STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315122	A. BUILDING _____ B. WING _____	C 02/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WESTFIELD, LLC	**1515 LAMBERTS MILL ROAD WESTFIELD, NJ 07090**

(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 not 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		
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness	E 001		2/28/23

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

Electronically Signed | 03/01/2023

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

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E 001	Continued From page 1 program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on observation and documentation review on 02/07/23, the facility failed to use an all-hazard assessment approach to determine the various disasters that might impact the operation of the facility and mitigate the risks accordingly. NJAC 8:39-31.2(e)	E 001	1) Facility Emergency preparedness plan (EPP) has been reviewed and updated and risk assessments using the all hazard assessment approach was completed based on the facility assessment and using the Union County, New Jersey Multi-Jurisdictional hazard mitigation plan; that was approved 12/15/21 and expires 12/14/2026. 2) All residents have potential to be affected by the same deficit practice. 3) Facility EPP was reviewed and revised utilizing Union County, New Jersey Multi-Jurisdictional hazard mitigation plan; that was approved 12/15/21 and expires 12/14/2026. All future EPP will utilize county and or state and or local and or federal material to evaluate for an all-hazard approach. 4) EPP will be reviewed annually and as	

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E 001	Continued From page 2	E 001	needed by facility Emergency management team led by Maintenance Director and Administrator with collaboration from local OEM officials to ensure it includes an all-hazard assessment approach. - Findings will be reported to QAPI committee X 1 year and to facility administrator. 5) Administrator will ensure compliance and facility is in compliance as of 2/28/2023.	
E 015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following:	E 015		2/28/23

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E 015	Continued From page 3 (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: . Based on observation and document review, the facility failed to develop and implement emergency preparedness policies and procedures based on a facility risk assessment for the loss of generator and how it would affect ventilator units. This deficient practice was evidenced by the following:	E 015	1) Facility Emergency preparedness plan (EPP) has been reviewed and updated and risk assessments using the all hazard assessment approach was completed based on the facility assessment and using the Union County, New Jersey Multi-Jurisdictional hazard mitigation plan; that was approved	

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E 015	Continued From page 4 A review of the facility Emergency Preparedness policy revealed the facility policy lacked a reference to plan for a facility risk assessment for the loss of generator and how it would affect ventilator units. NJAC 8:39-31.2(e) NFPA 99, 110 .	E 015	12/15/21 and expires 12/14/2026. Risk assessment added for loss of generator power. EPP also includes plan for loss of generator. 2) All residents have potential to be affected by the same deficit practice. 3) Facility EPP was reviewed and revised and includes plan for loss of generator power - Facility EPP includes plan in case of loss of generator power 4) EPP will be reviewed annually and as needed by facility Emergency management team led by Maintenance director and Administrator with collaboration from local OEM officials to ensure it includes an all-hazard assessment approach to include loss of generator power and plan for loss of generator power. - Findings will be reported to QAPI committee X 1 year and to facility administrator. 5) Administrator will ensure compliance and facility is in compliance as of 2/28/2023.	
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set	E 041		2/28/23

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E 041	Continued From page 5 forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan	E 041		

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E 041	Continued From page 6 for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition,	E 041		

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E 041	Continued From page 7 issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: . Based on documentation review on 02/06/23 in the presence of the Maintenance Director (MD), the facility did not have a written plan or policy for how it will keep the emergency power system operational during an emergency The emergency plan provided by the Maintenance Director indicated the plan did not address how the facility would keep its emergency power systems operational during an emergency in order to ensure continuity of meeting the residents and staffs subsistence needs whether the facility decides to shelter in place or relocate. NJAC 8:39-31.2(e) NFPA 99, 110 .	E 041	1) Facility Emergency preparedness plan (EPP) has been reviewed and updated to include plan for loss of generator power and specifically for those on the ventilator unit. 2) All residents utilizing a ventilator have potential to be affected by the same deficit practice. 3) Facility EPP was reviewed and revised. - All future EPP will utilize county and or state and or local and or federal material to include plan for loss of generator power and how it would affect ventilator units. 4) EPP will be reviewed annually and as needed by facility Emergency management team led by Maintenance Director and Administrator with collaboration from local OEM officials to ensure it includes an all-hazard assessment approach and includes plan	

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E 041	Continued From page 8	E 041	for loss of generator power and specifically for those on the ventilator unit. - Findings will be reported to QAPI committee X 1 year and to facility administrator. 5) Administrator will ensure compliance and facility is in compliance as of 2/28/2023.	
F 000	INITIAL COMMENTS Complaint # NJ00160907, NJ00160796, NJ00160615, NJ00160518, NJ00158684 STANDARD SURVEY: 2/13/23 CENSUS: 192 SAMPLE SIZE: 41 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. During a Standard Survey conducted on 2/13/23, it was determined that effective 1/4/23, the Facility was found to have been in Immediate Jeopardy for F600J. The Department of Health sent a Notice of Determination of Immediate Jeopardy to the Facility Administrator on 1/4/23, including the Immediate Jeopardy Template.	F 000		

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F 000	Continued From page 9 The Facility failed to: -address a new NJ Exec. Order 26 4.b.1 behavior displayed on Ex Order 26. 4B1 by a resident who, within weeks of the new NJ Exec. Order 26 4.b.1, Ex Order 26. 4B1 their roommate on Ex Order 26. 4B1 at 5:07 AM as the roommate slept in their bed. As a result of the Ex Order 26. 4B1 the roommate sustained the following Ex Order 26. 4B1 according to the Ex Order 26. 4B1 records: Ex Order 26. 4B1 [redacted], between the Ex Order 26. 4B1 extending to the Ex Order 26. 4B1, a Ex Order 26. 4B1 [redacted]. There was no documentation in the medical record or uncovered during multiple interviews with staff from the facility that showed the new NJ Exec. Order 26:4.b.1 was communicated across shifts or disciplines. The facility did not initiate a formal behavior monitoring process or develop a care plan for this new behavior of NJ Exec. Order 26 4.b.1 This deficient practice was identified for 2 of 4 residents reviewed for Ex Order 26. 4B1, Resident # 98 Ex Order 26. 4B1 and Resident # 190 Ex Order 2 [redacted]. The facility's failure to initiate interventions to address the new NJ Exec. Order 26 4.b.1 behavior displayed by Resident # 190 posed a serious and immediate threat to the safety and well being of all residents in the facility and placed them at risk of being Ex Order 26. 4B1. On 2/3/23 the Department of Health received an acceptable Ex Order 26. 4B1 for Removal of the	F 000		

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F 000	Continued From page 10 Immediate Jeopardy. The following Immediate Jeopardy (IJ) situation was identified for F600J. During a Standard Survey, the surveyors were onsite during that dates of 1/30/23, 1/31/23, 2/1/23, 2/2/23, 2/3/23, 2/6/23, 2/7/23, 2/8/23, 2/9/23, and completed the survey on 2/13/23, the survey team identified the following: 1. F600 scope and severity (s/s) of J: The IJ began on 1/4/23. The facility was notified of the IJ on 2/3/23, and an acceptable Removal Plan was received on 2/3/23. The survey team verified the implementation of the Removal Plan on 2/6/23.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		2/17/23

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F 550	Continued From page 11 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Complaint # NJ00158684 Based on interviews conducted during the 2/6/23 Resident Council Meeting and 2 additional resident representative interviews and review of facility documentation it was determined the facility failed to provide care and services in a dignified and respectful manner. The concern was evidenced by the following. On 2/6/23, the surveyor reviewed Resident Council meeting minutes for past meetings. The 6/2022 minutes noted resident complaints of staff speaking on their cell phones while in the nursing unit.	F 550	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Staff were educated on the facility□s policy on cell phone use. Staff are prohibited from using cell phones in resident care areas namely resident room, dayrooms, hallways and with resident or around residents or resident family. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:	

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F 550	Continued From page 12 On 2/6/23 at 10:30 AM, the surveyor conducted the Resident Council Facility Task group meeting with 5 NJ Exec. Order 26:4.b.1 residents who were selected for participation by the facility. Five of 5 residents stated they had seen nursing department staff members talking on cell phones while in resident care areas. One resident stated they observed a nurse speaking on a cell phone while standing at the medication cart. The Resident Council President stated they had spoken with facility administration about the concern. The residents stated the problem has continued. On 2/07/23 at 11:19 AM, the surveyor interviewed the responsible representatives of 2 sampled residents. The interviewees requested to remain anonymous. They stated they have seen staff speaking on cell phones in the hallways of 2 nursing units. On 02/08/23 at 10:46 AM, the surveyor discussed the cell phone concerns with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing. The LNHA stated staff was in-serviced in June of 2022 after he received complaints voiced at the resident council meeting. He stated he did not know it had been a continuing concern. The facility policy addressing cell phones and other communication devices was provided to the surveyor on 2/9/23. The policy was signed and dated on 2/9/23. The policy included the following statements, "personal cell phones should not be used during work time. . . Employees should not make or receive any personal calls or texts during work time."	F 550	All residents have the potential to be affected by this deficient practice. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: A) Staff will be educated on the cell phone use policy upon hire, Annually and as needed. B) Administrator or designee will conduct random audits of resident care areas and observation will be done for compliance with facility Cellphone policy and education or disciplinary action taken for Non-compliance. 4. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR The Administrator, Director of Nursing or designee will audit for compliance on cell phone use in resident care areas weekly x 4 then bi-weekly X1 month then monthly x 3. Result of audit will be reported to the administrator at the QAPI committee for review and recommendations monthly x 3 months then quarterly x 6 months. 5. Administrator will ensure compliance and facility was in compliance as of 2/17/2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315122	A. BUILDING _____ B. WING _____	C 02/13/2023

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F 550	Continued From page 13 NJAC 8:39-4.1(a)12	F 550		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Complaint # NJ00160796, # NJ00160907 Based on observation, interview, review of facility records, and other pertinent facility documents on 2/3/23, it was determined that the facility failed to address a new [NJ Exec. Order 26 4.b.1] behavior displayed on *Ex Order 26. 4B1* by a resident who, within weeks of the new [NJ Exec. Order 26 4.b.1] behavior, *Ex Order 26. 4B1* their roommate on [redacted] at 5:07 AM as the roommate slept in their bed. As a result of the [redacted], the roommate sustained the following injuries, according to the [redacted] records: *Ex Order 26. 4B1* [redacted]	F 600	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Resident #190 is no longer in the facility; Resident #190 was discharged on [redacted]. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by this deficient practice. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC	2/15/23

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F 600	Continued From page 14 Ex Order 26. 4B1 [redacted]; The resident Ex Order 26. 4B1 16 days after the Ex Order 26. 4B1 at the facility. There was no documentation in the medical record or uncovered during multiple interviews with staff from the facility that showed the new NJ Exec. Order 26 4.b.1 behavior was communicated across shifts or disciplines. The facility did not initiate a formal behavior monitoring process, develop a care plan, or start interventions for this new NJ Exec. Order 26 4.b.1 behavior. This deficient practice was identified for 2 of 4 residents reviewed for abuse, Resident # 98 Ex Order 26. 4B1 and Resident # 190 Ex Order 26. 4B1. The facility's failure to initiate interventions to address the new NJ Exec. Order 26 4.b.1 behavior displayed by Resident # 190 posed a serious and immediate threat to the safety and well-being of Resident #98 and placed all residents at risk of being NJ Exec. Order 26:4.b by a resident with new unaddressed NJ Exec. Order 26 4.b.1 behavior. This resulted in an Immediate Jeopardy (IJ) determination. The Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) were notified of the IJ and provided with the IJ template on 2/3/23 at 12:23 PM. The IJ began on Ex Order 26. 4B1 at 5:07 AM when Resident # 98 was Ex Order 26. 4B1 while sleeping by Resident # 190 and continued until Ex Order 26. 4B1 at 4:28 PM when the facility provided an acceptable removal plan. The removal plan was verified on-site on 2/6/23 during the survey. The evidence was as follows:	F 600	CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: A) Last 7 days of Progress notes of all residents were reviewed and care plans were updated as needed. B) Nursing and Recreation staff were educated on behavior monitoring, documentation, and care plan initiation and will be done during new hire orientation, yearly and as needed. C) The facility will ensure that any resident/patient with new documented behavior will have a formal behavior documentation monitoring process and that a care plan is updated/initiated. D) All residents identified with new behaviors will be addressed immediately to prevent any resident-to-resident and or staff Ex Order 26. 4B1. The team will conduct a full assessment, and initiate interventions to include behavior monitoring, update the care plan, notify the primary care physician and the family. This could also include the need for hospitalization, room change and discharge if appropriate. 4. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR A) The Director of Nursing or Designee will audit/review progress notes during the morning meeting Monday through Friday x three months, then monthly for three months. Any noted behaviors will be cross-referenced to ensure behavior monitoring sheets and care plans are in	

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F 600	Continued From page 15 On 2/1/23, 2/2/23, and 2/3/23, the surveyor reviewed the electronic medical record (EMR) of Resident # 190 and Resident #98. The EMR of Resident # 190 revealed the following: An admission record included the following diagnoses; *Ex Order 26. 4B1* [redacted]. The admission record indicated that the resident was admitted to the facility from an [redacted] A Quarterly Minimum Data Set Assessment dated 12/24/22 revealed that the resident scored a [redacted] when the Brief Interview for Mental Status was done. This indicated that the resident had [redacted]. The resident scored a [redacted] when the mood interview was conducted. That indicated there was NJ Exec. Order 26:4.b.1. The behavior section indicated there [redacted] been any physical, verbal, or other behavioral symptoms directed at others. The MDS also revealed that the resident could NJ Exec. Order 26:4.b.1 [redacted] The surveyor reviewed progress notes from the resident's day of admission to [redacted] at 11:05 AM when the resident was transferred to the [redacted] emergency room. From 11/23/22 to 1/4/23, twenty-five entries read: Was a behavior observed? [redacted] There was no description of the behavior documented as being observed. On 2/3/23 at 9:00 AM, the surveyor spoke with the Registered Nurse/Unit Manager (RN/UM) of	F 600	place. B) Director of Nursing or designee will audit CNA documentation for behavior monitoring. Any noted behaviors will be cross-referenced to ensure behavior monitoring sheets and care plans are in place. Results of these findings will be reported to the Administrator at the monthly QAPI meetings X3 months then Quarterly X 6 months. 5. Date of Compliance; Administrator will ensure compliance and facility was in compliance as of 2/15/2023.	

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F 600	Continued From page 16 the unit where Resident # 190 and Resident 98 resided. The surveyor asked about the entries that were in the progress notes indicating that the resident displayed behaviors. The RN/UM said those entries were referring to signs and symptoms of *Ex Order 26. 4B1* because the resident was receiving *Ex Order 26. 4B1* , so they were monitoring the resident for symptoms of *Ex Order 26. 4B1* . The surveyor also spoke with the author of those notes, Licensed Practical Nurse #1 (LPN #1), who was regularly assigned to Resident # 190 on the 7 AM to 3 PM shift. LPN # 1 made the same statement; the entries were for signs of *Ex Order 26. 4B1* . Five entries from 10/14/22 to 11/17/22 read: *Ex Order 26. 4B1* Four entries described the behavior as *Ex Order 26. 4B1* and one described the behavior as *Ex Order 26. 4B1* An additional entry dated 12/7/22 at 7:31 AM read, "Behavior Charting: Describe Behavior/Mood: *Ex Order 26. 4B1* . *Ex Order 26. 4B1* . What was the resident doing prior to or at the time of the behavior/mood: Ambulating in the hallway. Interventions attempted: *Ex Order 26. 4B1* , endorsed to 7 to 3 to monitor. Effectiveness of the interventions: *Ex Order 26. 4B1* The Behavior Monitoring and Interventions Report was provided by the Corporate Registered Nurse (CRN), who provided the document to the survey team on 2/3/23 at 1:00 PM. The report showed a behavior noted by the Certified Nursing Assistant (CNA) on 12/12/22 at 7:10 PM. The behavior was *Ex Order 26. 4B1* The surveyor	F 600		

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F 600	Continued From page 17 pointed that out to the CRN, who stated that the resident was [redacted] staff during care. The resident had a care plan in place with a focus that read: *Ex Order 26. 4B1* [redacted] Date initiated *Ex Order 26. 4B1* and revision 10/11/2022." There was also a care plan with a focus that read, "[Resident # 190] has the potential to be *Ex Order 26. 4B1* [redacted]. [Resident # 190] was *Ex Order 26. 4B1* [redacted] to [the resident's] roommate causing *Ex Order 26. 4B1* The date initiated was *Ex Order 26. 4B1*, and the revision was on 1/4/2023. There were no other care plans to address the new NJ Exec. Order 26 4.b.1 behavior displayed on 12/7/22 or the new *Ex Order 26. 4B1* [redacted] behavior displayed on 12/12/22. A Physician's Order Sheet (POS) with orders that read: *Ex Order 26. 4B1* [redacted] The order date was 11/21/22. *Ex Order 26. 4B1* [redacted] The order date was 10/10/22. *Ex Order 26. 4B1* [redacted]. Give *Ex Order 26. 4B1* by mouth at bedtime for *Ex Order 26. 4B1*." The order date was 10/10/22. The medication administration record (eMAR) with an entry that read, 'NJ Exec. Order 26:4.b.1; Resident is on *Ex Order 26. 4B1* every shift Order date 11/21/22." Many *Ex Order 26.* entries indicated a NJ Exec. Order 26:4.b.1 observed, but as the RN/UM stated, they were symptoms of *Ex Order 26. 4B1* [redacted]. A *Ex Order 26. 4B1* [redacted] note dated 12/12/22 read, "Pt (Patient) seen for f/u (follow up) today + *Ex Order 26. 4B1* [redacted]. Pt seen in room. No acute distress. Pt has h/o	F 600		

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F 600		F 600		

Continued From page 18

(history of) Ex Order 26. 4B1 . Staff reports patient's appetite is good. Pt had NJ Exec. Order 26 4.b.1. At times can be seen walking the halls, attends social activities at will. Sleep is good. Energy is good. No evidence of Ex Order 26. 4B1 . No Ex Order 26. 4B1 reported. Staff reports pt with 1 episode of Ex Order 26. 4B1 The diagnosis and plan read: Ex Order 26. 4B1 . 1. Continue Ex Order 26. 4B1 for Ex Order 26. 4B1, which may help the patient's appetite. Appetite improved, NJ Exec. Order 26:4. 2. Continue to monitor mood/behavior and report any changes or concerns to Ex Order 26. 4B1. 3. Continue to engage in group/unit activities. 4. Case discussed with treatment team in collaboration."

The Electronic Medical Record (EMR) for Resident # 98 revealed the following:

An admission record included the following diagnoses; Ex Order 26. 4B1 .

A quarterly MDS dated 12/23/22 revealed that the resident scored a Ex when the Brief Interview for Mental Status was done. This indicated that the resident had Ex Order 26. 4B1 . The MDS also indicated that the resident moved around the facility in a Ex Order 26. 4B1.

A progress note dated 1/4/23 at 5:07 AM read: "Supervisor was called to the resident's room by the primary nurse. I assessed the resident's vital

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F 600	Continued From page 19	F 600		

signs, which were [redacted] and [the resident's] presentation, and contacted 911 for transport to [redacted]." A second progress note dated 1/4/23 at 2:30 PM read, "Writer called JFK medical center for status report on resident, per [hospital employee] the resident will be kept for [redacted] due to [redacted]." A readmission note dated [redacted] at 9:21 PM "Resident arrived via stretcher. Resident was admitted from [redacted]."

A progress note dated 1/20/23 at 3:02 AM read: "12:00 AM resident was found [redacted] and [redacted] initiated, [redacted] was called at 12:03 AM. 12:07 AM MD informed, 12:15 AM [redacted name] POA informed. 12:15 AM paramedic arrived. Resident [redacted]

A progress note dated 1/20/23 at 12:27 AM read: "Supervisor was called to assess the resident. [redacted] initiated by the team. [redacted] placed on the [redacted]. No [redacted] electronic machine. [redacted] detected. No [redacted] assessed. No [redacted] assessed. EMTs arrived at [redacted] physician]."

On 2/1/23 at 12:54 PM, the surveyor spoke with the RN/UM of the unit where Resident # 190 and Resident # 98 resided [redacted].

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F 600	Continued From page 20 The surveyor asked about Resident # 190 and asked why the resident was moved into the secured unit that was kept locked. The RN/UM stated, "I believe because [the resident] was wandering over on [the unit where the resident previously resided]. [The resident] was moved here for security, [Resident # 190] was [redacted]. [Resident #190] was a very quiet [gender], never had any NJ Exec. Order 26:4.b.1. No [redacted]. Most of the time, I saw [Resident #190] [the resident] was [redacted] and walked up and down the hall. The surveyor asked the RN/UM about Resident # 98. The RN/UM stated [Resident #98] would self-propel in the hallway. [Resident #98] would never start anything with anyone. [Resident # 98] might say *Ex Order 26. 4B1* [redacted], but not in an [redacted]." On 2/1/23 at 1:05 PM, the surveyor spoke with LPN #1 of the unit where Resident # 190 and Resident # 98 resided. LPN # 1 stated she was regularly assigned to Resident # 190 and Resident # 98. The surveyor asked LPN # 1 about the incident where Resident # 190 *Ex Order 26. 4B1* Resident # 98. LPN # 1 stated, "I was off on 1/3, but when I returned on 1/4, I received a report from the nurse. I was told there was an incident. They had to send [Resident # 98] out. The surveyor asked LPN # 1 if, prior to that [redacted] by Resident # 190, there had been any incidents where Resident # 190 showed [redacted]. LPN # 1 stated, *Ex Order 26. 4B1* [redacted] The surveyor asked LPN # 1 what Resident # 190 was like, and LPN # 1 responded that [Resident # 190] was *Ex Order 26. 4B1* [redacted] The surveyor asked LPN # 1	F 600		

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F 600	Continued From page 21 what Resident # 98 was like. LPN # 1 said, *Ex Order 26. 4B1* [redacted] The surveyor asked LPN if Resident # 190 and Resident # 98 spoke to each other. LPN # 1 reiterated, *Ex Order 26. 4B1* [redacted] The surveyor asked if Resident # 98 spoke to Resident # 190. LPN # 1 stated, "No, they were barely in the room together. They would get up and be out of the room all day. I never got anything in the report that there was any altercation prior to this or that [Resident # 190] showed any NJ Exec. Order 26 4.b.1 [redacted] at all." On 2/1/23 at 1:12 PM, the surveyor spoke with the Director of the *Ex Order 26. 4B1* [redacted] (DMCU). The surveyor asked why Resident # 190 was moved from the previous unit to the MCU. DMCU stated *Ex Order 26. 4B1* [redacted] The surveyor asked the DMCU about Resident # 98. The DMCU stated [Resident # 98] self-propelled around the unit, NJ Exec. Order 26 4.b.1 [redacted] [Resident # 98] would *Ex Order 26. 4B1* [redacted] into other residents' rooms here and there, [Resident # 98] was NJ Exec. Order 26:4.b.1 [redacted]." The surveyor asked the DMCU if Resident # 190 ever had NJ Exec. Order 26 4.b.1 [redacted] behavior. The DMCU stated *Ex Order 26. 4B* [redacted] The surveyor asked the DMCU about the 12/7/22 *Ex Order 26. 4B1* [redacted] that was written in the progress notes. The DMCU said *Ex Order* [redacted] wasn't aware of it but said it happened with many	F 600		

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F 600	Continued From page 22 residents when they didn't want to do something they were being asked to do. On 2/1/23 at 1:20 PM, the surveyor spoke with Certified Nursing Assistant # 1 (CNA # 1) on the unit where Resident # 190 and Resident # 98 resided. CNA # 1 stated that she had worked at the facility for 21 years, full-time days, and sometimes the two residents were on her assignment. The surveyor asked CNA # 1 if she ever noticed any [NJ Exec. Order 26 4.b.1] between the two residents. CNA # 1 stated, *Ex Order 26. 4B1* [redacted] On 2/2/23 at 12:30 PM, the surveyor interviewed the Registered Nurse (RN) who worked in the MCU on the 3 PM to 11 PM shift on 1/3/23, the evening prior to the assault. The surveyor asked the RN to talk about how Resident # 190 was that evening/night. The RN stated [Resident # 190] walks in the hallway; I don't have any issue with [Ex Order]. [Resident # 190] was ok, they were ok, no problem at all between the two residents. They ate lunch, and they ate dinner. No issue at all. [Resident # 190] was never [NJ Exec. Order 26 4.b.1]." On 2/2/23 at 1:10 PM, the surveyor spoke with CNA #2, who worked the 11 PM to 7 AM shift from 1/3/23 into 1/4/23. CNA # 2 confirmed that she was assigned to Resident # 190 and Resident # 98 the night of the [Ex Order 26. 4B1]. The	F 600		

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F 600	Continued From page 23 surveyor asked CNA # 2 to talk about Resident # 190. CNA # 2 stated, *Ex Order 26. 4B1* [redacted] The surveyor asked if *Ex Order* heard anything after Resident # 190 went into their room. CNA # 2 stated, *Ex Order 26. 4B1* [redacted] The surveyor asked CNA # 2 if *Ex Order* feared Resident # 190. CNA # 2 stated, *Ex Order 26. 4B1* [redacted]	F 600		

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	315122	A. BUILDING _____ B. WING _____	C 02/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WESTFIELD, LLC	**1515 LAMBERTS MILL ROAD WESTFIELD, NJ 07090**

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F 600	Continued From page 24 *Ex Order 26. 4B1* [redacted] On 2/3/23 at 9:00 AM, the surveyor spoke with RN/UM from the unit where Resident # 190 and Resident # 98 resided. The surveyor asked what the process would be if a resident displayed a new NJ Exec. Order 26 4.b.1 behavior. The RN/UM said they would immediately initiate behavior monitoring and develop a care plan for the behavior. The staff had discussed with her the episode of NJ Exec. Order 26 4.b.1 displayed by Resident # 190 on 12/7/22 toward a nurse. She said they called Ex Order 26. 4B, and [Resident # 190] was NJ Exec. Order 26 4.b.1. The *Ex Order 26. 4B1* said to continue monitoring [the resident's] behavior, which they did. She said we would have documented it in the nurse's notes if there were more NJ Exec. Order 26 4.b.1 episodes. When asked if they have a process for behavior monitoring, the UM said they have *Ex Order 26. 4B1* behavior monitoring sheets. [Resident # 190] was already being monitored for symptoms of *Ex Order 26. 4B1* for the use of *Ex Order 26. 4B1*, but added, *Ex Order 26. 4B1* [redacted] On 2/3/23 at 10:05 AM, the surveyor spoke with the family member of Resident # 98. The family member stated, *Ex Order 26. 4B1* [redacted]	F 600		

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F 600	Continued From page 25	F 600		

Ex Order 26. 4B1 [redacted]

On 2/6/23 at 10:15 AM, the surveyor spoke with CNA # 2 again and asked about the doors on the unit. If it was the practice on the unit to keep the residents' doors closed. CNA # 2 stated, *Ex Order 26. 4B1* [redacted] The surveyor asked again about the practice on the units if the doors were kept closed. CNA # 2 stated, *Ex Order 26. 4B1* [redacted] When asked CNA # 2 why *Ex Order* thought no one heard anything. CNA # 2 stated, *Ex Order 26. 4B1* [redacted]

On 2/6/23 at 1:45 PM, the surveyor spoke with LPN # 2, the LPN who found Resident # 98 in bed *NJ Exec. Order 26-4* [redacted] after the *Ex Order 26. 4B1* [redacted]. The surveyor asked LPN # 2 to talk about the *Ex Order 26. 4B1* [redacted] that occurred on

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	315122	A. BUILDING _____ B. WING _____	C 02/13/2023

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F 600	Continued From page 26 1/4/23 by Resident # 190 toward Resident # 98. LPN # 2 stated, *Ex Order 26. 4B1* [redacted] The surveyor asked LPN # 2 if the resident's door was open or closed when she went in. LPN # 2 stated, *Ex Order 26. 4B1* The surveyor asked LPN # 2 why she had gone into the room at that time. LPN # 3 said to give Resident # 98 medication. The surveyor asked LPN # 2 if Resident # 190 displayed NJ Exec. Order 26 4.b.1 in the past. LPN # 2 stated, *Ex Order 26. 4B1* [redacted] The surveyor asked LPN # 2 if she had heard about the Ex Order 26. 4B1 that a CNA documented on 12/12/22 that the resident Ex Or a staff member. LPN # 2 stated, *Ex Order 26. 4B1* [redacted] On 2/3/22 at 10:30 AM, the surveyor reviewed the facility's policy and procedure titled "Abuse Prevention Program," with the most recent "reviewed" date of 1/2023. Under "Policy Interpretation and Implementation-As part of the resident abuse prevention, the administration will: "Number 1. read "Protect our residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives,	F 600		

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F 600	Continued From page 27	F 600		

friends, visitors, or any other individual." Number 4. reads, "Require staff training/orientation programs that include such topics as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior."

On 2/3/23 at 11:30 AM, the surveyor reviewed the facility's policy and procedure dated 12/12/2022 titled "Behavior Management: Interventions and Monitoring." Number 1 read: "Observe patients for early signs of withdrawal/decreased social interaction, frustration, agitation, and anger such as physical behavior symptoms directed toward others, verbal, behavioral symptoms directed toward others, and other behavioral symptoms not directed toward others." Bullet point number four under Number 5 read: "Initiate changes in care approaches and update care plan as indicated."

The IJ was identified on 2/3/23; the LNHA was notified of the IJ and provided with the IJ template on 2/3/23 at 12:23 PM. A removal plan was received the same day at 4:28 PM, which included the following: The Assistant Director of Nursing will educate staff on behavior monitoring, documentation, and care plan initiation during new hire orientation and yearly. All nursing and recreation staff are being educated on behavior monitoring, documentation, and care plan initiation, which will be done annually and as needed upon hire. Education has been initiated today, 2/3/23, and all shifts will be captured until it is completed on 2/6/23. Anyone not receiving the training will be trained prior to the beginning of their shift. Any resident with new documented behavior will have a formal behavior documentation monitoring process, and a care

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	315122	A. BUILDING _____ B. WING _____	C 02/13/2023

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F 600	Continued From page 28 plan will be initiated/updated. All residents with new behaviors will be addressed immediately to prevent any resident-to-resident altercation. The team will conduct a full assessment and initiate interventions to include behavior monitoring, update the care plan, and notify the primary care physician and the family. The clinical team will review the progress notes Monday through Friday during the morning meeting for three months, then monthly for three months. Any noted behaviors will be cross-referenced to ensure that the behavior monitoring documentation and the care plan are updated with appropriate interventions. The implementation of the removal plan was verified by the survey team on-site on 2/6/23 through observations, interviews, and a review of in-service education.	F 600		
F 695 SS=D	NJAC 8:39-4.1 (a) 5 Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including *Ex Order 26. 4B1* and *Ex Order 26. 4B1*. The facility must ensure that a resident who needs respiratory care, including *Ex Order 26. 4B1* and *Ex Order 26. 4B1*, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to implement *Ex Order 26. 4B1* measures for the	F 695	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN	2/17/23

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F 695	Continued From page 29 handling and storage of respiratory equipment for 1 of 2 residents reviewed for NJ Exec. Order 26:4.b.1, Resident #36. This deficient practice was evidenced by the following: 1. On 1/20/23 at 11:00, the surveyor spoke with Resident #36 who stated Ex Order had lived there for about a year and used at *Ex Order 26. 4B1* to communicate with the surveyor. The resident expressed concerns about her *Ex Order 26. 4B1*. On 2/3/23 at 9:11 AM, the surveyor began the observation of *Ex Order 26. 4B1* by the Licensed Practical Nurse (LPN) for Resident #36. At 9:30 AM, the surveyor observed the LPN prepare her supplies that included, *Ex Order 26. 4B1* Clean and Care kit that contained the following: -one pair of gloves -two hydrogen peroxide -one towel -two applicators -one *Ex Order 26. 4B1* -one twill tape -one drain sponge -four gauze sponges -one *Ex Order 26. 4B1* At 9:42 AM, the LPN confirmed with the surveyor she was ready to perform the *Ex Order 26. 4B1*. At 9:44 AM, the surveyor observed the LPN pick up the gauze and opened the *Ex Order 26. 4B1* and was about to administer *Ex Order 26. 4B1*. At that time the surveyor asked to speak with the LPN. The LPN identified the *Ex Order 26. 4B1*	F 695	AFFECTED BY THE PRACTICE The expired *Ex Order 26. 4B1* was removed from the room of resident #36 and disposed of. Central supply and all areas were checked to ensure dates on kits comply. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by this deficient practice 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR A) Licensed nursing staff, Respiratory staff and central supply were educated to check all medications and other medication supplies including NJ Exec. Order 26:4.b.1, for expiration date before use or placed in resident room. B) Nursing staff will be educated upon hire, annually and as needed. C) Director of Nursing and or designee will conduct audits weekly x 4 weeks then monthly X 3 months of medications and other medical supplies, including NJ Exec. Order 26:4.b.1 for expiration dates and discard if expired. 4. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR	

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F 695	Continued From page 30 expiration date which was 5/8/22 and confirmed she was about to use the expired item. At 9:49 AM, outside the resident's room, the LPN stated she should have checked the expiration date of the *Ex Order 26. 4B1* before entering the resident's room. She also stated that expired *Ex Order 26. 4B1* was no longer sterile. 2. On 2/3/23 at 10:51 AM, the surveyor and the LPN/Unit Manager entered resident #36's room to observe the stocked *Ex Order 26. 4B1* at bedside. At that time the surveyor and LPN/UM observed one *Ex Order 26. 4B1* that expired on 5/31/22. At 10:52 AM, the surveyor and LPN/UM exited the resident's room. During an interview with the surveyor, the LPN/UM stated the nurse should have checked the *Ex Order 26. 4B1* stored in the resident's room. The LPN/UM confirmed that *Ex Order 26. 4B1* is a sterile technique that required all items in the *Ex Order 26. 4B1* to be within date. The LPN/UM stated that the expectation was that all nurses checked all items stored and prior to start of care. According to the admission record, Resident #36 was admitted to the facility with diagnosis that included *Ex Order 26. 4B1* . A review of the most recent Minimum Data Set (MDS), an assessment tool used to facilitate residents care, dated 12/11/22, revealed a Brief Interview for Mental Status (BIMS) of [redacted]/15 which indicated Resident # 36 was *Ex Order 26. 4B1* . The MDS also revealed the received *Ex Order 26. 4B1* within the past 14 days.	F 695	Director of Nursing and or designee will conduct audit of medications and other medical supplies including [redacted] y supplies, for expiration dates and discard if expired. Weekly x 4 weeks then monthly X 3 months. Result of audit will be reported to the administrator at the QAPI meeting monthly X 3 months then quarterly x 6 months. 5. Administrator will ensure compliance and facility is in compliance as of 2/17/2023.	

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	315122	A. BUILDING _____ B. WING _____	C 02/13/2023

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F 695	Continued From page 31 A review of the Care Plan included, keep extra *Ex Order 26. 4B1* at bedside. A review of the current Order Summary Report revealed physician orders for change Ex Order 26. and NJ Exec. Order 26:4.b.1 and at every day shift. On 2/8/23 at 10:56 AM, the surveyor, in the presence of the survey team spoke with the Director of Nursing, Regional Nurses, and the Licensed Nursing Home Administrator (LNHA) about the concern with the expired Ex Order 26. 4B1 dated 5/22. The LNHA confirmed the Unit Manager replaced all items and a new order was added to change NJ Exec. Order 26:4.b.1 every night shift, every Monday after surveyor inquiry. A review of the facility provided policy, *Ex Order 26. 4B1* with a reviewed date of 12/2022 included: Purpose: This policy is to instruct how to effectively clean a patient's *Ex Order 26. 4B1* and surrounding area to reduce the risk of infection and maintain patent airway. Overview: 2. Each trach resident should have a spare back up NJ Exec. Order 2 at the bedside for emergency reinsertion. Procedure for Changing Disposable Ex Order 26. : 9. Moisten the new *Ex Order 26. 4B1* with sterile water or *Ex Order 26. 4B1* . This will facilitate insertion.	F 695		
F 755 SS=E	NJAC 8:39-19.4 (a), 27.1(a), 29.2(d), 29.4(g) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		2/17/23

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	315122	A. BUILDING _____ B. WING _____	C 02/13/2023

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F 755	Continued From page 32 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in 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 nursing staff failed to ensure a) each prescription medication had a pharmacy label affixed with the resident's name and prescribing information; b) medication	F 755	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE A)2 unopened 2 ml. vials of Ondansetron	

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	315122	A. BUILDING _____ B. WING _____	C 02/13/2023

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F 755	Continued From page 33 containers were labeled with the open date; c) an expired biological was removed from active inventory for an unsampled resident (Resident #141); d) expired medications were removed from active inventory. The deficient practice was observed in 4 of 4 nursing units and evidenced by the following. 1. On 02/03/23 at 1:35 PM the surveyor inspected the Jefferson Unit Medication Cart #2 in the presence of the unit Registered Nurse (RN #1). The surveyor observed 2 unopened 2 ml. vials of Ondansetron (Zofran) 4 mg/2 ml. The vials did not have pharmacy labels or dispensing bags. RN #1 stated all prescription medications should be labeled with the resident name and pharmacy information. RN #1 stated she did not know who placed the unlabeled medication in the medication cart. RN #1 removed the medication from the cart. 2. On 02/03/23 at 2:00 PM the surveyor inspected the Jefferson Unit medication storage room and medication refrigerator in the presence of the Unit Manager (UM #1). The surveyor observed 1 Mantoux (tuberculin purified protein derivative) Tubersol multidose 1 ml. opened and undated vial. The vial was stored in the pharmacy box dated with an open date of 02/01/23. The UM #1 stated the vial should have been dated when opened in addition to dating the box. 3. On 2/3/23 at 10:21 AM, the surveyor began the inspection of the non- controlled portion of	F 755	(Zofran) 4 mg/2 ml (House stock) were removed from medication cart and discarded. B)1 Mantoux (tuberculin purified protein derivative) Tubersol multidose 1 ml. (House Stock) opened and undated vial was removed from refrigerator and discarded. C)Unopened bottle of Lantus with Pharmacy date of 11/01/2022 for Resident #141 was removed from Cart 1 and discarded. D) Vitamin D3 10 microgram (mcg) Expiration 9/22; Vitamin E 400 international units (IU) Expiration 9/22; Zinc 50 mcg Expired 10/22 Were removed from cart #2 and discarded. E) Basaglar insulin pen that was open and undated with date on the bag 1/27 was removed and discarded. Facility ordered insulin through our pharmacy for the resident. F) 2 Lantus insulin pens, without pharmacy label or bag was removed and discarded with consent of resident. G) 2 bottles of Humulin R insulins without label and opened dated vial in the refrigerator were all discarded. H) Facility did order insulin through our pharmacy for the resident. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE	

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F 755	Continued From page 34 Hamilton Cart One in the presence of Licensed Practical Nurse LPN #1. The surveyor and LPN #1 observed an expired, unopened bottle of Lantus Insulin 10 milliliter (ml; a medication used to control high blood sugar levels in the blood) with a pharmacy labeled date of 11/1/22 for Unsampled Resident #141's name. LPN #1 confirmed the seal was not broken on the bottle. At that time, the surveyor and LPN #1 reviewed the Lantus package that had a cautionary label, "Refrigerate until opened". Further review of the Lantus package revealed the "date opened" label was left blank. The resident's label revealed the pharmacy dispense date of 11/1/22. LPN #1 stated the Lantus bottle should have been refrigerated until its intended use because unopened Lantus at room temperature must be discarded after 28 to 30 days. LPN #1 stated, the Lantus had been in the cart for 90 days and if administered after the expiration date, the medication would not have been effective to lower the Unsampled Resident's blood sugar level. A review of the manufacturer's specifications for Lantus under section 16.2 Storage reflected, "Store unused Lantus in a refrigerator between 36 degrees Fahrenheit (F) and 46 degrees F (2 degrees Celsius (C) and 8 degrees C)" ...10 ml multiple-dose vial not in-use (unopened) stored in room temperature (up to 86 degrees F) are in date for 28 days. 4. At 2:17 PM, the surveyor began the inspection of the Madison/Homestead Cart 2, in the presence of LPN #2 and observed the following items: -Vitamin D3 10 microgram (mcg) expired 9/22 -Vitamin E 400 international units (IU) expired	F 755	SAME DEFICIENT PRACTICE: All residents have the potential to be affected by this deficient practice 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR A) Licensed nursing staff were educated, and education will be done upon hire, annually and as needed. The education provided includes the information that resident prescription medication must have pharmacy label with resident name. Medication container labels or multi-dose vials consist of the open date and are stored in the original packaging, containers, or dispensing system in which they were received. Expired, discontinued medications and biologics are to be removed from medication cart or storage areas and disposed of as per state guidelines. Medications are to be stored at appropriate temperature in accordance with pharmacy and manufacturers recommendation. B) Unit manager or designees will check medication carts, medication refrigerators and storage rooms for undated or expired meds and proper storage of medications, daily. 4. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR	

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	315122	A. BUILDING _____ B. WING _____	C 02/13/2023

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F 755	Continued From page 35 9/22 -Zinc 50 mcg expired 10/22 At that time, LPN #2 stated that expired medications should not have been present with the active inventory. LPN #2 also stated "the residents who could have received the expired medication would not receive the full effect or full benefit of the medication". The regular nurse on this cart should have frequently checked to ensure all medications were in-date. 5. On 2/03/23 at 1:29 PM the surveyor inspected medication cart # 2 on the Washington Unit in the presence of LPN # 3. Inside of the cart there was one Basaglar insulin pen that was open and undated. The date on the bag holding the pen was 1/27. LPN # 3 confirmed that the pen was being used. According to manufacturer specifications once open Basaglar insulin pens should be discarded after 28 days, even if there is still insulin left in the pen. 6. On 2/03/23 at 1:45 PM the surveyor inspected the second cart #1 on the Washington Unit in the presence of LPN # 4. Inside of that cart there were two Lantus insulin pens. One insulin pen had a resident's last name, first intitial, and the date, 1/30/23, written on it with a black marker. The second insulin pen had the same resident's last name and first intitial written on it with black marker and no date. There was no pharmacy label or bag to hold the insulin pens. The LPN/UM came over to the cart and explained that the resident ordered the insulin pens, received the insulin pens and gave them to the nurse on duty. when they were delivered. The resident ordered through a mail order pharmacy. The resident was a private pay resident and ordered the insulin	F 755	Unit Manager or designee will audit cart, refrigerator, storage room for undated, expired, and unlabeled medications and proper storage of medications weekly x 4 then monthly x 3 Months. Results will be reported to the Director of Nursing and the Administrator at the monthly QAPI meeting x 3 months then Quarterly x 6 months. 5. Administrator will ensure compliance and facility is in compliance as of 2/17/2023	

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	315122	A. BUILDING _____ B. WING _____	C 02/13/2023

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F 755	Continued From page 36	F 755		

pens from an outside pharmacy because it costed less than getting it from the facility's pharmacy. According to manufacturer specifications once open Lantus insulin pens should be discarded after 28 days following the first use.

7. On 2/3/23 at 1:55 PM the surveyor inspected the medication refrigerator on the Washington unit in the presence of LPN # 3. Inside of the refrigerator there was a vial of Humulin R insulin that was open and dated 2/3/23. The vial was not in a bag and had no pharmacy label attached to it. LPN # 3 confirmed that it should have been in the cart and it should have had a pharmacy label on it. Additionally, there was one unopened vial of Humulin R insulin with no pharmacy label attached to it.

On 2/8/23 at 10:56 AM, the surveyor, in the presence of the survey team spoke with the Director of Nursing (DON), Regional Nurses, and the Licensed Nursing Home Administrator (LNHA) about the above concerns. The DON stated education was being given to the nurses for medication storage and medication cautionary after surveyor inquiry.

A review of facility provided policy, Medication Storage reviewed 11/22 included:
Policy: The facility shall store all medications and biologicals in a safe, secure, and orderly manner.
1. Medications and biologicals shall be stored in the packaging, containers, or other dispensing systems in which they are received.
5. Expired, discontinued and/or contaminated medications will be removed from the medication storage areas and dispose as per State guidelines.

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	315122	A. BUILDING _____ B. WING _____	C 02/13/2023

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F 755	Continued From page 37 6. Medications will be stored are the appropriate temperature in accordance with pharmacy and manufacturer labeling.	F 755		
F 759 SS=D	NJAC 8:39- 29.2 (d); 29.4 (a)8, (b)2, (f) (g) Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; 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 all medications were administered without error of 5% or more. During the medication observation conducted on 2/9/23, the surveyor observed four nurses administer medications to six residents. There were 29 opportunities, and two errors were observed which resulted in a medication error rate of 6.9%. This deficient practice was identified for one of six residents, that was administered by one of four nurses. This deficient practice was evidenced by the following: On 2/7/23 at 8:47 AM, the surveyor observed the Certified Nurse Assistant (CNA) inform the Licensed Practical Nurse (LPN) that Resident #47 was in Ex Order 2. At 8:55 AM, the surveyor observed the LPN	F 759	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE Resident # 47 was assessed, and no adverse effects were noted. The MD was notified of the medication error concerning *Ex Order 26. 4B1*, there were no new orders. The LPN who administered the *Ex Order 26. 4B1* as indicated was educated on administering medications as prescribed. Licensed nursing staff were educated on medication administration. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents have the potential to be affected by this deficient practice.	2/17/23

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	315122	A. BUILDING _____ B. WING _____	C 02/13/2023

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F 759	Continued From page 38 prepare medications for Resident #47. The medications included the following: -Ex Order 26. 4B1 , 1 tablet Ex Order 26. 4B1 , 1 tablet -Ex Order 26. 4B1 -Ex Order 26. 4B1 -Ex Order 26. 4B1 , 1 tablet -Ex Order 26. 4B1 , Ex Order 26. 4B1 -Ex Order 26. 4B1, 1 tablet -Ex Order 26. 4B1 , 1 tablet -Ex Order 26. 4B1 , 1 tablet At 9:31 AM, the surveyor observed the LPN administer the medications to Resident #47. The LPN also stated the resident was NJ Exec. Order 26 4.b.1. At that time, the LPN stated she had not observed any meal trays in the room. At 9:38 AM, the LPN stated she was unable to administer the order for NJ Exec. Order 26:4.b.1 because the CNA had not reported the percentage of Resident #47's meal intake and it was not documented on the electronic Medication Administration Record (eMAR). At that time, the surveyor and LPN reviewed the eMAR that reflected an order for: Ex Order 26. 4B1 after meals for variable intake at meals. Ex Order 26. 4B1 can after meals if Ex Order 26. 4B1 of meals; Ex Order 26. 4B1 if administered), UP at 9am/1pm/and 6pm, Ex Order 26. 4B1 if administered. At 9:40AM, the LPN confirmed with the CNA the percentage of meal intake for Resident #47. The LPN informed the surveyor that Resident #47 ate	F 759	3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR a))Licensed nursing staff are educated on medication administration, administering medication in a safe and timely manner, following orders as prescribed or written and following all precautionary recommendations for each medication. b)Licensed nursing staff will have competency on medication administration upon hire, annually and as needed. Unit Managers will review one random electronic medication administration record daily that it was administered in a safe and timely manner, as prescribed and follow up with nurses as needed. 4. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR Assistant director of Nursing or designee will complete 2 random medication administration evaluation that it was administered in a safe and timely manner, as prescribed weekly x 4 weeks then 2 medication administration evaluation monthly x 3 months. The result will be reported to the Director of Nursing and Administrator at the QAPI meeting monthly x 3 months then quarterly x 6 months. 5. Administrator will ensure compliance and facility is in compliance as of 2/17/2023	

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F 759	Continued From page 39 their whole meal which was delivered sometime between 7:00 AM and 8:00 AM. According to the admission record, Resident #47 was admitted to the facility with diagnosis that included, encounter for attention to *Ex Order 26. 4B1* [redacted]. A review of the Order Summary report reflected orders that included: -*Ex Order 26. 4B1* [redacted] give *Ex Order 26. 4B1* [redacted] before meals for *Ex Order 26. 4B1* [redacted] -*Ex Order 26. 4B1* [redacted] give 1 tablet via *Ex Order 26. 4B1* two times a day for *Ex Order 26. 4B1* [redacted] During a follow up interview, on 2/7/23 at 12:48 PM, the surveyor and the LPN reviewed Resident #47's eMAR for *Ex Order 26. 4B1*. The LPN stated, she should have administered the *Ex Order 26. 4B1* at 7:30 AM since the medication was to prevent the *Ex Order 26. 4B1*. The surveyor and the LPN reviewed the cautionary label on the *Ex Order 26. 4B1* bottle which reflected, Take this medicine ½ hour before a meal ...	F 759		

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F 759	Continued From page 40 At that time, the surveyor and LPN reviewed the manufacturer specification label attached to the *Ex Order 26. 4B1* . The administration instruction revealed, administer 10 to 60 minutes prior to eating and drinking. The LPN confirmed both medications were not administered prior to eating and drinking as indicated. The LPN acknowledged that giving both medications at the wrong time resulted in its ineffectiveness. On 2/8/23 at 10:56 AM, the surveyor, in the presence of the survey team spoke with the Director of Nursing (DON), Regional Nurses, and the Licensed Nursing Home Administrator (LNHA) about the above concerns. The DON stated education was being given to the nurses for medication administration and medication cautionary after surveyor inquiry. A review if the facility provided policy, Administering Medication updated 10/22 included: Policy Statement, Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation 2. Medications must be administered in accordance with the orders, including any required time frame. 3. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). N.J.A.C. 8:39-29.2 (d)	F 759		
F 880 SS=E	Infection Prevention & Control	F 880		3/15/23

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F 880	Continued From page 41 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §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	F 880		

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F 880	Continued From page 42 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Complaint NJ# 00160615, 00160518 Based on observation, interview, and record review, it was determined that the facility failed to follow appropriate measures to prevent and control the spread of infection for failure to properly wear personal protective equipment. The deficient practices were evidenced by the following:	F 880	Brief Narrative Description of Event (include time line if available): Deficient practices for Infection control, specifically relating to personal protective equipment was noted by survey team for 4 staff members including Social Worker, 2 food service workers and a CNA. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN	

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	315122	A. BUILDING _____ B. WING _____	C 02/13/2023

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F 880	Continued From page 43 On 1/30/23 at 11:00 AM, the surveyor observed the facility's Social Worker (SW) in the foyer near the receptionist with her N95 mask not covering her nose or mouth and there were three resident's present in the foyer at this time. At 11:05 AM, the surveyor interviewed the SW, who stated that she should have been wearing the N95 mask over her nose and mouth in the foyer and in all resident areas. At 11:15 AM, during the kitchen tour, in the presence of the Account Manager (AM), the surveyor observed two Food Service Workers with masks on that were not covering their noses. The AM stated that all the staff should be wearing a mask completely covering their nose and mouth. At 12:05 PM, the surveyor observed a Certified Nursing Assistant (CNA) in a resident's room with her surgical mask off of her nose and had a conversation with both residents who resided in that room. The CNA walked out of the room with her mask still off of her nose. At 12:10 PM, the surveyor interviewed the CNA who stated that she was having difficulty breathing but should have been wearing the face mask over her nose and mouth. On 2/01/23 at 12:20 PM, the surveyor interviewed the facility's Infection Preventionist, who stated that the facility policy is that staff should wear a mask covering their nose and mouth. Review of the facility's policy titled "Use of Personal Protective Equipment Utilized by Cohort" dated 5/20/2022, revealed that in a negative cohort, the minimal personal protective equipment worn is a surgical mask.	F 880	AFFECTED BY THE PRACTICE On 1/30/23 Employees SW, AM food service workers, and CNA were educated on [redacted] and why face mask must be worn to prevent transmission of [redacted]. A walk through and observation of other employees was done to ensure that employees are wearing face masks correctly. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents have the potential to be affected by this deficient practice. Root Causes and Contributing Factors: A Root Cause Analysis has been conducted by the Infection Preventionist with the assistance of the facility Quality Assurance and Performance Improvement committee and the facility Governing body. Certified Nursing Assistant, Social Worker and the food service workers that were identified by Department of Health Survey team on January 30, 2023 for deficient practice relating to personal Protective equipment, have been disciplined and a 1:1 education of facility mask wearing policy was completed. Review of facility education and auditing was conducted by facility management team and Root cause of this deficient practice can be attributed to 1) A lack of follow through by Social worker, 2 food service workers and CNA on education provided related to facility policy and procedures for PPE use 2) an insufficient education of staff on PPE policy and	

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F 880	Continued From page 44 NJAC 8:39-19.4 (a)	F 880	procedures 3) Insufficient amount of frontline auditing of employees and on the spot education of facility policy for PPE use and follow up education and disciplinary action if and when a deficient practice is identified. Team members including but was not limited to Asher Jacobs, LNHA, Administrator; Connie Opoku, RN, Director of Nursing; Dr Joseph Schulman, Medical Director; Gibril Sandy, RN,ADON/ Nurse Educator; Shanique Williams, LPN, Infection Preventionist; Rachel Thomas, Housekeeping Supervisor; Regina Chatman, Unit Manager; Sylvan Staples, Unit Manager; Jonathan Gutierrez, Unit Manager; Monina Abella, RN Supervisor; Ernest Kumi, RN Supervisor; Audrey Williams, CNA – Staffing Coordinator; William Roberts, Porter, Tamika Parrot, CNA, Sherley Cantave, RN Supervisor, Ruby Codjoe, RN Supervisor, Bentzy Davidowitz, Regional Director of Operations, Bal Grewal, VP of clinical services. Corrective Action Plans For each root cause identified, enter the corrective action plans intended to prevent the root cause from causing another harmful event. There can be more than one action plan for each root cause. Some action plans may be short-term interventions which can be accomplished quickly and some action plans require more long-term implementation steps. For each action plan designate the individual or group responsible for completing the	

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F 880	Continued From page 45	F 880	action and the time frame for completion: A) Root Cause: A lack of follow through by Social worker, 2 food service workers and CNA on education provided related to facility policy and procedures for PPE use. Corrective Action/s: Disciplinary action and follow up 1:1 Education provided on facility policy and procedures for mask wearing. Responsible individual: Director of Nursing, Food service Director, Administrator, Infection Preventionist B) Root Cause: an insufficient education of staff on PPE policy and procedures Corrective Action/s: A)Facility staff will be reeducated on facility mask wearing policy B) the following education will be provided as per the Directed Plan of Correction (DPOC) i)Nursing Home Infection Preventionist Training Course - Module 1 - Infection Prevention & Control Program to be provided to Topline staff and Infection Preventionist ii)CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID-19 Out! Provided To Frontline staff including social work staff and food service staff. iii)CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Use	

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F 880	Continued From page 46	F 880	PPE Correctly for COVID-19, Provided to Frontline staff including social work staff and food service staff. iv)Nursing Home Infection Preventionist Training Course - Module 5 –Outbreaks Provided to all staff including topline staff and infection preventionist v)Nursing Home Infection Preventionist Training Course - Module 6A – Principles of Standard Precautions Provided to All staff including topline staff and infection preventionist vi) Nursing Home Infection Preventionist Training Course Module 6B - Principles of Transmission Based Precautions to all staff including topline staff and infection preventionist Responsible individual: Director of Nursing Infection Preventionist Administrator Root Cause: Insufficient amount of frontline auditing of employees and on the spot education of facility policy for PPE use and follow up education and disciplinary action if and when a deficient practice is identified Corrective Action/s: Infection Preventionist or Designee will conduct Random observation audits for proper mask wearing have been instituted and is being conducted on random employees 3 X a week for 4 weeks, then 2 X a week for 4 weeks, then weekly for 4 weeks ; to ascertain the proper wearing of face mask by staff. The results of the audit will be documented on the face	

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F 880	Continued From page 47	F 880	mask audit tool. The infection Preventionist or Designate will present the findings of the audits to the administrator at the QAPI committee meeting X 6 months. Responsible individual: Director Of Nursing Infection Preventionist Facility is in compliance with F880 and with the DPOC as of 3/15/2023	

New Jersey Department of Health

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	062013	A. BUILDING: _____ B. WING _____	C 02/13/2023

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COMPLETE CARE AT WESTFIELD, LLC	1515 LAMBERTS MILL ROAD WESTFIELD, NJ 07090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #NJ00158684 Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18	S 560	1) a) Center staffing ratios as required by NJDOH were communicated to staffing coordinator and all Nurse managers and supervisors to match ratios of 1:8 on day shift; 1:10 on evening shift and 1:14 on night shift b) Center staffing schedule ratios are developed, reviewed and posted two weeks prior to utilization to comply with required staffing ratios. c) Administrator, DON and Staffing Coordinator meet every morning to go over daily staffing sheets and look ahead at copies of projected schedule of the next two weeks to ensure required staffing ratios. d) DON, Administrator and staffing	2/28/23

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

Electronically Signed | 03/01/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062013	A. BUILDING: _____ B. WING _____	C 02/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WESTFIELD, LLC	1515 LAMBERTS MILL ROAD WESTFIELD, NJ 07090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties, and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than	S 560	coordinator meet weekly to review the 4 week master schedule to ensure facility has staff that meets the needs. 2) All residents have potential to be affected by the same deficit practice. 3) a) If staffing deficits on master staffing schedule are identified, Center will communicate all unfilled shifts to in-house staff for coverage. b) Center will continue external recruitment efforts to fill open positions and review and revise as necessary c) Center will maintain multiple contacts with staffing agencies to meet required staffing ratios and review as necessary d) Center will continue to offer bonus structure to incentivize staff to fill shifts if needed and revise as necessary. e) Center will continue to make efforts to retain staff by way of employee engagement events. 4) a) Center Staffing Coordinator will review projected census and staffing ratio to assure staffing compliance. b) Administrator, DON, and Staffing Coordinator will continue to meet daily to go over projected staffing to assure required staff ratios. c) If ratios are projected to not be met, Center will post openings for in-house staff as well as contact contracted agencies to maintain staffing compliance. d) DON/Staffing Coordinator will conduct daily staffing audits for two weeks and bi-weekly for two months. e) Results of the audits will be presented to the monthly QAPI meetings for review and revision as deemed appropriate. 5) Interventions for compliance with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062013	A. BUILDING: _____ B. WING _____	C 02/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WESTFIELD, LLC	1515 LAMBERTS MILL ROAD WESTFIELD, NJ 07090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks of 1/15/23 and 1/22/23 for the 2/13/23 standard survey revealed the following. The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -01/15/23 had 18 CNAs for 194 residents on the day shift, required 24 CNAs. -01/16/23 had 19 CNAs for 194 residents on the day shift, required 24 CNAs. -01/17/23 had 21 CNAs for 194 residents on the day shift, required 24 CNAs. -01/18/23 had 23 CNAs for 194 residents on the day shift, required 24 CNAs. -01/19/23 had 20 CNAs for 200 residents on the day shift, required 25 CNAs. -01/20/23 had 20 CNAs for 198 residents	S 560	S560 are in place as of 2/28/2023. Administrator to monitor staffing post to see what happened and pre via measures listed above for ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062013	A. BUILDING: _____ B. WING _____	C 02/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WESTFIELD, LLC	**1515 LAMBERTS MILL ROAD WESTFIELD, NJ 07090**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3 on the day shift, required 25 CNAs. -01/21/23 had 16 CNAs for 193 residents on the day shift, required 24 CNAs. -01/22/23 had 18 CNAs for 190 residents on the day shift, required 24 CNAs. -01/23/23 had 21 CNAs for 190 residents on the day shift, required 24 CNAs. -01/24/23 had 20 CNAs for 190 residents on the day shift, required 24 CNAs. -01/25/23 had 18 CNAs for 190 residents on the day shift, required 24 CNAs. -01/26/23 had 21 CNAs for 195 residents on the day shift, required 24 CNAs. -01/27/23 had 16 CNAs for 194 residents on the day shift, required 24 CNAs. -01/28/23 had 17 CNAs for 193 residents on the day shift, required 24 CNAs. On 2/13/23 at 2:15 p.m. the surveyor informed the Director of Nursing and the Licensed Nursing Home Administrator of the shifts when the minimum direct care staff to resident ratio was not met.	S 560		

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
315122 Y1	A. Building B. Wing Y2	3/21/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WESTFIELD, LLC	1515 LAMBERTS MILL ROAD WESTFIELD, NJ 07090

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 E0001 Reg. # 483.73 LSC	Correction Completed 02/28/2023	ID Prefix E0015 Reg. # 483.73(b)(1) LSC	Correction Completed 02/28/2023	ID Prefix E0041 Reg. # 483.73(e) LSC	Correction Completed 02/28/2023
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 2/13/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315122 Y1	A. Building B. Wing Y2	3/21/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WESTFIELD, LLC	1515 LAMBERTS MILL ROAD WESTFIELD, NJ 07090

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550 Reg. # 483.10(a)(1)(2)(b)(1)(2) LSC	Correction Completed 02/17/2023	ID Prefix F0600 Reg. # 483.12(a)(1) LSC	Correction Completed 02/15/2023	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 03/15/2023
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	
2/13/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315122 Y1	A. Building B. Wing Y2	3/21/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WESTFIELD, LLC	1515 LAMBERTS MILL ROAD WESTFIELD, NJ 07090

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 F0550	Correction	ID Prefix F0600	Correction	ID Prefix F0695	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.12(a)(1)	Completed	Reg. # 483.25(i)	Completed
LSC	02/17/2023	LSC	02/15/2023	LSC	02/17/2023
ID Prefix F0755	Correction	ID Prefix F0759	Correction	ID Prefix F0880	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(f)(1)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	02/17/2023	LSC	02/17/2023	LSC	03/15/2023
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	
2/13/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062013	A. BUILDING: _____ B. WING _____	R-C 03/21/2023

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COMPLETE CARE AT WESTFIELD, LLC	1515 LAMBERTS MILL ROAD WESTFIELD, NJ 07090

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{S 000}	Initial Comments An onsite revisit was conducted on 3/21/2023 to verify the POC regarding the 2/13/2023 re-licensed survey. The facility was not in compliance.	{S 000}		
{S 560}	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff	{S 560}	1) a) Center staffing ratios as required by NJDOH were communicated to staffing coordinator and all Nurse managers and supervisors to match ratios of 1:8 on day shift; 1:10 on evening shift and 1:14 on night shift b) Center staffing schedule ratios are developed, reviewed and posted two weeks prior to utilization to comply with required staffing ratios. c) Administrator, DON and Staffing Coordinator meet every morning to go over daily staffing sheets and look ahead at copies of projected schedule of the next two weeks to ensure required staffing ratios. d) DON, Administrator and staffing coordinator meet weekly to review the 4 week master schedule to ensure facility has staff that meets the needs. 2) All residents have potential to be affected by the same deficit practice. 3) a) If staffing deficits on master staffing	3/31/23

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

Electronically Signed | 04/03/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062013	A. BUILDING: _____ B. WING _____	R-C 03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{S 560}	Continued From page 1 -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties, and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift	{S 560}	schedule are identified, Center will communicate all unfilled shifts to in-house staff for coverage. b) Center will continue external recruitment efforts to fill open positions and review and revise as necessary c) Center will maintain multiple contacts with staffing agencies to meet required staffing ratios and review as necessary d) Center will continue to offer bonus structure to incentivize staff to fill shifts if needed and revise as necessary. e) Center will continue to make efforts to retain staff by way of employee engagement events. 4) a) Center Staffing Coordinator will review projected census and staffing ratio to assure staffing compliance. b) Administrator, DON, and Staffing Coordinator will continue to meet daily to go over projected staffing to assure required staff ratios. c) If ratios are projected to not be met, Center will post openings for in-house staff as well as contact contracted agencies to maintain staffing compliance. d) DON/Staffing Coordinator will conduct daily staffing audits for two weeks and bi-weekly for two months. e) Results of the audits will be presented to the monthly QAPI meetings for review and revision as deemed appropriate. 5) Interventions for compliance with S560 are in place as of 3/31/2023. Administrator to monitor staffing post to see what happened and pre via measures listed above for ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{S 560}	Continued From page 2 begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks of 3/5/23 and 3/12/23 for the 3/21/23 revisit survey which revealed the following: The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -03/05/23 had 17 CNAs for 186 residents on the day shift, required 23 CNAs. -03/06/23 had 19 CNAs for 186 residents on the day shift, required 23 CNAs. -03/07/23 had 17 CNAs for 186 residents on the day shift, required 23 CNAs. -03/08/23 had 17 CNAs for 186 residents on the day shift, required 23 CNAs. -03/09/23 had 19 CNAs for 186 residents on the day shift, required 23 CNAs. -03/10/23 had 18 CNAs for 185 residents on the day shift, required 23 CNAs. -03/11/23 had 16 CNAs for 185 residents on the day shift, required 23 CNAs. -03/12/23 had 17 CNAs for 185 residents on the day shift, required 23 CNAs. -03/13/23 had 20 CNAs for 186 residents on the day shift, required 23 CNAs. -03/14/23 had 18 CNAs for 186 residents on the day shift, required 23 CNAs.	{S 560}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062013	A. BUILDING: _____ B. WING _____	R-C 03/21/2023

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{S 560}	Continued From page 3 -03/15/23 had 17 CNAs for 186 residents on the day shift, required 23 CNAs. -03/16/23 had 19 CNAs for 186 residents on the day shift, required 23 CNAs. -03/17/23 had 17 CNAs for 186 residents on the day shift, required 23 CNAs. -03/18/23 had 17 CNAs for 186 residents on the day shift, required 23 CNAs. On 3/21/23 at 1:15 p.m. the surveyor informed the Director of Nursing and the Licensed Nursing Home Administrator of the shifts that the minimum direct care staff to resident ratio was not met.	{S 560}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315122	A. BUILDING _____ B. WING _____	R 04/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WESTFIELD, LLC	**1515 LAMBERTS MILL ROAD WESTFIELD, NJ 07090**

(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	{E 000}		
{F 000}	INITIAL COMMENTS	{F 000}		

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

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.

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062013	A. BUILDING: _____ B. WING _____	R 04/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WESTFIELD, LLC	**1515 LAMBERTS MILL ROAD WESTFIELD, NJ 07090**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S 000}	Initial Comments	{S 000}		
{S 560}	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by:	{S 560}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315122	A. BUILDING **01** B. WING _____	C **02/13/2023**

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K 000	INITIAL COMMENTS The nursing home building construction was stated to be 70's with an addition wing constructed in 2006 (Jefferson Wing). The facility is a 1- story building Type II (000) unprotected construction and is fully sprinklered and has 14 smoke-zones. The facility is divided into 4-wings: Jefferson Hall (2006) Washington Hall (70's) Hamilton Hall (70's) Madison Hall (70's) The generator does approximately 80% of the building and the facility currently has 8- dialysis beds and 13- Hemodialysis beds and can provide dialysis for that unit located in Jefferson Hall. The Jefferson Hall wing has piped in medical gas for the above beds The building has a partial basement that includes: Laundry room, staff lounge, maintenance shop, housekeeping storage, housekeeping office, electrical room, boiler room, paint room, wheel chair room, and fire panel room. The basement has 3-exits that lead up to the public way. The basement measures approximately 80' x 60'. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health	K 000		

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

Electronically Signed | 03/01/2023

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K 000	Continued From page 1 Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 227 certified beds. At the time of the survey the census was 194. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 111 SS=E	Building Rehabilitation CFR(s): NFPA 101 Building Rehabilitation Repair, Renovation, Modification, or Reconstruction Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: * Requirements of Chapter 18 and 19 * Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1 Change of Use or Change of Occupancy Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2 18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7) Additions Any building undergoing an addition shall comply	K 111		3/28/23

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K 111	Continued From page 2 with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a 2-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2-hour fire resistance rating. Additions comply with the requirements of Section 43.8. 18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/06/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure seperation from an edition was provided with a 90 minute fire rated door in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.1.1.4.3, 19.1.1.4.4, 19.1.3.10, 19.3.2, 19.3.2.1, 19.3.2.1.2 8.4, 8.5, 4.6.10, 4.6.10.1. The deficient practice was observed for 1 of 1 doors by the following: At 01:45 PM, the surveyor and MD observed that the added on Jefferson Hall wing addition seperation from old to newer wing must have communicating openings occur only in corridors and must be protected by an approved self-closing fire door with at least a 1-1/2 hour fire resistance rating. The current seperation has a 45 minute fire rated door. The findings were verified by the Maintenance Director, at the time of the observation and he confirmed the current seperation has a fire rated	K 111	Facility noted out of compliance; Jefferson Hall wing addition separation that seperates from old to newer wing must have communicating openings occur only in corridors and must be protected by an approved self-closing fire door with at least a "1-1/2" hour fire resistance rating. The current seperation has a 45 minute fire rated door. Plan of Correction has been implemented to address Root cause of the deficient process. 1) How the corrective actions will be accomplished for those residents found to be affected by the practice: - No residents were found to be affected by this deficient practice. - New self-closing fire door with a fire resistance rating of "1-1/2" hour rating, was installed in place of current door. 2) All residents have the potential to be affected by the deficient practice.	

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K 111	Continued From page 3 door labeled 45 minutes. The Administrator and Corporate staff were informed of the finding at the Life Safety Code exit conference on 02/07/23. NJAC 8:39-31.2(e)	K 111	3) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur: a) New self-closing fire door with a fire resistance rating of "1-1/2" hour rating, was installed in place of current door. b) All new construction and or renovations will be monitored to ensure compliance with K 111. 4) How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What quality assurance will be put in place: a. Administrator and Maintenance Director will confirm that door replacement completed and meets NFPA requirements and facility is in compliance with K 111. b. Maintenance Director or designee will audit weekly x 4 weeks then monthly x 3 months to ensure the door is in compliance with K111. b. Maintenance Director Will report compliance to Quarterly QAPI committee x 2 quarters. 5) Date of Compliance: Administrator will ensure compliance and facility is in compliance with K 111 as of 3/28/2023.	
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless	K 222		2/19/23

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K 222	Continued From page 4 using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4	K 222		

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K 222	Continued From page 5 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/06/23, in the presence of the Maintenance Director (MD) and Maintenance Director from a sister facility (MDSF), it was determined that the facility failed to provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6 This deficient practice was identified for 1 of 4 sets of doors and was evidenced by the following: At 11:45 AM, the Surveyor, MD observed two sets of glass sliding exit/egress doors located at the Jefferson Hall entrance. the exterior set of sliding glass doors indicated with a red strip sign approximately 2" x 20" that "IN EMERGENCY PUSH TO OPEN". The door's were observed to not have the ability to push to open in the event of an emergency due to the	K 222	1) How the corrective actions will be accomplished for those residents found to be affected by the practice: No residents found to be affected by the deficient practice. Thumb Turn latch was shaven down. There is no ability to lock into door frame. 2) All residents have the potential to be affected by the deficient practice. 3) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur: Thumb Turn latch was shaven down. There is no ability to lock into door frame. 4) How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What quality assurance will be put in place:	

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K 222	Continued From page 6 door having a thumb turn latch that locked into the door frame. If that thumb latch was in the locked position the door could not be pushed open as stated "IN EMERGENCY PUSH TO OPEN" The current evacuation plan indicated that the front doors were designated an exit/egress route. The MD and MDSF both confirmed the findings during the observations. The Administrator and Corporate staff were informed of the findings at the Life Safety Code exit conference on 02/07/23. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section - 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. NFPA 101:2012 Edition, Section - 7.2.1.6.1.1(3)C	K 222	a. Administrator, Maintenance Director or designee will audit weekly X 4 weeks then monthly x 3 months to ensure that door latch has no ability to lock into door frame and is in compliance with K 222. b. Maintenance Director will report compliance to QAPI committee. 5) Date of Compliance: Administrator will ensure compliance and Facility is in compliance with K 222 as of 2/19/2023.	
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/06/23, in the presence of facility Maintenance Director (MD), it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. The deficient practice	K 281	Plan of Correction has been implemented to address Root cause of the deficient process. 1) How the corrective actions will be accomplished for those residents found to be affected by the practice: Electrical work was completed to ensure	3/9/23

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K 281	Continued From page 7 affected 4 of 12 occupied access areas observed and was evidenced by the following: 1). At 09:11 AM, the surveyor in the presence of the MD, observed outside the conference room in the exit/egress corridor, wall switches (2) when turned off the corridor was not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention in that area. 2). At 10:38 AM, the surveyor in the presence of the MD and MD from a sister facility, observved that the basement exit/egress corridor wall switches (2) when turned off the room was not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention in that area. 3). At 11:32 AM, the surveyor in the presence of the MD and MD from a sister facility, observved the Jefferson Hall corridor exit/egress corridor outside resident room 104 leading to the courtyard that wall switches (2) when shutoff did not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention in that area. 4). At 11:40 AM, the surveyor in the presence of the MD and MD from a sister facility, observved in the Jefferson Hall dayroom that wall switches (2) shutoff all the illumination along the means of egress in that room. The room was was not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention. the room was occupied and observed to have 14	K 281	all deficient areas have illumination of the means of egress via continuous operation without manual intervention. 2) All residents have the potential to be affected by the deficient practice. 3) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur: Electrical work was completed to ensure all deficient areas have illumination of the means of egress via continuous operation and without manual intervention. - Any new construction will be monitored for compliance with K 281. 4) How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What quality assurance will be put in place: a. Administrator and Maintenance Director will confirm that all electrical work in deficient areas has been completed. b. Administrator, Maintenance Director or designee will audit weekly x 4 weeks then monthly x 3 months to ensure that the means of egress in corridors/Day room is illuminated without manual intervention in the 4 areas identified. c. Results of Audits to be reported to QAPI committee. 5) Date of Compliance: Administrator will ensure compliance and Facility is in compliance with K281 as of 3/09/2023.	

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K 281	Continued From page 8 ceiling light fixtures. The Maintenance Director confirmed the finding at the time of observation. The Administrator and Corporate staff were informed of these findings at the Life Safety Code survey exit conference on 02/07/23. NFPA 101-2012 edition Life Safety Code: 7.8 Illumination of Means of Egress: 7.8.1.3* (2) NJAC 8:39-31.2(e)	K 281		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons)	K 321		3/24/23

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K 321	Continued From page 9 e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/06/23, in the presence of the Maintenance Director (MD) and Maintenance Director from a sister facility (MDSF), it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, labeled and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was identified in 9 of 25 hazardous storage room doors and was evidenced by the following: 1). Basement fire door no label indicating fire rating. 2). Laundry room door has a label that cannot be identified and the door will not latch. 3). Personal laundry/PPE storage room door will not latch into frame. 4). Activities room filled with combustible storage bins, the door has an auto closer installed, but the door gets stuck on the floor and will not close into its frame. 5). Environmental services room has an auto closing device installed but the arm is not attached. 6). Wheel chair storage room needs an auto closing device installed. 7). Fire alarm panel and fire sprinkler room door	K 321	1) How the corrective actions will be accomplished for those residents found to be affected by the practice: No residents were found to be affected by this deficient practice. 2) All residents have the potential to be affected by the deficient practice 3) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur: a) Basement door brought into compliance and new door installed with fire rated door; b) Laundry room door scheduled to be replaced with fire rated door; c) Personal Laundry/PPE storage room, hardware replaced/Fixed and door latches correctly; d) Activities room, Door and hardware fixed and door does not get stuck on floor; e)Environmental services room, Arm reattached and door closes automatically; f) Wheelchair storage room, Auto closing device installed; g) Fire alarm panel room, Hardware replaced/Fixed and door latches correctly; h) Maintenance door, door replaced to a fire rated door;	

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K 321	Continued From page 10 will not latch into its frame due to broken hardware. 8). Maintenance room door not fire rated. 9). Therapeutic recreation room auto closing device on door, but the door sticks to the floor. The Maintenance Director confirmed the finding's during the observations. The Administrator and Corporate staff were informed of the finding's at the Life Safety exit conference on 02/02/23. NJAC 8:39-31.2 (e) Life Safety Code 101-2012 edition	K 321	i) Therapeutic recreation room, door and hardware fixed and door does not get stuck on floor. Maintenance Director and or designee will monitor all new construction and or renovations in facility for facility compliance with K 321. 4) How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What quality assurance will be put in place: a. Administrator and Maintenance Director will confirm that all work in deficient areas has been completed. b. Maintenance Director or designee will audit weekly x 4 weeks Then monthly x 3 months to ensure compliance in 9 areas noted to be deficient for K 321. b. Will report compliance to Quarterly QAPI committee X 2 Quarters. 5) Date of Compliance: Administrator will ensure compliance and Facility is in compliance with K321 as of 3/24/2023.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.	K 345		3/13/23

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	315122	A. BUILDING **01** B. WING _____	C **02/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WESTFIELD, LLC	**1515 LAMBERTS MILL ROAD** **WESTFIELD, NJ 07090**

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K 345	Continued From page 11 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review on 02/07/23, in the presence of the Maintenance Director, it was determined that the facility failed to ensure that their building's fire alarm system was maintained in accordance with the requirements of NFPA 70 and 72. This deficient practice had the potential to affect all residents in the facility and was evidenced by the findings below: 1). On 02/06/23 and 02/07/23 the surveyor observed that the fire alarm panel was in trouble mode. On 02/06/23 the main fire panel was observed and the annunciator screen indicated: yellow indicator light: activated 0001 common trouble ACT Duct detector: Hamiliton wing by central supply An interview was conducted with the Maintenance Director during the fire panel observations where he stated the fire alarm vendor was notified and the part was ordered to repair the system. No further documentation was provided from the fire alarm vendor. The MD stated the facility was changing fire alarm vendors, but provided no documentation indicating so. On 02/07/23 at 11:27 AM, the surveyor had the Maintenance Director activate the fire alarm system, after putting it on test mode and calling the proper authorities. The MD tested the system to make sure the system activated in all wings of	K 345	1) How the corrective actions will be accomplished for those residents found to be affected by the practice: No residents were found to be affected by this deficient practice a) Part was replaced for the duct detector and system was reprogrammed and fire panel is in working order. Annunciator panel screen showing system Normal. b) Battery replaced on Control Unit 2) How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents are at risk of the deficient practice. 3) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur: a) Facility has corrected the issue noted and panel and system in in regular working mode. b) Facility has corrected the issue with duct detector and batteries were replaced on the panel as per the recommendation of the report of alarm vendor. 4) How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What quality assurance will be put in place: - Maintenance Director will ensure that facility is in compliance. - Maintenance director will audit annunciator panel and fire panel weekly x	

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K 345	Continued From page 12 the building and fire doors closed as intended. The fire alarm system activated in : Jefferson Hall Washington Hall Hamilton Hall Madison Hall All smoke barrier doors closed properly 2). At 10:45 AM, the MD provided documentation from the fire alarm vendor dated: 09/29/22 the report indicated: Control Unit Batteries: Charger test and Discharge test both "failed" The Maintenance Director was unaware the report indicated this and would reach out to the vendor for clarification. No updated information was provided at the Life Safety Code exit conference. The Administrator and Corporate staff were informed of the findings at the Life Safety Code Exit Conference on 02/07/23. NFPA 70 NFPA 72 NJAC 8:39-31.2(e) NFPA 101- 2012 edition 9.6.1.3- 9.6.1.5	K 345	4 weeks then monthly X 3 months to ensure compliance with K345. - Findings will be reported to the QAPI committee. 5) Date of Compliance: Administrator will ensure compliance and facility is in compliance as of 3/13/2023.	
K 347 SS=F	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1.	K 347		2/28/23

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K 347	Continued From page 13 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review on 02/06/23, in the presence of the Maintenance Director (MD) and Maintenance Director from a sister facility (MDSF), it was determined that the facility failed to ensure that there was a testing, maintenance, and battery replacement program to ensure proper operation of the battery operated smoke detectors as per NFPA 72. This deficient practice was evidenced for 100 of 108 observed battery operated smoke detectors and evidenced by the following: A tour of the facility from 09:30 AM, to approximately 02:00 PM, revealed that the facility resident rooms were provided with battery operated smoke detectors, except for the Jefferson Hall wing. A review of the facility's preventative maintenance logs did not indicate that there was a preventative maintenance and testing documentation, for the testing of the detectors for battery replacement (including the make, model, installation date, type of battery and replacement date. The Maintenance Director provided a "smoke detector check list" indicating room numbers only, with a sheet for notes that was left blank. In an interview during the observation's, the facility's Maintenance Director, stated that there was no documentation other than a "smoke detector check list " indicating room numbers only and a blank notes form. The administrator and Corporate Staff were	K 347	1) How the corrective actions will be accomplished for those residents found to be affected by the practice: Testing was completed of the detectors for battery replacement (including the make, model, installation date [when known], type of battery and replacement date [if applicable]. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents are at risk of the deficient practice. 3) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur: Facility will add to routine maintenance audits, monthly and not less than quarterly; to include testing and preventative maintenance of smoke detectors (including make, model, installation date [when known] type of battery and replacement date (when applicable). 4) How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What quality assurance will be put in place: - Maintenance Director will ensure that facility is in compliance. - Maintenance Director or designee will complete Audits monthly and not less than quarterly to ensure facility compliance with K 347. - Audit check off will be added to TELS	

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K 347	Continued From page 14 informed of the findings at the Life Safety Code exit conference on 02/07/23. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.3.6.1, 19.3.4.5.2	K 347	maintenance monitoring system for reporting of the completion of audits. - Maintenance Director will report audit findings to the QAPI committee X 3 months. 5) Date of Compliance: Administrator will ensure compliance and facility is in compliance as of 2/28/2023.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 02/06/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to a.) provide complete sprinkler coverage as required by Centers for	K 351	Facility noted out of compliance; observed the exterior overhang approximately 15' x 6' leading into the Jefferson Hall wing was observed to have no fire sprinkler coverage. The overhang	3/21/23

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K 351	Continued From page 15 Medicare/Medicaid Services regulation § 483.90(a) physical environment and b.) to install the sprinkler system in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.3.5, 4.6.12 and 9.7, NFPA 13, 2012 Edition, Section 6.2.7.1, 8.1, 8.1.1, 8.5.2.1, 8.5.5, 8.5.5.2 8.15.7, 8.15.7.1 and 8.15.7.5. The lack of sprinkler coverage could delay or prevent the extinguishment of a fire in this area. This deficient practice was identified for 1 of 1 exterior combustible overhangs leading to the Jefferson Hall wing and was evidenced by the following: On 02/06/23 at 12:50 PM, the surveyor and MD observed the exterior overhang approximately 15' x 6' leading into the Jefferson Hall wing was observed to have no fire sprinkler coverage. The overhang was finished in a combustible white vinyl type board material. The MD confirmed the finding during the exterior overhang observation, and he stated the area was not provided with any fire sprinkler protection. The Administrator and Corporate staff were informed of the finding at the Life Safety Code exit conference on 02/07/23. NJAC 8:39-31.2(e)	K 351	was finished in a combustible white vinyl type board material. Plan of Correction has been implemented to address Root cause of the deficient process. 1) How the corrective actions will be accomplished for those residents found to be affected by the practice: Sprinkler system was installed in overhang outside Jefferson Hall wing. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents are at risk of the deficient practice. 3) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur: Sprinkler system was installed in overhang outside Jefferson Hall wing. 4) How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What quality assurance will be put in place: - Maintenance Director will ensure that facility is in compliance with K 351 and that installation was completed for sprinkler system on overhang outside Jefferson Hall. - Maintenance Director or designee will audit New sprinkler heads outside Jefferson Hall wing weekly X 4 weeks then monthly X 3 months to ensure sustained compliance with K 351. - Maintenance Director will report findings of audits to QAP Committee. - All new construction will be monitored	

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K 351	Continued From page 16	K 351	for compliance with K 351. 5) Date of Compliance: Administrator will ensure compliance and facility is in compliance as of 3/21/2023.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview and document review on 02/06/23, in the presence of the Mainntenance Director (MD) and Maintenance Director from a sister facility (MDSF), the facility failed to provide documentation that the facility Essential Electrical System (EES) for critical care residents on ventilators was a Type I system divided into Critical branch, life safety branch, and equipment branch as required. The deficient practice affected one of twelve smoke compartments with the capability of affecting 13 ventilator residents. At the time of the survey the facility had 12 residents on ventilators. This deficient practice was evidenced by the following: It was observed on 05/31/07 at 4:00 p.m., that the facility had one main generator located outside,	K 901	1) How the corrective actions will be accomplished for those residents found to be affected by the practice: No residents found to be affected by the deficient practice. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents using a ventilator are at risk of the deficient practice. 3) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur: Time Limited Waiver request has been submitted on 3/16/2023. During the upgrades; a) the facility will be inspected daily to	3/19/23

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K 901	Continued From page 17 with one control/transfer switch panel inside the facility in the main electrical room. The facility's documentation for testing of the emergency power supply (EPS) did not indicate what type of system the facility had. Observation of the electrical panels did not show a critical power circuit, life safety circuit, and emergency systems circuit. Interview with the facility Maintenance Director on 02/06/23, revealed that the facility did not know what was on the generator load bank completely. No documentation could be provided that indicated what type of Emergency Power System (EPS) was in place and what type of Essential Electrical System (EES) was wired in the building and by what circuits. The facility could not provide documentation of a Type I Essential Electrical System (EES) with critical branch/ life safety branch, and emergency system branch for a facility with life support equipment (ventilator residents) as required in a Type I (EES) system. Actual NFPA requirement: Type I essential electrical systems are comprised of two separate systems capable of supplying a limited amount of lighting and power service, which is considered essential for life safety and effective facility operation during the time the normal electrical service is interrupted for any reason. These two systems are the emergency system and the equipment system. The emergency system shall be limited to circuits essential to life safety and critical patient care. These are designated the life safety branch and the critical branch. The equipment system shall supply major electrical equipment necessary for patient care and basic Type I operation. Both systems shall be arranged for connection,	K 901	ensure all exits are free from obstruction and the job site is free from any hazardous and unsafe material. All systems will be checked monthly. b) All staff working in the affected area will receive additional in-service training on fire safety, prevention, and response. c) Fire drills will be performed monthly in the affected area. Facility will be upgrading its electrical systems for compliance with a ventilator unit and with K 901. Work required for facility compliance with K 901 will be evaluated with the initial engineering plans and will be completed as per requirements of K 901. 4) How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What quality assurance will be put in place: During the upgrades; Maintenance Director or designee will conduct daily audits to ensure all exits are free from obstruction and the job site is free from any hazardous and unsafe material. Maintenance Director or designee will conduct monthly audits to ensure systems are working correctly. Maintenance Director or designee will audit monthly x 3 months to ensure all staff working in the affected area have received training. Maintenance Director or designee will audit fire drills monthly x 3 months. Maintenance director will report results of audits to QAPI committee. Maintenance Director will audit quarterly to ensure work is being completed at pace set out in Limited Time Waiver.	

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K 901	Continued From page 18 within time limits specified in this chapter, to an alternate source of power following a loss of the normal source. The number of transfer switches to be used shall be based upon reliability, design, and load considerations. Each branch of the emergency system and each equipment system shall have one or more transfer switches. One transfer switch shall be permitted to serve one or more branches or systems in a facility with a maximum demand on the essential electrical system of 150 kVA (120 kW). NFPA 99 section 3.4.2.2.1. The Administrator and Corporate staff were informed of the finding's at the Life Safety Code exit conference on 02/07/23. NJAC 8:39-31.2(e) NFPA 99, 2010 edition section 6.4 Category 1 spaces. 6.7.5.1.1	K 901	Maintenance director will report audit findings QAPI committee and to the administrator. 5) Date of Compliance: Administrator will ensure compliance and facility has submitted a limited time waiver to New Jersey Department of Health on 3/16/2023 for an extension for work to be completed by 5/15/2024. Facility is in compliance with requirements as of 3/19/2023.	
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/06/23, in the presence of the Maintenance Director (MD), the facility did not ensure guarding of live parts of electrical equipment and controls with	K 911	1) How the corrective actions will be accomplished for those residents found to be affected by the practice: All Electrical Panels identified as not	2/24/23

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K 911	Continued From page 19 unlocked panels in resident accessible areas in accordance with NFPA 101, 2012 Edition, Section 19.5.1,19.5.1.1, 9.1, 9.1.2, NFPA 99 2012 Edition, Section 6.3.2.1, 15.5.1.2 and NFPA 70 2011 Edition, Section 110.26, 110.27 and 110.16. This deficient practice of electrical panels not guarded against accidental contact by approved enclosures and unlocked panels in resident accessible areas for 11 of 11 open electrical panels observed. While touring the building from 09:30 AM, to 02:30 PM, the surveyor and Maintenance Director (MD), observed open electrical wall panels throughout the facility, that were not locked. The open panels were located in the following exit/egress corridor's of the facility: Jefferson Hall Washington Hall Hamilton Hall Madison Hall The observations were confirmed by the MD during the tour of the facility. The Administrator and Corporate staff were informed of the above observations at the Life Safety Code exit conference on 02/07/23. NJAC 8:39-31.2(e) NFPA 70, 99	K 911	locked were locked and those needing a new lock, a new lock was installed. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents are at risk of the deficient practice. 3) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur: All Electrical Panels identified as not locked were locked. Locks added to Those that were missing lock hardware. 4) How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What quality assurance will be put in place: - Maintenance Director will ensure that facility is in compliance with K 911 and that locks are on each electrical panel . - Maintenance Director will audit biweekly the electrical panels to ensure they are locked. - All new construction will be monitored for compliance with K 911. - Compliance will be reported the QAPI committee X 3 months. 5) Date of Compliance: Administrator will ensure compliance and facility is in compliance as of 2/24/2023.	
K 915 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Categories	K 915		3/19/23

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	315122	A. BUILDING **01** B. WING _____	C **02/13/2023**

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K 915	Continued From page 20 *Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. *General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. *Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1-1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 02/06/23, in the presence of the Maintenance Director (MD) and Maintenance Director from a sister facility (MDSF), it was determined that, the facility failed to provide a Type 1 Essential Electrical System in accordance with NFPA 99. This deficient practice was evidenced by the following: At approximately 11:00 AM, the surveyor observed all documents provided by the facility for record review. The provided electrical annual inspection (visual electrical survey) dated: 12/09/22 did not provide any information on "Essential Electrical System Design Standards". The facility currently has a Ventilator (vent) unit that requires a TYPE 1 ESS (NFPA Essential Electrical System Classification Type) system. The surveyor observed only one generator transfer switch in the basement and could not	K 915	1) How the corrective actions will be accomplished for those residents found to be affected by the practice: No residents were found to be affected by the deficient practice. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents using a ventilator are at risk of the deficient practice. 3) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur: Time Limited Waiver request has been submitted on 3/16/2023. During the upgrades; a) the facility will be inspected daily to ensure all exits are free from obstruction and the job site is free from any	

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COMPLETE CARE AT WESTFIELD, LLC	**1515 LAMBERTS MILL ROAD** **WESTFIELD, NJ 07090**

(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 915	Continued From page 21 identify any electrical panels indicating: Life Safety, Critical and Equipment branches. At 01:25 PM, the surveyor observed the electrical panels in the Jefferson Hall wing where the Vent unit was located. The panels were not identified as required for a Type 1 Essential Electrical System in accordance with NFPA 99. At approximately 12:15 PM, the surveyor interviewed the Maintenance Director where he indicated that he was not sure if the current electrical system for the vent unit was a TYPE 1 ESS (NFPA Essential Electrical System Classification Type) system. At approximately 01:15 PM, while touring the facility, the surveyor, Maintenance Director could not locate the required three branch panels that are divided as follows: 1) Life Safety 2) Critical 3) Equipment (Each branch is required to have at least 1-transfer switch) The Administrator and Corporate staff were informed of the finding at the Life Safety Code exit conference on 02/07/23. *Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. NJAC 8:39-31.2(e)	K 915	hazardous and unsafe material. All systems will be checked monthly. b) All staff working in the affected area will receive additional in-service training on fire safety, prevention, and response. c) Fire drills will be performed monthly in the affected area. Facility will be upgrading its electrical systems for compliance with a ventilator unit and with K 915. Work required for facility compliance with K 915 will be evaluated with the initial engineering plans and will be completed as per requirements of K 915. 4) How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What quality assurance will be put in place: During the upgrades; Maintenance Director or designee will conduct daily audits to ensure all exits are free from obstruction and the job site is free from any hazardous and unsafe material. Maintenance Director or designee will conduct monthly audits to ensure systems are working correctly. Maintenance Director or designee will audit monthly x 3 months to ensure all staff working in the affected area have received training. Maintenance Director or designee will audit fire drills monthly x 3 months. Maintenance director will report results of audits to QAPI committee. Maintenance Director will audit quarterly to ensure work is being completed at pace set out in Limited Time Waiver. Maintenance director will report audit	

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	315122	A. BUILDING **01** B. WING _____	C **02/13/2023**

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COMPLETE CARE AT WESTFIELD, LLC	**1515 LAMBERTS MILL ROAD** **WESTFIELD, NJ 07090**

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K 915	Continued From page 22 NFPA 99- 6.7.5.1.1 6.7.5.1.3* Critical Branch 6.7.5.1.4 Equipment Branch 6.7.5.1.2 Life Safety Branch	K 915	findings QAPI committee and to the administrator. 5) Date of Compliance: Administrator will ensure compliance and facility has submitted a limited time waiver to New Jersey Department of Health on 3/16/2023 for an extension for work to be completed by 5/15/2024. Facility is in compliance with requirements as of 3/19/2023.	
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 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	K 918		3/8/23

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K 918	Continued From page 23 maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/06/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure a remote manual stop station for one of one generators and installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice could affect all residents and was evidenced by the following: At 1:05 PM, the surveyor and MD observed the exterior generator. There was no remote manual stop station observed remotely outside the area of the generator location. An interview was conducted during the time of the observation with the MD, who confirmed that the exterior generator did not have a remote manual stop station to prevent inadvertent or unintentional operation, located remotely outside the area of the enclosure housing the prime mover. The Administrator was informed of the findings at the Life Safety Code exit conference on 02/07/23. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and	K 918	Facility noted out of compliance; It was determined that the facility failed to ensure a remote manual stop station for one of one generators. Plan of Correction has been implemented to address Root cause of the deficient process. 1) How the corrective actions will be accomplished for those residents found to be affected by the practice: No residents were found to be affected by the deficient practice. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents are at risk of the deficient practice. 3) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur: Manual Stop station was installed to prevent inadvertent or unintentional operation, located remotely outside the area of the enclosure housing the prime mover. 4) How the facility will monitor its	

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K 918	Continued From page 24 5.6.5.6.1.	K 918	corrective actions to ensure that the deficient practice will not recur. What quality assurance will be put in place: - Maintenance Director will ensure that facility is in compliance with K 918 and that manual station is installed - Maintenance Director or Designee will audit weekly X 4 weeks then monthly x 3 months to ensure that facility is in compliance with K 918. - Maintenance Director will report results of the audits to the QAPI committee. 5) Date of Compliance: Administrator will ensure compliance and facility is in compliance as of 3/08/2023.	
K 921 SS=E	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily	K 921		2/24/23

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K 921	Continued From page 25 available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observations, interview, and documentation review on 02/06/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that PCREE (patient care-related electrical equipment) were maintained in accordance with NFPA 99-testing and maintenance requirements PCREE as per NFPA 99-99:10.5.3 The deficient practice was evidenced for three of three PCREE area observations and was evidenced by the following: 1). At 11:46 AM, the surveyor observed in resident Ex Order 26. 4B1 that a resident Ex Order 26. 4B1 was on and the filter was against the nightstand and privacy curtain blocking the intake and exhaust of the unit, not allowing the Ex Order 26. 4B1 to have clear access. 2). At 01:08 PM, the surveyor observed in resident room 221 at bed #1, that a resident Ex Order 26. 4B1 was on and the filter was against the rear wall, blocking the intake and exhaust of the unit, not allowing the Ex Order 26. 4B1 to have clear access.	K 921	Facility noted out of compliance; In resident Ex Order 26. 4B1; Ex Order 26. 4B1 Bed #1; Ex Order 26. 4B1 that a Ex Order 26. 4B1 was on and in use and the filter was against something blocking the intake and exhaust of the unit, not allowing the Ex Order 26. 4B1 to have clear access Plan of Correction has been implemented to address Root cause of the deficient process. 1) How the corrective actions will be accomplished for those residents found to be affected by the practice: On 2/06/23; In Room 117, Ex Order 26. 4B1 was moved away from nightstand and privacy curtain allowing for clear access. On 2/06/2023; In Ex Order 26. 4B1, Bed #1 Ex Order 26. 4B1 was moved away from rear wall allowing for clear access. On 02/06/2023; In Ex Order 26. 4B1, Ex Order 26. 4B1 was moved away from the nightstand and privacy curtain allowing for clear access. 2) How the facility will identify other	

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K 921	Continued From page 26 3). At 01:31 PM, the surveyor observed in resident Ex Order 26. 4B1, that a resident Ex Order 26. 4B1 was against the nightstand and privacy curtain, blocking the intake and exhaust of the unit, not allowing the Ex Order 26. 4B1 to have clear access. An interview was conducted during the observations with the Maintenance Director where he stated that the Ex Order 26. 4B1 were put into use by the nurses and he would inform them of the observation's of being to close, blocking the intake and exhaust of the unit, not allowing the Ex Order 26. 4B1 to have clear access. The Administrator and Corporate staff were informed of the finding's at the Life Safety Code exit conference on 02/07/23. NJAC 8:39-31.2(e) NFPA 99-99:10.5.3 NFPA 99- 5.1.3.3.3.3 ventilation for motor-driven equipment	K 921	residents having the potential to be affected by the same deficient practice: All residents using a Ex Order 26. 4B1 are at risk of the deficient practice. 3) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur: - Education will be provided to Licensed nurses, Certified Nurse aides on proper usage of Ex Order 26. 4B1 . - Audits will be completed to ensure compliance. 4) How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What quality assurance will be put in place: a) Maintenance director or designee will Audit NJ Exec. Order 26:4.b.1 weekly x 4 weeks; then monthly X 2 months of 5 residents who use a NJ Exec. Order 26:4.b.1 to ensure that intake and exhaust of unit are not obstructed. b) Maintenance Director will present audit findings to the facility QAPI Committee X 3 months. 5) Date of Compliance: Administrator will ensure compliance and facility is in compliance as of 2/24/2023.	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet	K 923		2/24/23

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K 923	Continued From page 27 Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/06/23, in the presence of the Maintenance Director (MD) and Maintenance Director from a sister facility (MDSF), the facility failed to provide storage of cylinders, so empty cylinders are segregated from full cylinders, or appropriately labeled full and empty in accordance with NPFA 99, 2012 Edition	K 923	Facility noted out of compliance; facility failed to provide storage of cylinders, so empty cylinders are segregated from full cylinders, or appropriately labeled full and empty in accordance with NPFA 99, 2012 Edition	

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K 923	Continued From page 28 Sections 11.3.1, 11.3.2, 11.3.3, 11.3.4, and 11.6.5. The deficient practice was evidenced for 1 of 1 O2 storage rooms observed by the following: At 01:02 PM, The Surveyor, Maintenance Director and Maintenance Director from a sister facility, observed that the Washington Hall oxygen storage room contained 15 portable oxygen cylinders on one cart. The facility uses a red zip tie system to determine empty cylinders and currently the oxygen storage cart contained both empty and full cylinders and the empty cylinders could not be determined as the zip ties were not being used at the time of the observation's. An interview was conducted with the Maintenance Director at the time of the observations, where he stated and confirmed that the oxygen cylinders revealed full and empty cylinders and were not segregated and not marked to identify which were full or empty. The Administrator and Corporate Staff were informed of the observations at the life safety code exit conference on 02/07/23. NJAC 8:39-31.2(e)	K 923	Plan of Correction has been implemented to address Root cause of the deficient process. 1) How the corrective actions will be accomplished for those residents found to be affected by the practice: No residents were found to be affected by the deficient practice. Facility immediately acquired and installed additional Oxygen cylinder holding racks and clearly labeled 1 rack Empty and 1 rack Full for the Oxygen holding areas in facility. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents are at risk of the deficient practice. 3) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur: - New racks installed to ensure Full cylinders are segregated from empty cylinders as the primary method of compliance - Education was provided to managers and maintenance team to ensure managers and maintenance team are aware of facility policy relating to Oxygen storage and the new racks 4) How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What quality assurance will be put in place: a) Maintenance director or designee will conduct Audits of Oxygen room to ensure compliance; Weekly X 4 weeks; then monthly X 3 months.	

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K 923	Continued From page 29	K 923	b) Findings will be presented to the facility QAPI committee X 4 months. 5) Date of Compliance: Administrator will ensure compliance and facility is in compliance as of 2/24/2023.	

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
315122 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	6/15/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WESTFIELD, LLC	1515 LAMBERTS MILL ROAD WESTFIELD, NJ 07090

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 K0111	03/28/2023	LSC K0222	02/19/2023	LSC K0281	03/09/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0321	03/24/2023	LSC K0345	03/13/2023	LSC K0347	02/28/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	03/21/2023	LSC K0901	03/19/2023	LSC K0911	02/24/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0915	03/19/2023	LSC K0918	03/08/2023	LSC K0921	02/24/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0923	02/24/2023	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	
2/13/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO