	F 755	3. All nurses were educated on following physician orders related to hold parameters The DON or Designee will audit all residents on [redacted] daily x 14, then weekly x 4, then monthly x 3. 4. The DON or designee will report the results of the audit in the monthly QAPI meeting x 4 months to ensure compliance and if further action is necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 755	Continued From page 27	F 755		

A review of the resident's NJ Exec Order 26.4b1 at its highest revealed the resident's [redacted] on [redacted] was [redacted] and on [redacted]. The resident had no indication of a NJ Exec Order 26.4b1 from [redacted] administration when given above the parameter of [redacted] during those times.

Reviewed the primary physician's progress notes dated [redacted] who stated, Reviewed medications and vital signs with no changes."

On 7/25/24 at 11:13 AM, the surveyor interviewed the US FOIA (b)(6)) from NJ Exec Order 26.4b1 who has been working in the facility for [redacted]. She stated, "The evening nurse should have held the [redacted] medication at night because the NJ Exec Order 26.4b1. The nurse didn't pay attention because you can make the NJ Exec Order 26.4b1 go higher."

On 7/25/24 at 11:35 AM, interviewed the [redacted], who has been working in the facility for [redacted]. The [redacted] stated, "The [redacted] should had been held when the [redacted] was above [redacted] as ordered. I see that it was the evening shift nurse who has been giving it. The resident has had no problems with [redacted] or had complained to me that NJ Exec Order 26.4b1."

On 7/25/24 at 1:30 PM, in the presence of the survey team, the surveyor discussed findings with the NJ Exec Order 26.4b1 [redacted] regarding the concern of [redacted] administration outside the [redacted] parameters.

On 7/26/24 at 8:48 AM, interviewed the 3-11 shift

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 755	Continued From page 28	F 755		

NJ Exec Order 26.4b1 regarding NJ Exec Order 26.4b1 administration on his shift. The LPN stated, NJ Exec Order 26.4b1 is a medication for a NJ Exec Order 26.4b1 . The resident sometimes has a NJ Exec Order . I take the NJ Exec O to make sure it's in range before giving it. I've been making mistakes in the computer; I've been holding the medication, but I didn't know that I had to go back to strike it out. The NJ Exec Order showed me yesterday how to hold it in the computer. I didn't know I had to document in the progress notes if I held a medication. I've been working with this EHR for about NJ Exec Order 26.4b1 . If I sign a medication, it means it was given, but I made a mistake with the NJ Exec Order 26.4b1 on how to cancel it in this EHR. I've been working in the facility for NJ Exec Order 26.4b1 . I didn't know I had to notify anyone when a medication has been held for a couple of times."

On 7/26/24 at 10:30 AM, the surveyor received from the NJ Exec Order the NJ Exec Order 26.4b1 Consultants Medication Administration Observation competencies for the NJ Exec O dated NJ Exec Order 26.4b1 which revealed competencies for NJ Exec Order 26.4b1 check and cautionaries for the preparation and administration of medications were met by the NJ Exec O .

On 7/26/24 at 10:40 AM, interviewed the NJ Exec Order 26.4b1 who has been a consultant in the facility for NJ Exec Order 26.4b1 , stated, "They get their Medication Review Report (MRR) once monthly. We follow up a month later to make sure it was done. If it was a med error, we call them up to look into it. If I get the report again the next month, the facility needs to follow it up, that's the expectation."

A review of the NJ Exec Order 26.4b1 MRR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 755	Continued From page 29 dated NJ Exec Order 26.4b1 revealed NJ Exec Order 26.4b1 was signed numerous times as given when it should have been held for NJ Exec Order 26.4b1. Please reevaluate the resident's need for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1." On 7/26/24 at 11: AM, the surveyor in the presence of the survey team discussed with the U.S. FOIA (b) the MRR process and recommendations above and she stated, "The unit manager follows through the MRR recommendations, unfortunately in this case it fell through the cracks for the NJ Exec Order 26.4b1 MRR. I did speak to the [redacted] involved yesterday and he did not know how to work the screen of EHR, but the expectation is, if something is held for a few days, the NJ Exec Orde should have told his manager, the primary doctor and should have documented in the progress notes when medications were held." No additional documentation was provided by the facility. A review of the facility policy and procedure titled, "Medication Administration" revised on 6/7/24 revealed, "Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters."	F 755		
F 812 SS=F	NJAC 8:39-29.2 (d) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812		9/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 812	Continued From page 30 state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Repeat Deficiency Based on observation, interview, and record review, it was determined that the facility failed to a.) store potentially hazardous foods (PHFs) in a manner to prevent food borne illness and b.) maintain kitchen equipment in a clean and sanitary manner as evidenced by the following: (PHFs) are foods that must be kept at certain temperatures to minimize the growth of pathogenic microorganisms that may be present in the food or to prevent the formation of toxins in the food. Generally, PHFs are moist, nutrient-rich and have a neutral ph.) On 7/24/24 at 10:05 AM in the presence of the NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1) the surveyor observed the following: 1. The surveyor and US FOIA (b) went into the walk-in freezer, during observation it was noted that there	F 812	A rental Freezer was obtained and The Freezer was repaired. Open, unsealed foods were immediately discarded. Potentially Hazardous Foods which were not in temp were immediately discarded. PHF were moved to the back of the fridge and were within temperature. Fridge temps are reading withing range (41 or less) Walk In fridge # 2 was fixed. The microwave, meat slicer and shelf under the griddle were cleaned. Dietary staff were inserviced on storing potentially hazardous foods (PHFs) in a manner to prevent food borne illness and to maintain kitchen equipment in a clean	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 812	Continued From page 31 were sheets of ice on the floor, icicles hanging from the ceiling, the condenser fans and food boxes. The kitchen supervisor was actively scraping the ice off the floor with a long-handled ice scraper. 2. In the walk-in freezer, the surveyor observed several boxes of opened, not labeled with open or expiration dates, and unsealed food items. The items are as follows: croissants, turkey burgers, and breaded eggplant. All the items in the freezer were covered with snow, frost, and ice crystals. 3. On 7/22/24 at 10:18, the surveyor observed that the walk-in refrigerator #1 had inconsistent temperature readings from 3 different thermometers. ~44 degrees Fahrenheit (F) interior built in thermometer, ~46 degrees F, exterior built in thermometer, ~42 degrees F, portable interior thermometer, ~Survey reviewed Refrigerator #1 temperature log which revealed a written temperature of 36 degrees F on 7/21/24 at 730pm. 4. Further observations in Refrigerator #1 by the surveyor was a box of bacon that was opened, unsealed and unlabeled. 5. Walk-in refrigerator #2, was out of service and not working, upon surveyor entry on 7/22/24 there was not a plan for it to be repaired. Surveyor reviewed service order # 4548236, dated 6/26/24 and two emails dated 6/26/24 and post survey team entry on 7/23/24. All three indicated communication FROM the repair service. There were NOT any emails or documents provided to the surveyor indicating correspondence FROM the facility or that repairs	F 812	and sanitary manner. Fridges and freezers will be audited weekly x 4 for 3 months to ensure they are working properly. PHF will be temped to ensure they are in a safe range weekly x 4 for 3 months. Random kitchen equipment will be audited to ensure they are clean weekly x 4 for 3 months. Items stored in the fridge and freezer will be schecked for proper storage weekly x 4 for 3 months. Findings will be reported to QAPI committee who will determine if further actions are needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 812	Continued From page 32 were in the process of being initiated or waiting for parts. 6. On 07/22/24 at 01:17 PM, the [NJ Exec Order] Surveyor #1 and Surveyor #2 took temperatures of 2 items in walk-in refrigerator #1. [NJ Exec Or] stated that the kitchen thermometers had been calibrated. ~Heavy Cream: 1 liter container, The [NJ Exec Or] inserted the calibrated thermometer into the center of the container, it read 46.7 degrees F. ~Cottage Cheese: 32-ounce container. The [NJ Exec Or] inserted the calibrated thermometer straight down in the center of the container. The temperature read 50.4 degrees F with the first thermometer. The [NJ Exec Order] inserted a second calibrated thermometer that read 49.4 degrees F. 7. The microwave interior ceiling was covered with multi-color splatter debris. The [NJ Exec Or] acknowledged that it had not been cleaned correctly. 8. The meat slicer was covered in a plastic bag which the [NJ Exec Or] indicated it meant that it was clean. Upon removal of the bag the slicer pusher spikes were soiled with caked on brown debris. The [NJ Exec Or] stated that it should have been cleaned and then covered with the bag. 9. The shelf under the griddle had sediment and debris. The [NJ Exec Or] acknowledged it had not been clean thoroughly. On 7/22/24 at 11:00 AM, the surveyor interviewed the [NJ Exec Or]. who stated, "the freezer items should have been labeled with an opening date and if only partial of a bag was used it should be resealed and labeled." He further stated, "the cooking equipment should be cleaned and	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 812	Continued From page 33 maintained in a sanitary way to prevent food borne illness and contamination." On 7/22/24 at 10:44 AM the surveyor interviewed the kitchen supervisor (KS), who stated, "the ice and frost in the freezer is a reoccurring issue." He acknowledged that the frost and snow in the freezer and on the products can degrade the food quality and has the potential to cause food borne pathogens. On 7/22/24 at 11:26 AM, the surveyor interviewed the [redacted]) who stated, "the freezer has been an issue for last 4 months. It is discussed in morning meeting." On 7/24/24 at 10:33 AM, the surveyor interviewed the [redacted]) who stated, "the refrigerators and freezer need to be in working condition because it can cause potentially hazardous food, food borne illnesses and degrades the quality of the food. I acknowledge what the survey team saw. A review of the policy titled, "Food Safety Requirements Policy" dated 4/9/24, which was provided by the LNHA read ... Policy: Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety. Definition: "food service safety" refers to the handling, preparing, and storing food in ways that prevent food borne illness." "Food borne illness refers to an illness caused by the ingestion of contaminated food or beverages." Policy Explanation and Compliance Guidelines: #1-b) Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms. e)	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 812	Continued From page 34 Equipment used in the handling of food, including dishes, utensils, mixers, grinders, and other equipment that comes in contact with food. #3-c) Refrigerated storage- foods that require refrigeration shall be refrigerated immediately upon receipt or placed in the freezer whichever is applicable. Practices to maintain safe refrigerated storage include: iv.) labeling, dating, and monitoring refrigerated food, including but not limited to leftovers, so it is used-by date, or frozen (where applicable) /discarded. v.) Keeping food covered or in tight containers. #6) all equipment used in the handling of food shall be cleaned and sanitized and handled in a manner to prevent contamination. a) Staff shall follow facility procedures for dishwashing and cleaning fixed cooking equipment. #8) Additional strategies to prevent foodborne illness include but are not limited to: d) Proper refrigeration of meat, poultry, and pasteurized dairy products. A review of the policy titled, "Physical Environment: Electrical Equipment" dated 7/2024, which was provided by the LNHA read ... #4) Essential equipment shall be repaired or replaced as soon as practicable. e) Kitchen refrigerator /freezer. A review of the policy titled, "Monitoring of Cooler / Freezer Temperature" dated 7/2024, which was provided by the LNHA read ... Policy: It is the policy of this facility to maintain temperatures of coolers and freezers at the appropriate temperature to promote food safety. This policy also addresses refrigerated storage. Policy Explanation and Compliance Guidelines: #2) Thermometers shall be placed inside each cooler/ freezer and calibrated at least once per week. #3) All refrigerated storage must be	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 812	Continued From page 35 maintained at or below 41 degrees F, unless otherwise specified by law. #5) If temperatures are above 41 degrees F for coolers or 10 degrees F for freezer, the supervisor will be notified immediately for corrective action. a) The unit will be repaired as soon as possible. If the problem cannot be corrected within 2 hours, all food items will be relocated to another unit that can hold foods in an acceptable temperature range. b) Internal temperature readings of all perishables of potentially hazardous food shall be taken and discarded if not in an acceptable range. 11) Refrigerated food shall be labeled, dated, and monitored so that it is used by the use-by date, frozen or discarded, whichever is applicable NJAC 8:39-17.2(g)	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		9/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 880	Continued From page 36 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 880	Continued From page 37 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to a.) minimize the potential spread of infection to residents during medication administration for 1 of 2 nurses observed during medication pass on 1of 2 units NJ Exec Order 26.4b1) and b.) follow Center for Disease Control recommendations and guidelines for Hand Hygiene. This deficient practice was evidenced by the following: On 7/24/24 at 7:56 AM, during the medication administration observation, the surveyor observed the U.S. FOIA (b)(6) prepare medication for administration to an unsampled resident in NJ Exec Order 26.4b1. The NJ Exec opened the drawer of the medication cart, retrieved the blister packs (multi-use medication packs), and removed the medications NJ Exec Order 26.4b1 The NJ Exec administered the medications, returned to the medication cart, opened the drawer, removed the blister packs from the cart, and utilized the computer to sign the electronic medical record (eMR) indicating the medications had been administered. The NJ Exec D did	F 880	1. The US FOIA (b)(6) was educated on the facility policy Medication Administration and Enhanced Barrier Precautions. A hand hygiene competency was conducted on the Registered Nurse. The housekeeper was educated on the facility policy Hand Hygiene. A hand hygiene competency was conducted on the housekeeper. 2. All residents have the potential to be affected by this deficient practice. None were identified. 3. All nurses were educated on the facility policy Medication Administration and Enhanced Barrier Precautions. All staff were educated on the facility policy Hand Hygiene. The IP or Designee will audit the files of all new hires and new agency staff to ensure education on Hand Hygiene policy was conducted, weekly x 4 then monthly x 3. The IP or Designee will conduct a random observation of at least 1 nurse a week x 4, then monthly x 3 to ensure nurses are compliant with practicing hand hygiene during medication administration.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 880	Continued From page 38 not perform hand hygiene before preparation or after administration of the medications. On 7/24/24 at 8:06 AM, the surveyor observed the [NJ Exec] prepare medication for administration to Resident #47. The surveyor observed signage posted to the left of the entrance door to Resident #47's room which read: NJ Exec Order 26.4b1 [redacted] STOP. Everyone must clean their hands before entering and exiting the room. Providers and staff must also wear gloves and gown during high-contact resident care activities. The surveyor observed the [NJ Exec] open the drawer of the medication cart, retrieve the blister packs and remove the medications NJ Exec Order 26.4b1 [redacted] The [NJ Exec] administered the medications, returned to the medication cart, opened the drawer, removed the blister packs from the cart, and utilized the computer to sign the eMR indicating the medications had been administered. The [NJ Exec] did not perform hand hygiene before preparation or after administration of the medications. On 7/24/24 at 8:14 AM, the surveyor observed the [NJ Exec] prepare medication for administration to Resident #117. The surveyor observed signage posted to the left of the entrance door to Resident 47's room which read: 'NJ Exec Order 26.4b1 [redacted] Stop. Everyone must clean their hands before entering and exiting the room. Providers and staff must also wear gloves and gown during high-contact resident care activities. The surveyor observed the [NJ Exec] opened the drawer of the medication cart, retrieved the blister packs and removed the medications [NJ Exec Order 26.4b1] [redacted]	F 880	The IP or Designee will conduct random observations of 5 staff daily x 7, then weekly x 4, then monthly x 3 to ensure staff are compliant with practicing hand hygiene. 4. The IP or designee will report the results of the audits in the monthly QAPI meetings x 4 months to ensure compliance and if further action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 880	Continued From page 39 [redacted], from the blister packs. The [redacted] administered the medications, returned to the medication cart, opened the drawer, removed the blister packs from the cart, and utilized the computer to sign the eMR indicating the medications had been administered. The [redacted] did not perform hand hygiene before leaving Resident #117's room or after administration of the medications. On 7/24/24 at 8:27 AM, the surveyor discussed the breaks in technique with the [redacted]. The [redacted] stated that she had not performed hand hygiene during the medication administration because she "didn't touch the residents." The surveyor asked the [redacted] if she should perform hand hygiene before preparing medications and after handling the cups that the residents had also handled. The [redacted] acknowledged that she should have performed hand hygiene before preparing medications and after administration of medications. The surveyor showed the [redacted] signage outside of Resident #47 and Resident #117's rooms. The [redacted] acknowledged that she should have performed hand hygiene before entering and exiting a resident's room who was on [redacted] to prevent the spread of infection. The surveyor reviewed the facility policy titled, "Medication Administration last reviewed 6/7/24, which revealed the following: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection...wash hands prior to administering medication per facility protocol and product.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 880	Continued From page 40 The surveyor reviewed the facility policy titled, "Enhanced Barrier Precautions" last reviewed 3/20/24 which revealed the following: Enhanced Barrier Precautions refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and gloves. 2. On 7/22/24 at 02:00 PM, in a conference room inside the facility, the surveyor observed a [redacted]) go to the sink to wash his hands. The surveyor observed the [redacted] put soap on his hands and rubbed his hands together for 12 seconds, then, with his soapy hands, he turned the faucet on and rinsed his hands off. The surveyor observed the [redacted] turn the faucet off with his bare hands and the surveyor observed the [redacted] rub his hands directly onto his pants to dry his hands off. A review of the Hand Hygiene policy and procedure, dated 5/29/24, revealed that All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. This applies to all staff working in all locations within the facility ...including between resident contacts ...before preparing or handling medications. And, "Hand Hygiene technique when using soap and water: wet hands with water, apply to the hands the amount of soap recommended by the manufacturer, rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers, rinse hands with water, dry thoroughly with a single-use towel, use clean towel to turn off the faucet."	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 880	Continued From page 41 On 7/24/24 at 2:00 PM, the survey team met with the NJ Exec Order 26.4b1 to discuss the above observations. The NJ Exec Order acknowledged that the NJ Exec was expected to wash her hands or use Alcohol Based Hand Rub (ABHR) prior to handling medications, between residents and before entering and exiting resident rooms who were on NJ Exec Orde On 7/29/24 at 10:42 AM, the surveyor interviewed the NJ Exec Order 26.4b1, who stated that the NJ Exec was recently educated on hand hygiene and should have known how to properly wash their hands according to CDC and facility policy. The [redacted] also stated that nurses during medication pass should also be performing hand hygiene between residents, especially those who are on any type of precautions. According to the U.S. CDC guidelines Hand Hygiene Recommendations, Guidance for Healthcare Providers (HCP) for Hand Hygiene and COVID-19, page last reviewed 1/8/2021 included that the HCP should perform hand hygiene before and after direct contact with the residents and immediately after glove removal. In addition, when cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers, and this should be done outside the water when rubbing your hands, then rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Other entities have recommended that cleaning your hands with soap	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE 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
F 880	Continued From page 42 and water should take approximately 20 seconds. NJAC 8:39-19.4 (a)	F 880		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315091 Y1	A. Building B. Wing Y2	9/16/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	205 BIRCHWOOD AVE 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 F0584	Correction	ID Prefix F0641	Correction	ID Prefix F0656	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	08/27/2024	LSC	09/03/2024	LSC	09/03/2024
ID Prefix F0686	Correction	ID Prefix F0698	Correction	ID Prefix F0711	Correction
Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.30(b)(1)-(3)	Completed
LSC	09/03/2024	LSC	09/03/2024	LSC	09/03/2024
ID Prefix F0755	Correction	ID Prefix F0812	Correction	ID Prefix F0880	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	09/03/2024	LSC	09/03/2024	LSC	09/03/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
8/6/2024	☐ 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
315091 Y1	A. Building B. Wing Y2	9/16/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	205 BIRCHWOOD AVE 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 F0584 Reg. # 483.10(i)(1)-(7) LSC	Correction Completed 08/27/2024	ID Prefix F0641 Reg. # 483.20(g) LSC	Correction Completed 09/03/2024	ID Prefix F0686 Reg. # 483.25(b)(1)(i)(ii) LSC	Correction Completed 09/03/2024
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	
8/6/2024	☐ 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
	315091	A. BUILDING **01** B. WING _____	**08/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE** **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 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/05/2024 and 08/06/2024 and Birchwood Rehabilitation and Nursing Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Birchwood Healthcare Center is a two story, Type II Protected building that was built in January 1970. The facility is divided into 10 smoke zones. The long term care facility has a 120 kW diesel generator located inside the facility. The generator provides partial power for the offices, dining room, lobby, corridor emergency lighting and red outlets according to the Maintenance Director. There are 3 fire hydrants located on the property and the facility maintains 1 of the 3 fire hydrants, the township maintains the other two. There were 2 other occupancies that were located in the building and separated by 2 hour fire rated separation. There was a dialysis suite located in the front portion of the building complex that is operational and there was an assistant living unit occupying the second floor portion of the building. The second floor assisted living has not been occupied since COVID in 2020 according to the NJ Exec Order 26.4b1 and was closed at the time of survey.	K 000		

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

Electronically Signed | 08/22/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING 01 B. WING _____	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	205 BIRCHWOOD AVE 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 000	Continued From page 1 Dialysis has its own diesel generator located outside.	K 000		
K 281 SS=F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/6/24 in the presence of the NJ Exec Order 26.4b1 [redacted] it was determined the facility failed to provide exit discharge lighting in accordance with NFPA 101: 2012 edition, Sections 7.8, 7.8.1.4, 7.9.2.3 and 19.2.8. This deficient practice had the potential to affect 128 residents and was evidenced by: An observation between 9:37 AM and 1:00 PM, revealed 7 of 22 exterior exit discharges had illumination that was not arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle in any designated area. These exits were identified as W5 main, W5 rear, rotunda main, rotunda park, W1, W2 and 4B rear. In an interview at the time, the U.S. FOIA (b)(6) confirmed the observations. The facility U.S. FOIA (b)(6) [redacted] of	K 281	1. The 7 exit discharge lighting areas in W5 main, W5 rear, Rotunda Main, Rotunda Park, W1, W2, 4B Rear were rearranged to ensure that failure of any single unit will result in sufficient illumination in excess of .2 ft-candle. 2. All residents could have been affected in those areas by this deficient practice. 3. Administrator educated Maintenance Director on illumination of means of egress requirements. Facility wide audit on remaining exit discharge lighting areas were conducted by Maintenance Director to ensure sufficient lighting is in place. Maintenance director to conduct weekly audit for 4 weeks then monthly for 2 months to ensure compliance. 4. Findings of the audits will be monitored by Administrator during monthly QAPI meeting for 3 months.	9/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING 01 B. WING _____	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	205 BIRCHWOOD AVE 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 281	Continued From page 2 Operations were informed of the concerns during the Life Safety Code exit conference at 2:00 PM.	K 281		
K 353 SS=F	NJAC 8:39-31.2(e) Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/6/24 in the presence of the NJ Exec Order 26.4b1 [redacted] it was determined the facility failed ensure fire sprinkler system sprinkler heads and heat detectors were maintained in accordance with NFPA 101: 2012 edition, Sections 9.7.5 and 19.3.5.1, NFPA 25: 2011 edition and NFPA 72: 2010 edition. This deficient practice had the potential to affect 128 residents and was	K 353	1. Escutcheon plates by W5 breakroom bathroom, room [redacted] bathroom, main shop, mechanical room by entrance, housekeeping office, room [redacted], room [redacted] closet [redacted] room [redacted] by window, human resource office in Rotunda have been replaced and/or refastened to their proper positions. Heat detectors by mechanical room, above chiller, and in ceiling corridor by room [redacted] have been repositioned to	9/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING 01 B. WING _____	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	205 BIRCHWOOD AVE 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 353	Continued From page 3 evidenced by: 1. An observation between 9:37 AM and 1:00 PM, revealed fire sprinkler escutcheon plates were missing or hanging down in the following locations: W5 break room bathroom, room [redacted] bathroom, maintenance shop (1 of 5 sprinklers), mechanical room by entrance (1 of 10 sprinklers), house keeping office (1 of 2 sprinklers), room [redacted] (1 of 2 sprinklers), room [redacted] close[redacted] room [redacted] by window (1 of 2 sprinklers) and human resource office in rotunda (1 of 2 sprinklers). In an interview at the time, the U.S. FOIA (b)(6) confirmed the observations. 2. An observation between 9:37 and 1:00 PM, revealed 3 heat detectors were dislodged down from their proper position in the following areas: mechanical room one down 4-Inches (with hole around detector) and one above chiller down 1-inch, and one in the corridor ceiling by room 105. In an interview at the time, the U.S. FOIA (b)(6) confirmed the observations. The facility U.S. FOIA (b)(6) [redacted] were informed of the concerns during the Life Safety Code exit conference at 2:00 PM. NJAC 8:39-31.2(e) NFPA 25, 72	K 353	their proper positions. 2. All residents could have been affected by this deficient practice. 3. Administrator educated the US FOIA (b)(6) [redacted] on proper escutcheon plates, sprinkler head, and heat detector positioning requirements. Maintenance director/designee conducted a facility wide audit on all escutcheon plates, sprinkler heads, and heat detectors to ensure proper placement. Maintenance director/designee will conduct a monthly audit for 3 months to ensure proper positioning in place. 4. Audit findings will be monitored by administrator during monthly QAPI committee meeting for 3 months.	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than	K 363		8/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING 01 B. WING _____	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	205 BIRCHWOOD AVE 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 363	Continued From page 4 required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/6/24 in the presence of the U.S. FOIA (b)(6)	K 363	1. Gaps under door room [NJ Exec O], and above doors NJ Exec Order 26.4b1, and [NJ Exec O] have	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING 01 B. WING _____	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	205 BIRCHWOOD AVE 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 363	Continued From page 5 and U.S. FOIA (b)(6) it was determined the facility failed to ensure corridor doors resist the passage of smoke for 7 of 42 doors observed in accordance with NFPA 101: 2012 edition, Sections 8.3.3, 8.5, 19.3.6.3, 19.3.6.3.3 and NFPA 80: 2010 edition. The deficient practice had the potential to affect 128 residents and was evidenced by: An observation between 9:37 AM and 1:00 PM revealed the following: 1. Resident room NJ Exec O had a 1-1/4 inch space across the bottom of the door when the door was closed in its frame, measured with a standard tape measure in the presence of facility management. 2. NJ Exec Order 26.4b1 Unit soiled work room door did not close into its frame and latch when open to 90 degrees and released. 3. NJ Exec Order 26.4b1 Unit nourishment room door did not latch when closed. 4. Resident room NJ Exec O had a 1/2-inch gap on the top of the door when closed in its frame. 5. Resident room NJ Exec O had a 1/2-inch gap on top of the door when closed in its frame. 6. Resident room NJ Exec O had a 1/4-inch gap on top of the door when closed in its frame. 7. Resident room NJ Exec O had a 1/4-inch gap on top of the door when closed in its frame and did not latch. In an interview at the time, the NJ Exec Order 26.4b1	K 363	been sealed. NJ Exec Order 26.4b1 unit soiled work room door and nourishment room, and door room NJ Exec O latches have been repaired. 2. All residents had the potential to be affected by this deficient practice. 3. Administrator educated the US FOIA (b)(6) on the requirements of proper latching and sealed gaps of Corridor doors. Maintenance Director or designee will conduct a facility wide audit on all corridor doors to ensure appropriate seal and latch. Maintenance director will conduct weekly audit for 1 month and monthly for 2 months to ensure appropriate latch and seal in place. 4. Audit findings will be monitored by administrator during monthly QAPI meeting for 3 months to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING 01 B. WING _____	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	205 BIRCHWOOD AVE 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 363	Continued From page 6 confirmed the observations. The facility U.S. FOIA (b)(6) were informed of the concerns during the Life Safety Code exit conference at 2:00 PM.	K 363		
K 761 SS=F	NJAC 8:39-31.2(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 record review and interview on 8/5/24 in the presence of the U.S. FOIA (b)(6), it was determined the facility failed to ensure the fire and smoke barrier doors are tested and inspected annually and part of a maintenance program with written record in accordance with NFPA 101: 2012 edition, Sections 8.3.3.1, 19.7.6 and NFPA 80: 2010 edition, Sections 5.2 and 5.2.3 . The deficient practice had the potential to affect 128 residents and was evidenced by:	K 761	1. All fire and smoke doors were inspected, and results were recorded. 2. All residents have the potential to be affected by this deficient practice. 3. Administrator educated the US FOIA (b)(6) on Maintenance program for annual inspection and record of fire and smoke doors. Maintenance director or designee will audit the maintaining of the records of inspection monthly for 3 months.	8/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING **01** B. WING _____	**08/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE** **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 761	Continued From page 7 Record review between 10:00 AM and 2:30 PM, revealed no policy and procedure for routine maintenance and inspection of fire, smoke and corridor doors and no documentation of the annual door inspections. In an interview at 2:33 PM, the [US FOIA] stated that he does not keep a written record of the fire and smoke door inspections. The facility[U.S. FOIA (b)(6) redacted] were informed of the concerns during the Life Safety Code exit conference on 8/6/24 at 2:00 PM. NJAC 8:39-31.2(e) NFPA 80	K 761	4. Audit results will be monitored by administrator during monthly QAPI meeting for 3 months.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete	K 918		8/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING 01 B. WING _____	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	205 BIRCHWOOD AVE 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 918	Continued From page 8 simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview on 8/5/24 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined the facility failed to ensure the emergency power generator was exercised at 30% or greater of its nameplate rating during the monthly load tests or perform a 90 minute annual load bank test and failed to measure and record that the time to transfer power from utility to generator is within 10 seconds in accordance with NFPA 101: 2012 edition, NFPA 99: 2012 edition, Sections 6.4.4, 6.5.4, 6.6.4, and NFPA 110: 2010 edition, Section 8.4, 8.4.1, 8.4.2, 8.4.2.3. This deficient practice had the potential to affect 128 residents and was evidenced by: Record review at 2:25 PM of the monthly emergency power generator logs for each of the last 12 months from July 15th 2024 to August	K 918	1. 90 minute annual load bank test was performed. Administrator educated Maintenance director on requirement to record transfer time from normal power source to alternate power source in order to determine transfer time was within 10 seconds. 2. All residents had the potential to be affected by this deficient practice. 3. Maintenance director or designee to conduct monthly audit for 3 months to ensure records of annual 90 minute load bank test and transfer times are present and within appropriate range. 4. Audit findings will be monitored by administrator during monthly QAPI meeting for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING **01** B. WING _____	**08/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE** **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 918	Continued From page 9 21st 2023 revealed the following: 1. The facility did not record the percentage of the emergency power system nameplate kilowatt rating that the generator was exercised to determine if the load met the 30% of the rating requirement or performed a 90 minute annual load bank test. 2. The facility did not record the transfer time from the normal utility power source to the alternate power source being tested to determine the time was within 10 seconds or provide a process to annually confirm this capability to the life safety and critical branches. In an interview at the time, the [redacted] confirmed the record review findings. The facility [redacted] were informed of the concerns during the Life Safety Code exit conference on 8/6/24 at 2:00 PM. NJAC 8:39-31.2(e) NFPA 99,110	K 918		

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
315091 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/16/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	205 BIRCHWOOD AVE 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0281	09/05/2024	LSC K0353	09/05/2024	LSC K0363	08/30/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0761	08/30/2024	LSC K0918	08/30/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
8/6/2024	☐ YES ☐ NO