STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315375	A. BUILDING _____ B. WING _____	C 12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILLS CENTER FOR REHABILITATION AND HEALING	**497 MT PROSPECT AVE NEWARK, NJ 07104**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint #s: NJ00168941, NJ00164363, NJ00165457 STANDARD SURVEY: 12/12/23 CENSUS: 108 SAMPLE SIZE: 28 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 with an exit date of 12/12/23, it was determined that effective 12/4/23, the Facility was found to have been in Immediate Jeopardy for F689K. The Department of Health sent a Notice of Determination of Immediate Jeopardy to the Facility Administrator on 12/4/23, which included the Immediate Jeopardy Template. The Facility failed to: - provide 4 of 10 residents with a [redacted] NJ Exec. Order 26:4.b.1, which should have been smooth,	F 000		

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

Electronically Signed | 12/26/2023

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F 000	Continued From page 1 soft, and homogenous in consistency. The pureed mashed potatoes served to the residents from the kitchen on 12/4/23, were served with several chunks mixed into the mashed potatoes, which put the residents at risk of aspiration and choking. - report the improper food consistency when it was served to the residents. On 12/5/23, the Department of Health received an acceptable allegation for Removal of the Immediate Jeopardy. The survey team verified the implementation of the Removal Plan on 12/5/23.	F 000		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format	F 640		1/26/24

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F 640	Continued From page 2 that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on the interview and record review, it was determined that the facility failed to electronically transmit the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care of all residents, within 14 days of completing the resident's assessment for 5 of 22 residents, (Resident #6, 28, 4, 56, and #58) reviewed for resident assessment.	F 640	Corrective Action: MOS coordinator received in-service training on 12/6/23 to ensure MDS assessments completed timely to electronically transmit within 14 days to the CMS system. Identification of other residents affected by the Deficient practice:	

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F 640	Continued From page 3 The deficient practice was evidenced by the following: 1. Resident #6 was observed to have an Annual MDS with an Assessment Reference Date (ARD) on [redacted] and was due to be transmitted no later than [redacted]. The Annual MDS was not transmitted unti[redacted] 2. Resident #28 had an Annual MDS with an ARD on [redacted]. The assessment was completed and was due to be transmitted no later than [redacted] The Annual MDS was not transmitted until [redacted]. 3. Resident #4 was observed to have a Significant Change MDS with an ARD on [redacted] and was due to be transmitted no later than [redacted]. The Significant Change MDS was not transmitted until [redacted]. 4. Resident #4 was observed to have a Quarterly MDS with an ARD on [redacted]. The assessment was completed and was due to be transmitted no later than [redacted] The Quarterly MDS was not submitted until [redacted] 5. Resident #56 was observed to have an Admission MDS of [redacted] and was due to be transmitted no later than [redacted]. The Admission MDS was not transmitted until [redacted]. 6. Resident #58 was observed to have an Admission MDS of [redacted] and was due to be transmitted no later than [redacted]. The Admission MDS was not transmitted until [redacted]	F 640	All other residents have the potential to be affected by this deficient practice. The Nursing Administration audited and reviewed the scheduled MDS assessments, for completion and timely submission on 12/21/23 and noted facility in compliance. Preventive Measures/Systemic Changes: The Administrator and Nursing Administration reviewed MDS Submission and Transmittal Policy and Procedure. It was determined that the policies were sufficient and required no changes. Nursing Administration in-serviced the MDS coordinator /Designee and the interdisciplinary team on 12/6/23 on timely completion of MDS assessment for submission and transmittal of MDS within 14 days to the CMS System. Quality Assurance: The Quality Assurance Performance Improvement Committee (QAPI} shall be responsible for ascertaining the effectiveness of the corrective actions and preventive measures. MDS coordinator/designee shall review 5 random MDS assessments for timely submission 02every 2 weeks x 2 weeks, monthly x 2 months, then quarterly x 3 months. The result of the findings shall be reported to the Administrator for any additional corrective actions.	

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F 640	Continued From page 4 On 12/06/23 at 12:45 PM, the surveyor interviewed the facility's Registered Nurse (RN)/MDS Coordinator (MDSC) and stated that he started last week. On 12/06/23 at 1:06 PM, the RN/MDSC provided the surveyor a copy of the form titled "MDS 3.0 Final Validation Report," which revealed the above resident's name and confirmed the late MDS assessment submission. On 12/06/23 at 1:20 PM, the surveyor brought the above concerns to the attention of the Director of Nursing and Administrator.	F 640		
F 656 SS=D	NJAC 8:39 - 11.1 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		1/26/24

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F 656	Continued From page 5 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to develop a comprehensive, person-centered care plan for a resident using an [NJ Exec. Order 26:4.b.1] and [EX Order 26.4B1]. This deficient practice was identified for 1 of 22 residents (Resident #12) reviewed for a comprehensive Care Plan (CP) and was evidenced by the following:	F 656	Corrective Action¿ 1. A comprehensive and person-centered care plan was developed and implemented on resident#12 using [EX Order 26.4B1] [NJ Exec. Order 26:4] on 12/6/23. Resident expired on [redacted]. Identification: All other residents have the potential to	

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F 656	Continued From page 6 On 11/29/23 at 10:32 AM, the surveyor observed Resident #12 resting in bed in their room. Resident #12 received EX Order 26.4B1 NJ Exec. Order 26:4.b.1 connected to a NJ Exec. Order 26:4.b.1). The NJ Exec. Order 26:4.b.1 was set at LPM (liters per minute). The surveyor observed a machine in the resident's left drawer. On 12/1/23 at 10:28 AM, the surveyor observed Resident #12 out of bed in a wheelchair. The resident received EX Order 26.4B1 attached to an EX Order 26.4B1 set at LPM. The surveyor reviewed the Electronic Health Record (EHR) of Resident #12, which revealed the following: The resident's Admission Record documented that Resident #12 was admitted with diagnoses that included but were not limited to EX Order 26.4B1 The Admission Minimum Data Set (MDS), an assessment tool dated EX Order 26.4B1 indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of out of 15, which indicated that the resident had EX Order 26.4B1 . 1. The Order Summary Report (OSR) for EX Order 26.4B1 ordered, 'EX Order 26.4B1 via EX Order 26.4B1 continuously and monitor saturation every shift for EX Order 26.4B1	F 656	be affected by this deficient practice. The nursing administration audited and reviewed the care plans for all residents using Oxygen and Bilevel-positive airway pressure (BIPAP) to determine if they were affected by this deficient practice. No other residents were identified to be affected. Preventive Measures/Systemic Changes: The Administrator and Director of Nursing reviewed the facility's policy and procedure on Care Planning. It was determined that the Policy and Procedure was sufficient and required no changes. In addition, all nurses and the Interdisciplinary team received in¿ service training on 12/6/23 and completed on 12/19/23. Quality Assurance¿ The Quality Assurance Performance Improvement (QAPI) committee shall be responsible for ascertaining the effectiveness of the corrective actions and preventive measures. The Nursing Administration will review 5 care plans on residents with oxygen weekly for 3 months to determine the level of compliance with the dialysis Policy and Procedure for comprehensive and person-centered care planning. Any findings will be reported to the Administrator for any additional corrective actions.	

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F 656	Continued From page 7 EX Order 26.4B)." The resident's CP review revealed no CP for EX Order 26.4B1. 2. The OSR for EX Order 26.4B1 ordered, "apply EX Order 26.4B1 at bedtime, on at EX Ord, off at EX Ord at bedtime for a EX Order 26 and remove per schedule." The resident's CP review revealed no CP for EX Order 26.4B use. On 12/6/23 at 1:17 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to care for the resident. The LPN stated they do not initiate CP. On 12/6/23 at 1:23 PM, the surveyor interviewed the MDS Coordinator, who began employment NJ Exec. Order 26:4.b.i in the facility. He stated that it is part of the responsibility of MDS Coordinators to initiate and check the CP. On 12/6/23 at 2:23 PM, the surveyor interviewed the Director of Nursing, who reviewed the resident's EHR with the surveyor and confirmed there was no CP related to EX Order 26.4B1 and EX Order 26.4B1 used for Resident #12. She stated that the nurses do not document the CP because they need to focus on giving medication. The facility's Policy and Procedure, dated 9/2023, is titled "Care Planning" and is stated under "Policy Interpretation and Implementation 3. Each resident's comprehensive care plan is designed to Incorporate identified problem areas and Reflect treatment goals, timetables, and objectives in measurable outcomes..."	F 656		

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F 656	Continued From page 8 NJAC 8:39- 11.2 (d)	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow Professional Standards of Practice by failing to assess a weight change for 2 of 3 residents reviewed for [redacted] which did not contribute to harm, Resident #73 and #58. Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." 1. On 11/29/23 at 11:11 AM, the surveyor interviewed Resident #73, who stated that he/she had not lost weight and that he/she looks the same. The resident stated that he/she had no	F 658	Corrective Action: 1. Resident #73 was re-weighed on 12/8/23 to verify weight accuracy and noted to have the same weight 2. Resident #58 was re-weighed on 12/8/23 to verify weight accuracy. There was a [redacted] lbs. weight change from the previous month. 3. Registered dietitian received in-service training on 12/8/23 on consistent and accurate weight documentation as ordered by MD. IDENTIFICATION OTHER RESIDENTS: All other residents have the potential to be affected by this deficient practice. The nursing administration audited and reviewed all other resident's weight documentation if they were affected by this deficient practice. No other residents were identified to be affected. PREVENTIVE MEASURES/SYSTEMIC	1/26/24

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F 658	Continued From page 9 issues with appetite and is happy with his/her weight. On 12/1/23 at 12:25 PM, the surveyor observed Resident #73 who was eating lunch, the resident received a diet consisting of NJ Exec. Order 26:4.b.1 s ordered by the Physician. The resident consumed about 50-75% of the meal. A review of the Admission Record revealed that Resident #73 had diagnoses which included but were not limited to EX Order 26.4B1). A review of the resident's Order Summary Report (OSR) revealed a current order for monthly NJ Exec. Order 26:4.b.1 to be obtained with a start date of EX Order 26.4B1 A review of Resident #73's NJ Exec. Order 26:4.b.1 revealed that on NJ Exec. Order 26:4.b.1 the resident weighed pounds (lbs) and on EX Order 26.4B1 the resident weighed EX Order lbs, which indicated a NJ Exec. Order 26:4.b.1 of EX Order 26.4B1 weight NJ Exec. Order in EX Order month. There was no monthly weight recorded for the month of EX Order 26.4B1 . The resident's current weight was recorded at EX Order 26.4B1 lbs on EX Order 26.4B1 and EX Order 26.4B1 on EX Order 26.4B1 The Registered Dietitian (RD) had documented NJ Exec. Order 26:4.b.1 /progress notes on the dates of NJ Exec. Order 26:4.b.1 he RD did not have a documented NJ Exec. Order 26:4.b.1 or progress note written after the resident had NJ Exec. Order 26:4.b.1 in the month of EX Order 26.4B1 . Review of the Medical Professional Note (MPN) dated 9/6/23, revealed "Assessment: Patient	F 658	CHANGES: Director of Nursing and Administrator reviewed Policy and Procedure on Weights. It was determined that the Policy and Procedure was sufficient and required no changes. All licensed professional nursing staff received in-service training on 12/8/23 and completed on 12/19/23 regarding accurate weight documentation. MONITORING: The Quality Assurance Performance Improvement (QAPI) committee shall be responsible for ascertaining the effectiveness of the corrective actions and preventive measures. The Nursing Administration will review 5 random charts on weight documentation weekly for 3 months to determine the compliance with the facility's Policy and Procedures on accurate weight documentation. At the conclusion of three months the review shall be the responsibility of the QAPI committee and report any findings to the Administrator for any additional corrective actions.	

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F 658	Continued From page 10 reported with [redacted] since June. Patient noted with fair/good appetite consuming about 50-75% of meals. Although [redacted] was not planned, it is stabilized and still within an ideal BMI weight at [redacted] A MPN dated [redacted], revealed "Assessment: Patient reported with [redacted] weight. Patient noted with fair/good appetite consuming about [redacted] of meals. Although [redacted] was not planned, it is stabilized and still within an ideal BMI weight at [redacted]." A MPN dated [redacted], revealed "Assessment: Patient reported with a [redacted]. Patient noted with fair/good appetite and consumption of meals varies. Although [redacted] was not planned, it is stabilized and still within an ideal BMI weight of [redacted]." A MPN dated [redacted], revealed [redacted] A review of the comprehensive Minimum Data Set, an assessment tool used to facilitate care management dated [redacted] revealed a Brief Interview for Mental Status score of [redacted] which indicated EX Order 26.4B1 The resident was able to answer all questions asked by the surveyor. On 12/5/23 at 12:39 PM, the surveyor observed Resident #73 who was eating lunch, the resident received a diet consisting of [redacted] as ordered by the Physician, The resident consumed about 50-75% of the meal.	F 658		

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F 658	Continued From page 11 On 12/5/23 at 1:15 PM, the surveyor interviewed the RD who stated that she was aware of Resident #73's documented [NJ Exec. Order 26:4.b.1] which occurred between the months of June 2023 and July 2023. The RD stated that the resident had an order for [NJ Exec. Order 26:4.b.1] and they should be done every month. The CNA weighs the resident and then she will document the weights in the Electronic Health Record (EHR). The RD stated that she did not document about the [NJ Exec. Order 26:4.b.1] occurrence which happened in July as she was waiting for a reweigh to be done. The RD stated that she asked the nursing staff multiple times to do the re-weight but did not document about the situation since she was not sure if the [NJ Exec. Order 26:4.b.1] was accurate. The RD also stated that the resident's appearance did not change around that time of the weight discrepancy, and she has not had to buy any news clothes. The RD stated that she interviewed the resident, who did not indicate [NJ Exec. Or] or changes in appetite or food intake either. The RD stated that the scales are calibrated on occasion and brought the surveyor calibration information from the month of June 2023. She stated that maybe the calibration in June "fixed" a problem with the scale. The RD did not document this interview with the resident either. The RD stated that the reweigh should be done by 10th of the month and that she should have continued to follow up on the need for the re-weigh in [EX Order 26.4B1]. The RD also stated that she did not realize that the weight was not recorded in [EX Order 26.4B1] as well. The RD stated that the resident is actually at a desirable weight	F 658		

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at this time and that the resident is happy with his/her weight. The RD stated that she also did add a [NJ Exec. Order 26:4.b.1] when the [NJ Exec. Order 26:4.b.1] was noticed in September 2023 to ensure no further [NJ Exec. Order 26:4.b.1] would occur.

On 12/8/23 at 10:30 AM, the surveyor interviewed the Certified Nursing Assistant (CNA), who cared for Resident #73. The CNA stated that she weighed the residents each month If there was a weight discrepancy then the weight would be re-taken, the weights were recorded on a piece of paper and the RD checked those weights and would ask for re-weights as needed. The CNA stated that the RD also imported the weights into the EHR each month. The CNA could not remember if a re-weight was requested for Resident #73 during the time of the weight discrepancy. The CNA stated that Resident #73 had a good appetite and ate about 50-75% of most meals. She did not appear to have any weight loss or gain. The CNA stated that the resident was weighed yesterday and was also weighed a few days before as well.

On 12/8/23 at 10:50 AM, the surveyor interviewed the Licensed Practical Nurse (LPN), who stated that Resident #73 has not had an appearance of [NJ Exec. Order 26:4.b.1] She stated the resident ate approximately 50-75% at most meals and was prescribed a [NJ Exec. Order 26:4.b.1] as well. The LPN stated that Resident #73's family was here often and did not report a change in the resident's appearance which would indicate [NJ Exec. Order 26:4.b.1] either. The LPN stated that the scale may have been calibrated which could cause a discrepancy, but did not recall any other residents having [NJ Exec. Order 26:4.b.1]

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F 658	Continued From page 13 around that time. The LPN stated that the CNAs weigh the resident and it gets recorded into the EHR by the RD. The LPN stated that there was no [NJ Exec. Order 26:4.b.1] or physical harm to the resident, the resident's clothing is still tight on the resident and no other clothes have been purchased which would have indicated weight change. On 12/8/23 at 11:10 AM, the surveyor conducted a phone call to Resident #73's representative/family member, who stated that he comes to visit his family member almost every day since admission and there has not been any weight loss or gain. He stated that he resident has not had any new clothing purchased and the resident has not needed any new clothes which would indicate a weight change. He stated that the resident has always eaten about 50 to 75% of the meal and had no concerns about the food provided here. He also stated that the resident had no [NJ Exec. Order 26:4.b.1] and no [NJ Exec. Order 26:4.b.1] that would suggest a weight loss or gain. He stated that the resident is happy with the current weight and care here. 2. On 12/8/23 at 11:00 AM, the surveyor observed Resident #58 lying in bed asleep inside the room. A review of the admission record for Resident #58 reflected that the resident was admitted to the facility with diagnoses that included but were not limited to [EX Order 26.4B1] The resident's	F 658		

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F 658	Continued From page 14 most recent Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted], reflected that Resident #58 had a Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted] which indicated that the resident had EX Order 26.4B1 [redacted]. A review of the November 2023 OSR did not show an order for monthly weights. A review of Resident #58's weight revealed that on [redacted], the resident's admission weight was [redacted]. on [redacted] the resident weighed [redacted] lbs. Resident #58's weight on [redacted] was [redacted] lbs., which indicated a significant [redacted] of [redacted] in one month in [redacted]. No weight was documented in EX Order 26.4B1 The resident did not [redacted] weight, with a registered weight of [redacted]. on [redacted]. The Nutrition and Dietary Note dated [redacted] indicated there was [redacted] significant unplanned [redacted] for one month. The care plan initiated on [redacted] revealed that "[resident name] is at risk for EX Order 26.4B1 BMI, [redacted] intake. NJ Exec. Order 26:4.b.1 [redacted] On 12/8/23 at 11:10 AM, the surveyor interviewed the CNA who worked with the resident, who stated the monthly weight was done every first week of the month, and the re-weigh should be done within a week. On 12/8/23 at 11:13 AM, the surveyor interviewed the LPN on the unit, who stated he would	F 658		

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F 658	Continued From page 15 document the weight that the CNA reported to him. On 12/8/23 at 11:52 AM, the surveyor interviewed the RD, who works in the facility [NJ Exec. Order 26.4.b.1] per week. She stated that Resident #58's admission weights of [EX Order 26.4B1]. and [EX Order 26.4B1]. on [EX Order 26.4B1] were inaccurate. However, she did not address the cause of the weight discrepancy. On 12/08/23 at 01:45 PM, the surveyor interviewed the Director of Nursing (DON) regarding the order for weights in POs and the weight discrepancy. The DON stated that the weight should be done monthly. The DON provided no further information. On 12/6/23 at 2:09 PM, the surveyor discussed the above concerns with the DON and the Administrator. The facility's Policy and Procedure titled "Weights," with a revised date of 9/20/23, revealed under the procedure, "If there is a discrepancy of plus or minus 5 pounds, the resident will be reweighed with the nurse supervising. The nurse will document the reweigh and the date." "When a weight change of 5 pounds plus or minus occurs, the physician will be notified, and a dietary alert sheet filled out for notification of the dietitian."	F 658		
F 689 SS=K	NJAC 8:39-27.2(a) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		1/26/24

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F 689	Continued From page 16 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documents on 12/4/2023, it was determined that the facility failed to provide four of ten residents with a prescribed [NJ Exec. Order 26:4.b.1], which should have been smooth, soft, and homogenous in consistency. The pureed mashed potatoes served to the residents from the kitchen on 12/4/23, were served with several chunks of potato mixed into the mashed potatoes. The facility's failure to prepare and provide the proper NJ Exec. Order 26:4.b.1 and, failure of the nursing staff to report the improper food consistency, placed Resident #61, #28, #31 and #69, as well as all other residents, at risk of aspiration and choking which could cause serious harm, impairment or death. This resulted in an Immediate Jeopardy (IJ) situation that began on 12/4/23. The facility's Licensed Nursing Home Administrator (LNHA) was notified of the IJ on 12/4/23 at 4:18 PM. An acceptable written Removal Plan was received on 12/5/23 at 10:00 AM. The Removal Plan was verified by the survey team onsite on 12/5/23 at 1:10 PM, lifting the immediacy, and the survey team continued verification of the Removal Plan onsite	F 689	Corrective action: Residents□ #61, 31, 28, & 69 were immediately assessed, and it was determined that there were no adverse effects. Facility□s commercial puree blender was determined to need repair. The blender was immediately removed on12/4/2023 and replaced with a new one. Food Service Cook who served the rice instead of potatoes was immediately in serviced on 12/4/2023 to follow the menu and to use dried potato product instead of raw boiled potato for pureed diet CNAs #1,#2, #3 immediately in-serviced on 12/4/2023 regarding diet consistency and report immediately to Food Service staff for replacement CNAs educated not to alter food consistency by mashing food and food types for pureed diet Dietary staff immediately in-services to check consistency of food and diet accuracy during prep and prior to serving Identification of Others	

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F 689	Continued From page 17 throughout the survey while onsite for the dates of 12/6/23, 12/7/23, 12/8/23, and 12/11/23. The evidence was as follows: On 12/4/23 at 12:15 PM, during the lunch meal, Resident #61's family member, who was feeding the resident, asked the surveyor to look at the resident's meal, specifically the mashed potatoes. The resident was prescribed a [NJ Exec. Order 26:4.b.1] and that was indicated on the resident's tray ticket which was provided with the meal. Resident #61's tray ticket also indicated an alternate required starch and the resident had received pureed mashed potatoes as part of their meal which was served by the facility's kitchen. The surveyor observed 14 ¼- ½ inched sized chunks of potatoes in the pureed mashed potatoes. On 12/4/23 at 12:20 PM, the surveyor observed the pureed lunch meal, which was served by the facility's kitchen, for all of the residents who were prescribed a [NJ Exec. Order 26:4.b.1]. The surveyor observed that the lunch tray tickets for Resident #28, which indicated that the residents were to receive boiled rice (pureed) but the resident actually received pureed mashed potatoes on their trays instead. The surveyor observed Resident #28 lunch meal and also identified several ¼- ½ sized chunks of potatoes within the pureed mashed potatoes served to those residents. At 12:20 PM, the surveyor observed the pureed lunch meal, which was served by the facility's kitchen, for all of the residents who were prescribed a [NJ Exec. Order 26:4.b.1]. The surveyor observed that the lunch tray tickets for Resident #31, which	F 689	All residents on puree diet have the potential to be affected by this deficient practice. An audit was done on all residents with the potential to be affected. The audit concluded that no residents were affected. Systemic Change: Policy and Procedure on Pureed Diet was reviewed and found to be compliant. All facility staff were educated on 12/4/2023 for Meal Safety including to return trays that are not the proper diet consistency for the pt diet , including facility policy for Pureed Diet The policy on Food and Nutrition Services was reviewed and found to be compliant. The policy was revised to include matching the contents of the food tray to the meal ticket prior to tray being loaded on to cart. Facility staff were in-serviced on revised policy. Quality Assurance: An audit tool was developed to ensure compliance with revised policy on food tray accuracy. Nursing will audit 10 tray each day for 1 week, and then monthly for 3 months, and then as needed. Any concerns identified will be immediately referred to administration for review and corrective action. Audit findings will be presented to the QA Committee for evaluation and follow up as indicated. Food Service Director/designee will	

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F 689	Continued From page 18 indicated that the residents were to receive boiled rice (pureed) but the resident actually received pureed mashed potatoes on their trays instead. The surveyor observed Resident #31 lunch meal and also identified several ¼- ½ sized chunks of potatoes within the pureed mashed potatoes served to those residents. At 12:21 PM, the surveyor interviewed the Food Service Worker (FSW) who prepared the pureed mashed potatoes, he stated that he had used fresh, boiled mashed potatoes without the skin and he used the commercial puree machine to puree it, then, he checked the smoothness with a rubber spatula. He stated that he did not see any chunks in the pureed mashed potato. He stated that he did not use the dried potato product for the pureed potatoes because when he uses that for puree, the consistency comes out like glue. The FSW provided the ingredients and procedure for pureed mashed potato which revealed to "whip the potatoes on low speed until smooth, add hot milk, margarine and salt. Then, whip until creamy." At 12:31 PM, the surveyor interviewed the Certified Nursing Assistant (CNA) #2 and #3. Both the CNA #2 and #3, who were feeding Resident #31 and Resident #28 stated that they observed chunks in the pureed mashed potato and mashed the chunks before feeding it to Resident #31 and #28. The CNA #2 and #3 did not report this to anyone else. At 12:40 PM, the surveyor observed the pureed lunch meal, which was served by the facility's kitchen, for all of the residents who were prescribed a NJ Exec. Order 26:4.b.1 The surveyor observed	F 689	monitor diet accuracy during prep and prior to serving	

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that the lunch tray tickets for Resident #69, which indicated that the residents were to receive boiled rice (pureed) but the resident actually received pureed mashed potatoes on their trays instead. The surveyor observed Resident #69 lunch meal and also identified several ¼- ½ sized chunks of potatoes within the pureed mashed potatoes served to those residents. The CNA #1, who was feeding Resident #69, stated that she did not give the pureed mashed potato to Resident #69 because it did not look like a pureed consistency. The CNA #1 did not report this to anyone else.

At 12:45 PM, the surveyor interviewed the Director of Dietary (DD), who stated that the commercial puree machine used in the kitchen for making pureed foods smooth had dull blades from wear and tear and he just ordered a new blade recently. The DD stated that they should have used the immersion blender if there was a problem with the commercial puree machine. The FSD was not aware of the pureed mashed potatoes containing chunks. The DD stated that the staff should never puree freshly cooked raw potato and the staff should have used a dried potato product sfor puree. The DD stated that the lunch tray tickets did indicate that all the residents who received a [redacted] were supposed to receive boiled rice (pureed) but all the residents actually received pureed mashed potato and he was not sure why that occurred.

At 12:50 PM, the surveyor interviewed the Speech Language Pathologist (SLP), who observed the plate of pureed mashed potatoes and stated that there should not be any chunks and that the pureed item should be smooth. The

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F 689	Continued From page 20 SLP stated that all four of the residents are [redacted]. The SLP stated that Resident #28's [redacted] could freeze up and then cannot finish the chewing the food, and it could build up and cause pocketing which could lead to EX Order 26.4B1. The SLP stated that Resident #69 had a risk of EX Order 26.4B1 due to decreased [redacted]. The SLP stated that Resident #31 had EX Order 26.4B1 and needed to [redacted]. The resident did not have awareness of the [redacted] in the resident's mouth which could lead to [redacted] and [redacted] The SLP stated that Resident #61 had EX Order 26.4B1 and cannot chew chunks of food, which could lead to EX Order 26.4B1. The SLP stated that the CNAs cannot alter food consistency to meet the needs of the resident, however a licensed professional can. At 1:01 PM, the Director of Nursing (DON) stated that a CNA should inform the staff if the consistency is not correct but can mash the food or add a liquid. The surveyor reviewed the records for Resident #61, which revealed the following: The Order Summary Report (OSR) revealed an order for a NJ Exec. Order 26:4.b.1 [redacted] The Speech therapy Evaluation and Plan of Treatment (SLP EPT) dated [redacted] revealed that the resident exhibits a primarily [redacted] According to the residents' Quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], revealed the resident scored [redacted] of	F 689		

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F 689	Continued From page 21 possible [redacted] on the Brief Interview for Mental Status, which indicated EX Order 26.4B1 [redacted] The surveyor reviewed the records for Resident #31, which revealed the following: The Admission Record (AR) revealed Diagnoses which included but were not limited to [redacted], EX Order 26.4B1 [redacted]. The resident's OSR revealed an order for a EX Order 26.4B1 [redacted] The nurse progress note (PN) dated [redacted], revealed that the resident EX Order 26.4B1 during feeding, needed EX Order 26.4B1 and also pocketed food in the mouth. The Rehabilitation order from the SLP dated EX Order 26.4B1 revealed that the resident need SLP treatment for EX Order 26.4B1 and recommended a [redacted]. According to the residents' Quarterly MDS, an assessment tool dated EX Order 26.4B1 revealed the resident scored [redacted] possible 15 on the Brief Interview for Mental Status, which indicated EX Order 26.4B1 [redacted] The surveyor reviewed the records for Resident #28, which revealed the following: The AR revealed Diagnoses which included but were not limited to EX Order 26.4B1. The OSR revealed an order for a [redacted] diet. The SLP EPT dated [redacted] revealed that the resident required treatment of EX Order 26.4B1 and/or EX Order 26.4B1 for feeding and needs treatment based on EX Order 26.4B1 [redacted] phase. According to the residents' Comprehensive MDS, an assessment tool dated	F 689		

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F 689	Continued From page 22 EX Order 26.4B1, revealed the resident scored EX of possible 15 on the Brief Interview for Mental Status, which indicated EX Order 26.4B1 EX Order 26.4B1 The surveyor reviewed the records for Resident #69, which revealed the following: The AR revealed Diagnoses which included but were not limited to EX Order 26.4B1. The OSR revealed an order for a NJ Exec. Order 26:4.b.1 diet. The SLP Diagnoses dated NJ Exec. Order 26:4.b, revealed that the resident had a Diagnosis of EX Order 26.4B1 EX Order 26.4B1 Rehabilitation Orders by the SLP dated EX Order 26.4B1, revealed the resident had safety precautions due to NJ Exec. Order 26:4.b.1. According to the residents' Quarterly MDS, an assessment tool dated NJ Exec. Order 26:4.b, revealed the resident scored that he/she was EX Order 26.4B1 understood for the Brief Interview for Mental Status. This indicated the resident had EX Order 26.4B1. The Administrator provided the surveyor with the Food and Nutrition Services policy dated 8/2023, which revealed "If an incorrect meal is provided to a resident, nursing staff will report it to the Food Service Manager so that new food tray can issued." The DON provided the surveyor with the Puree Diet Consistency policy dated 9/20/23, which revealed "Puree foods should be prepared in such a manner to prevent lumps or chunks. The goal is a smooth, soft, homogenous consistency." On 12/5/23 at 10:00 AM, the LNHA submitted the	F 689		

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F 689	Continued From page 23 removal plan. The surveyor verified the plan which included the following interventions. The facility removed the commercial puree machine and replaced it with a new one, the FSW who served the rice instead of potatoes was immediately in serviced to follow the menu and to use dried potato product instead of raw boiled potato for pureed diet, the CNAs #1, #2, #3 were immediately in-serviced regarding diet consistency and were educated to report concerns immediately to food service staff for replacement, the CNAs were educated not to alter food consistency by mashing food and food types for pureed diet, the dietary staff were immediately in-serviced about checking consistency of food and diet accuracy during prep and prior to serving. An audit tool was developed to ensure compliance with revised policy on food tray accuracy, nursing will audit 10 trays each day for 1 week, and then monthly for 3 months, and then as needed. Any concerns identified will be immediately referred to administration for review and corrective action. An audit of findings will be presented to the QA Committee for evaluation and follow up as indicated. The DD/designee will monitor diet accuracy during prep and prior to serving. The noncompliance for F689 remained at a lower scope and severity after the immediacy was removed.	F 689		
F 698 SS=E	NJAC 8:39-31.7 (h) Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis.	F 698		1/26/24

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F 698	Continued From page 24 The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide care and services in accordance with professional standards by adjusting medication times of administration to accommodate for dialysis scheduled times and documenting accurate medication administration times from October until December surveyor inquiry. This deficient practice was identified for one (1) of (1) resident, (Resident #22), reviewed for EX Order 26.4B1 services and was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and	F 698	Corrective Action: 1. Resident #22 medication administration timing was immediately adjusted on EX Order 26.4B1 to accommodate EX Order 26.4B1 appointments. 2 The RN identified on the statement of deficiency who received the call for change in EX Order 26.4B1 time was in serviced on EX Order 26.4B1 identification: All other dialysis residents have the potential to be affected by this deficient practice. Nursing Administration reviewed the medication administration timing of residents on dialysis treatment. No other dialysis residents were affected by this deficient practice. Preventive Measures/Systemic Changes: The Director of Nursing and Administrator reviewed the Policy and Procedure on Medication Administration and Dialysis. It was determined that the Policies and Procedures were sufficient and required no changes. All licensed professional nursing staff received in service training on 12/6/23 and completed on 12/19/23 on proper and	

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F 698	Continued From page 25 responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 12/1/23 at 11:56 AM, the surveyor interviewed Resident #22. The resident stated that he/she had been in the facility almost three (3) months and went out for EX Order 26.4B1 [redacted] he resident also stated that he/she had previously gone to EX Order 26.4B1 later in the evening, but the time was changed. The surveyor reviewed the medical record for Resident #22. A review of the Admission Record (an admission summary) reflected diagnoses which included EX Order 26.4B1 [redacted] A review of the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated EX Order 26.4B1 reflected the resident had a brief interview for mental status (BIMS) score of [redacted] out of 15, indicating that the resident had a EX Order 26.4B1 [redacted]. A review of the resident's EX Order 26.4B1 communication book that was available at the nursing station	F 698	accurate medication administration timing to accommodate dialysis scheduled appointments. Quality Assurance: The Quality Assurance Performance Improvement (OAPI) committee shall be responsible for ascertaining the effectiveness of the corrective actions and preventive measures. The nursing administration will review all residents on dialysis treatment weekly for 3 months to determine the level of compliance. At the conclusion of three months, the review shall be the responsibility of the OAPI committee and report any findings to the Administrator for any additional corrective actions.	

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F 698	Continued From page 26	F 698		

indicated on the cover that the [EX Order 26.4B1] days for the resident was on Monday, Wednesday, Friday with a [EX Order 26.4B1] time of 3:00 PM and pick up time of 2:15 PM.

A review of the nursing progress notes reflected a Health Status Note dated [NJ Exec. Order 26:4.b.1], "FMC, the [EX Order 26.4B1] center, called the facility re: a new chair time for [EX Order 26.4B1]. The center has 3pm available and wants to know if we can change transportation p/u for tomorrow. The unit clerk notified [name redacted] and the p/u time is now 215pm, the resident and [initials redacted] aware and agree with the new [EX Order 26.4B1] time, will continue to monitor."

A review of the electronic Medication Administration Record (eMAR) for the months of 10/2023, 11/2023 and 12/2023 reflected the dates that the resident went to [NJ Exec. Order 26:4.b.1]: 10/4/23, 10/6/23, 10/9/23, 10/11/23, 10/13/23, 10/16/23, 10/18/23, 10/20/23, 10/23/23, 10/25/23, 10/27/23, 10/31/23. The following medications were documented as administered at the time when the resident was out of the building at dialysis.

EX Order 26.4B1
(6 PM).
EX Order 26.4B1
EX Order 26.4B1

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F 698	Continued From page 27 documented as administered 17:30 (5:30 PM) EX Order 26.4B1 [redacted] A review of the Consultant Pharmacist's report titled "Consultant Pharmacist's Monthly Report" dated NJ Exec. Order 26:4.b.1 [redacted] provided by the Director of Nursing (DON) reflected a recommendation for Resident #22, "Please be sure that medication times are charted to accommodate resident's EX Order 26.4B1 [redacted] times. Clarify EX Order 26.4B1 [redacted]." On 12/6/23 at 11:14 AM, the surveyor interviewed the Registered Nurse (RN) who stated that when a resident had dialysis she would call the dialysis nurse at the dialysis center to follow up and would send the necessary medications with the resident to dialysis. The RN added that she would document it in the dialysis communication book. The RN stated she does not normally work the 3-11 shift. On 12/6/23 at 11:30 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated there should not be any orders for medications to be given to a resident when the resident is out of the building. The LPN added there should be a physician's order to give the medications later or hold the medications when a resident is out to dialysis. LPN also stated that if there was a medication ordered for one of her residents that was scheduled to be given when the resident was out of the building, she would call physician to get the time changed. On 12/8/23 at 10:46 AM, the surveyor interviewed the Director of Nursing (DON) who	F 698		

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F 698	Continued From page 28 stated that the medications for Resident #22 should have been changed when the [EX Order 26.4B1] times were changed in October. The DON then stated that the RN was incorrect, and no medications were sent with the resident to [NJ Exec. Order 26:4.b] The DON also stated that the usual procedure was to address the CP recommendations as soon as possible. The DON stated that she was unaware if there was a policy regarding this procedure. The DON acknowledged that the CP report dated [EX Order 26.4B1] for Resident #22 to change the medication administration times was not addressed. On 12/11/23 at 10:45 AM, the surveyor interviewed the DON. The DON was not aware of any policy on addressing the CP report but stated that she was responsible for addressing the reports. A review of an untitled policy and procedure for medication administration, dated 9/2023 was provided by the DON. The policy reflected "Nursing personnel shall ensure the safe and effective administration of medications." In addition, the policy reflected under "General Information of Importance: Section I. It is a standard of practice that medications be administered as ordered by the physician. Medication be administered to the resident within a one-hour time frame before/after the indicated administration time, unless otherwise specified by drug information. e-MAR must be signed by the nurse who administered the medication. In the event of e-MAR downtime, system interface configurations or software failure, a paper documentation of medication administration must	F 698		

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F 698	Continued From page 29 be completed and file in the resident's chart." An untitled policy and procedure for dialysis, dated 9/2023, was provided by the DON. The policy reflected under section H, "Diabetic Management: Diabetic management including finger sticks and medication administration timing will be adjusted appropriately as needed."	F 698		
F 711 SS=F	NJAC: 8:39-11.2(b), 27.1(a), 29.2(a)(d) Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that the residents' primary physician signed and dated monthly physician orders to ensure that the residents' current medical regimen was appropriate. This deficient practice was	F 711	Corrective Action- 1. The Facility contacted Point Click care Company on 12/6/23 to enable the access for the Physicians to electronically sign the Monthly Orders review function. Once access was provided by PCC, the	1/26/24

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F 711	Continued From page 30 observed for 20 of 22 residents (Resident #86, 14, 31, 34, 48, 54, 152, 22, 28, 49, 1, 4, 12, 56, 58, 16, 40, 61, 69, and #73) reviewed. Some of the residents had not had physician signed orders since December 2022. This deficient practice was evidenced by the following: The surveyors reviewed the hybrid medical records (paper and electronic) for the residents listed above that revealed the residents' primary physician had not hand signed the Order Summary Reports (monthly physician's orders) located in the residents chart. In addition, there were no electronic signatures under the physician's orders in the electronic medical record for the following residents: 1. Resident #86's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for October 2023 and November 2023. 2. Resident #14's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders from May 2022 to November 2023. 3. Resident # 31's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders from May 2022 to November 2023.	F 711	physicians were immediately in-serviced on 12/6/23. 2. Residents #86, 14,31, 34, 48, 54, 152, 22, 28, 49, 1, 4, 12, 56, 58, 16, 40, 61, 69 and 73 were affected and monthly orders were reviewed and electronically signed by attending Physicians on 12/6/23. Identification of other Residents: All residents have the potential to be affected by this deficient practice. The nursing Administration audited and reviewed the entire monthly orders to identify other residents that may have been affected by this deficient practice. Forty-two other residents were identified. Physicians were further notified to review and sign the orders on 12/6/23 and were all completed on 12/7/23. Preventive Measures/Systemic Changes¿ The Administrator and Director of Nursing reviewed the facility's policy and procedure on Physician Services. It was determined that the policy and procedure was sufficient and required no changes. All Physicians were reminded and given repeat in-service training on reviewing and signing electronically all monthly orders during their visits. Quality Assurance: The Quality Assurance Performance Improvement (QAPI) committee shall be responsible for ascertaining the effectiveness of the corrective actions and preventive measures.	

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F 711	Continued From page 31 4. Resident #34's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders from September 2023 to November 2023. 5. Resident #48's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders from October 2022 to November 2023. 6. Resident #54's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders from May 2022 to November 2023. 7. Resident #152's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for November 2023. 8. Resident #22's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders from October 2023 to November of 2023. 9. Resident #28's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders from January 2023 to November of 2023. 10. Resident #49's hybrid medical records	F 711	The Nursing administration shall review monthly orders of 5 residents weekly for three months to determine Physicians compliance. The QAPI committee shall review any findings and report any findings to the Administrator for any additional corrective actions.	

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F 711	Continued From page 32 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders from September 2023 to November of 2023. 11. Resident #1's hybrid medical record revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders from January 2023 to November of 2023. 12. Resident #4's hybrid medical record revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders from January 2023 to November of 2023. 13. Resident #12's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders from January 2023 to November of 2023. 14. Resident #56's hybrid medical record revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders from January 2023 to November of 2023. 15. Resident #58's hybrid medical record revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders from January 2023 to November of 2023. 16. The surveyor reviewed Resident #16's hybrid medical records, which revealed the resident's	F 711		

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F 711	Continued From page 33	F 711		

physician had not hand signed or electronically signed the monthly physician's orders from June 2023 to November of 2023.

17. The surveyor reviewed Resident #40's hybrid medical records, which revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders from January 2023 to November of 2023.

18. The surveyor reviewed Resident #61's hybrid medical records,, which revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders from February 2023 to November of 2023.

19. The surveyor reviewed Resident #69's hybrid medical records, which revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders from January 2023 to November of 2023.

20. The surveyor reviewed Resident #73's hybrid medical records, which revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders from January 2023 to November of 2023.

On 12/6/23 at 12:30 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the physician's should have been signing monthly for each of the resident's orders in the Electronic Health Record (EHR). The DON stated that the facility did not realize that the monthly orders had not been signed as there was no access in their EHR for the physician to do so. The monthly orders had not been printed into a paper format since December of 2022. The

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F 711	Continued From page 34 physician's were expected to sign their monthly orders electronically starting in January 2023, which did not occur. The surveyor reviewed the Physician Services policy and procedure dated 9/2023, which revealed "review of orders are provided during monthly physician's visits and documentation in Physicians noted and update and needed."	F 711		
F 756 SS=D	NJAC 8:39-35.2,7 Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a	F 756		1/26/24

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F 756	Continued From page 35 minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that the Consultant Pharmacist (CP) recommendations were acted upon in a timely manner regarding adjusting the timing of medications to be administered when a resident was available in the facility. The deficient practice was identified for one of 21 residents (Resident #22) reviewed for CP recommendations and was evidenced by the following: On 12/1/23 at 11:56 AM, the surveyor interviewed Resident #22. The resident stated that he/she had been in the facility almost [redacted] and went out for [redacted] The	F 756	Corrective Action¿ Pharmacy Consultant monthly drug regimen review and recommendation on [redacted] for resident #22 was immediately addressed on [redacted] The Administrator immediately in serviced the Director of Nursing on timely response to drug regimen review. Identification: All other residents have the potential to be affected by this deficient practice. Nursing Administration reviewed the monthly consultant Pharmacy report and recommendations on12/5/ 23. No other resident was identified to be affected by this deficient practice. Preventive Measures/Systemic Changes:	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 36 resident also stated that he/she had previously gone to [EX Order 26.4B1] later in the evening, but the time was changed. The surveyor reviewed the medical record for Resident #22. A review of the Admission Record (an admission summary) reflected diagnoses that included EX Order 26.4B1 [redacted]. A review of the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [EX Order 26.4B1], reflected the resident had a brief interview for mental status (BIMS) score of [EX Ord] out of 15, indicating that the resident had a EX Order 26.4B1 [redacted]. A review of the resident's [EX Order 26.4B1] communication book that was available at the nursing station indicated on the cover that the [EX Order 26.4B1] days for the resident were on EX Order 26.4B1 [redacted] chair time of [EX Order 26.4B1] and pick up time of [EX Order 26.4B1]. A review of the nursing progress notes dated [NJ Exec. Order 26:4.b.1] 19:45 (7:45 PM) Health Status Note indicated that the resident returned from [NJ Exec. Order 26:4.b.] at 7:40 PM (19:40). A review of the electronic Medication Administration Record (eMAR) for [NJ Exec. Order 26:4.b.1] reflected the following medications documented as administered at a time when the resident was out of the facility to [NJ Exec. Order 26:4.b.]	F 756	The Administrator and Director of Nursing reviewed the facility's policy and procedure on Drug Regimen Review. It was determined that the policy and procedure was sufficient and required no changes. the Director of Nursing and designee, provided in service to licensed professional nursing staff and Physicians on timely response to Drug regimen review report and recommendations on 12/5/23 and completed on 12/21/23. Quality Assurance: The Quality Assurance Performance Improvement Committee (QAPI} shall be responsible to ascertain the effectiveness of the corrective actions and preventive measures. Nursing administration will review the Pharmacy Consultant's Drug Regimen Review report and recommendation monthly for three months to determine compliance. Upon completion of 3 months, the QAPI committee shall be responsible for the review of the corrective actions and preventive measures. The result of the findings shall be reported to the Administrator for any additional corrective actions.	

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	315375	A. BUILDING _____ B. WING _____	C 12/12/2023

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F 756	Continued From page 37	F 756		

NJ Exec. Order 26:4.b.1

A review of the CP report "Consultant Pharmacist's Monthly Report" dated NJ Exec. Order 26:4.b.1 provided by the Director of Nursing (DON) reflected a recommendation for Resident #22, "Please be sure that medication times are charted to accommodate resident's NJ Exec. Order 26:4.b.1 times. Clarify NJ Exec. Order 26:4.b.1."

On 12/5/23 at 1:11 PM, the surveyor interviewed the CP. The CP stated she is the regular consultant for the facility. The CP stated she reviews charts and medication times. The CP stated she reviews dialysis times and sends recommendations for corrections to the facility administration.

On 12/8/23 at 10:46 AM, the surveyor interviewed the DON who stated that the usual procedure was to address the CP reports as soon as possible. The DON also stated that she was unaware if there was a policy regarding this procedure. The DON acknowledged that the CP

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F 756	Continued From page 38 report dated [redacted] for Resident #22 to change the medication administration times was not addressed. On 12/11/23 at 10:45 AM, the surveyor interviewed the DON. The DON was not aware of any policy on addressing the CP report but stated that she was responsible for addressing the reports. REFER TO F698	F 756		
F 803 SS=D	NJAC 8:39- 29.3 (a)(1) Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition	F 803		1/26/24

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F 803	Continued From page 39 professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. 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 dietary staff were following the meal tickets for three (3) of 10 residents reviewed for [NJ Exec. Order 26:4.b.1]. This deficient practice was evidenced by the following: On 12/4/23 at 12:20 PM, the surveyor observed the pureed lunch meal for residents who were prescribed a [NJ Exec. Order 26:4.b.1]. The surveyor observed that the lunch tray tickets for Resident # 28, # 31 and # 69 indicated that the residents were to receive boiled rice (pureed) but all three (3) of the resident's actually received pureed mashed potatoes on their trays instead. At 12:45 PM, the surveyor interviewed the Dietary Director (DD), who stated that the lunch tray tickets indicated that all the residents who received a [NJ Exec. Order 26:4.b.1] were supposed to receive boiled rice (pureed). The DD added that all the residents actually received pureed mashed potatoes and he was not sure why that occurred. At 4:18 PM, the surveyor discussed the above concerns with the Administrator and Director of Nursing, who did not provide any further information. NJAC 8:39-17.4(a)(1)	F 803	Corrective Action¿ 1. Residents #28, 31 and 69 were immediately assessed and interviewed for tolerance of Pureed mashed potatoes on their trays instead of boiled rice. No complaints made and no adverse effects noted. 2. Director of Dietary and Cook were immediately in serviced to prepare meals following the menu on 12/4/23. Identification: All other residents have the potential to be affected by this deficient practice. All residents on pureed diet with boiled rice on the menu were assessed and no other residents were identified by this deficient practice. Preventive Measures/Systemic Changes: 1. All Dietary staff were in serviced on 12/4/2023 and completed on 12/21/2023 to follow, and properly execute all meal menus, both diets and consistencies. 2. Facility Cook was then terminated. 3. Policy and Procedure on Food and Nutrition Services and Pureed Diet Consistency were reviewed and	

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F 803	Continued From page 40	F 803	determined to be sufficient, and no changes needed. Quality Assurance¿ 1. The Quality Assurance Performance Improvement Committee (QAPI) shall be responsible for ascertaining the effectiveness of the corrective actions and preventive measures. 2. Director of Dietary will audit daily for 4 weeks, then weekly for 2 months to determine compliance. 3. Upon completion of 3 months, the QAPI committee shall be responsible for the review of the corrective actions and preventive measures. 4. The result of the findings shall be reported to the Administrator for any additional corrective actions.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 842		1/26/24

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F 842	Continued From page 41 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain-	F 842		

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F 842	Continued From page 42 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to accurately document in the medical record the status of a resident who left the facility on a pass. The concern was cited for 1 (Resident #154) of 22 residents reviewed and is evidenced by the following. The surveyor observed Resident #154 in bed with eyes closed on 11/29/23 at 11:27 AM. The surveyor observed the resident's room on 11/30/23 at 10:38 AM and the resident was not in the room. The bed linens had been removed, and no personal items were visible. A review of the electronic medical record revealed the following information in the Progress Notes. The Admission Record indicated the resident was admitted to the facility on [EX Order 26:4B1] services. Diagnoses included but were not limited to, [NJ Exec. Order 26:4.b.1]	F 842	Corrective Action: Resident #154 Social Service Director wrote a late entry note on 12/4/23 and Director of Nursing on 12/6/23 to document resident's disposition status. Resident #154 remains [NJ Exec. Order 26:4.b.1]. identifications: All residents have the potential to be affected by this deficient practice. The nursing administration reviewed and audited medical records of residents that went out on pass to determine if disposition is properly and timely documented. No other resident was identified to be affected by this deficient practice. Preventive Measures/Systemic changes: The Administrator and Director of Nursing reviewed the facility's policy and procedure on Resident off the premises, Leave of Absence. The policy and procedure is revised on 12/20/23 to reflect the procedure to be implemented	

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F 842	Continued From page 43 The Minimum Data Set (MDS) assessment tool indicated the resident was discharged on [EX Order 26.4B1] with an anticipated return to the facility. Electronic Progress Notes reflected on [NJ Exec. Order 26:4.b.1] at 1 PM, the resident went out on pass with a responsible party. At 3:30, the responsible party took the resident to the hospital. At 9:49 PM, an emergency department physician called the facility stating, the resident was in their hospital. On [NJ Exec. Order 26:4.b.1] at 8:20 AM, the facility staff called the hospital and was told the resident was discharged. The surveyor interviewed the unit nurse on 12/4/23 at 11:39 AM. She stated the resident had gone out on pass with family, and the family sent the resident to the hospital because of [EX Order 26.4B1]. The unit nurse stated the resident was discharged from the hospital. The unit nurse stated she had no further information regarding the resident's status. She directed the surveyor to the Social Services Director (SSD) for more information about the status and condition of the resident. The surveyor interviewed the SSD on 12/4/23 at 12:03 PM. The SSD stated she had a family meeting the previous week with the resident and a family member. The resident wanted to be discharged home, and the SSD encouraged the resident to stay at the facility. The resident agreed to stay and then requested to go out on a pass with family. The SSD stated she called the [EX Order 26.4B1] nurse and received approval for the resident to go out on pass. The SSD stated she usually would document a family meeting; however, she did not document information	F 842	that by 8:00 PM, the family will be called to check resident's disposition. In addition, the Social Service Director and licensed professional nursing staff received in service training regarding accurate and timely documentation of residents leaving and returning to and from facility. Quality Assurance: The Quality Assurance Performance Improvement Committee (QAPI) shall be responsible for ascertaining the effectiveness of the corrective actions and preventive measures. Nursing administration shall review 5 random residents who went out on pass weekly for three months to determine compliance. The QAPI committee shall be responsible for the review of the corrective actions and preventive measures. The result of the findings shall be reported to the Administrator or for any additional corrective actions.	

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F 842	Continued From page 44 regarding this family meeting since it was not a pre-scheduled appointment. The SSD stated she did not follow up on the resident's status since the resident was discharged home. When asked by the surveyor to clarify, the SSD corrected herself, saying that the resident was out on pass, not discharged home. The surveyor interviewed the Director of Nursing (DON) on 12/6/23 at 2:17 PM regarding the resident's status. The DON responded on 12/7/23 at 9:18 AM with copies of SSD and DON Progress Notes written on [redacted] and [redacted] respectively, with updates on the resident's condition. The DON stated she told the SSD she should have written an update on the resident's status, and when the SSD did not document it, the DON wrote it herself on [redacted] On 12/7/23, the DON provided the surveyor with the facility's policy for "Resident off the Premises, Leave of Absence" reviewed 9/2023. The policy did not address procedures to be implemented by the facility when the resident does not return from leave of absence at the expected time. NJAC 8:39-35.2	F 842		

New Jersey Department of Health

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General	S 560	Corrective Action. The facility has an active recruitment program for attracting and hiring Certified Nursing Assistants (CNA). Three CNAs were recently hired and are currently participating in the facility's orientation program. The facility will continue its efforts to recruit and employ CNAs in order to comply with the recently enacted minimum staffing requirements for CNAs. Identifications:	1/26/24

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

Electronically Signed | 12/26/23

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S 560	Continued From page 1 Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) One certified nurse aide to every eight residents for the day shift. (2) One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties, and (3) One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place.	S 560	Nursing Administration identified that the week-end CNA staffing schedules were affected by this deficient practice. 6 of the 14 shifts identified in the Statement of Deficiencies were mainly week-end shifts. Each shift was CNA below the minimum CNA staffing requirement. Preventive Measures. The Administrator and Director of Nursing shall continue to review the daily CNA staffing schedules to ensure compliance with the state's minimum CNA staffing requirement. In addition, the facility will continue its recruitment and hiring efforts, as well as its CNA staff retention programs in order to meet the staffing requirements. The facility shall offer overtime, incentive pay, and bonuses to current staff when a staffing shortage is identified or occurs throughout the day. The facility also maintains a contract with a nursing contracted agency in the event of any prolonged CNA and/ or nursing vacancies. Quality Assurance. The Director of Nurses and Administrator or designee shall review the CNA staffing schedule daily for four weeks and then weekly for an additional two months to determine compliance with the state's minimum CNA staffing requirement. The Administrator shall continue to monitor the facility's hiring and retention practices to identify potential areas of improvement. Upon the completion of the three-month review, the QAPI committee shall review on a quarterly basis the center's CNA	

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S 560	Continued From page 2 (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 begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two weeks of staffing from 11/12/2023 to 11/25/2023 for the 12/12/2023 Standard survey revealed the deficient practice was evidenced by the following: The facility was deficient in CNA staffing for residents on 6 of 14-day shifts as follows: -11/12/23 had 12 CNAs for 104 residents on the day shift, which required at least 13 CNAs. -11/18/23 had 12 CNAs for 108 residents on the day shift, which required at least 13 CNAs. -11/19/23 had 12 CNAs for 108 residents on the day shift, which required at least 13 CNAs. -11/22/23 had 12 CNAs for 110 residents	S 560	staffing level. Findings shall be reported to the Administrator for any additional corrective actions.	

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S 560	Continued From page 3 on the day shift, which required at least 14 CNAs. -11/23/23 had 13 CNAs for 110 residents on the day shift, which required at least 14 CNAs. -11/24/23 had 13 CNAs for 109 residents on the day shift, which required at least 14 CNAs. The surveyor observed daily staffing reports for nursing on each day of the survey. On 12/08/23 at 11:20 AM, the surveyor received the facility Staffing Policy and Procedure from the Director of Nursing (DON). The facility staffing policy stated, "Certified Nursing Assistants (CNA) are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan. We require the CNA to have resident to staff ratio as per the NJDOH 7-3 shift 1/8, 3-11 shift 1/10 and 11-7 shift 1/14." On 12/11/23 at 12:00 PM, the team leader surveyor informed the DON, Licensed Nursing Home Administrator, and administrative team that the staffing concern related to lower than minimum direct care staffing to resident ratio on 6 of 14 shifts 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
315375 Y1	A. Building B. Wing Y2	1/29/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILLS CENTER FOR REHABILITATION AND HEALING	497 MT PROSPECT AVE NEWARK, NJ 07104

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 F0640	Correction	ID Prefix F0656	Correction	ID Prefix F0658	Correction
Reg. # 483.20(f)(1)-(4)	Completed	Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	01/26/2024	LSC	01/26/2024	LSC	01/26/2024
ID Prefix F0689	Correction	ID Prefix F0698	Correction	ID Prefix F0711	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.30(b)(1)-(3)	Completed
LSC	01/26/2024	LSC	01/26/2024	LSC	01/26/2024
ID Prefix F0756	Correction	ID Prefix F0803	Correction	ID Prefix F0842	Correction
Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.60(c)(1)-(7)	Completed	Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed
LSC	01/26/2024	LSC	01/26/2024	LSC	01/26/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/12/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
62203 Y1	A. Building B. Wing Y2	1/29/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILLS CENTER FOR REHABILITATION AND HEALING	497 MT PROSPECT AVE NEWARK, NJ 07104

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 01/26/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 12/12/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315375	A. BUILDING **01** B. WING _____	**12/12/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILLS CENTER FOR REHABILITATION AND HEALING	**497 MT PROSPECT AVE** **NEWARK, NJ 07104**

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K 000	INITIAL COMMENTS Forest Hill Healthcare Center is a five story building that was built in 90's, It is composed of Type II construction. The facility is divided into 12 smoke zones. The exterior 800 KW diesel generator does approximately 90% of the building. The facility is licensed for 120 beds and currently occupies 108.	K 000		
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations and review of facility documentation on 12/11/23 and 12/12/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that 13 of 15 sets of exit access stairwell doors tested, were capable of maintaining the 1-1/2 hour fire rated construction.This deficient practice was evidenced by the following: On 12/11/23 during the survey entrance at approximately 9:20 AM, a request was made to the Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various	K 311	Corrective action The maintenance director on 12/14/2023 went around and placed the latches on the fire doors this way there is no ear space between the fire door and the frame and placed an order for extra material that was needed to fix some of the doors. identification The maintenance director did rounds on	1/26/24

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

Electronically Signed | 12/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 311	Continued From page 1 rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a five (5) story building. There are three (3) interior stairwells that Residents, Visitors and Staff could use in the event of an emergency. There are resident sleeping rooms on floors #4 and #5. The following stairwell exit/egress doors were observed and did not latch into its frame,when in the closed position, the doors were closed and locked by a keypad and electro-magnetic release system. When the keypad released the electro-magnetic device or fire alarm activation, the doors could be pushed open to exit, but when the doors were closed they did not latch into its frame. The stairwell doors would need to positive latch into its frame to maintain the 1-1/2 hour fire rated construction to prevent fire, smoke and poisonous gases from entering the exit stairwell in the event of a fire in the following locations: Floor #5 Stairwell #1 Floor #5 Stairwell #2 Floor #5 Stairwell #3 Floor #4 Stairwell #1 Floor #4 Stairwell #2 Floor #4 Stairwell #3 Floor #3 Stairwell #1 Floor #3 Stairwell #2 Floor #3 Stairwell #3 Floor #2 Stairwell #1 Floor #2 Stairwell #2 Floor #1 Stairwell #1 Floor #1 Stairwell #2 The facility MD confirmed the findings at the time	K 311	all the fire doors of the center and there were no other deficiencies found. Preventive measures The maintenance staff was in serviced that all fire doors must latch close and by not having the latch can be a danger a log was created, and the maintenance staff will do rounds monthly for 6 months to ensure that the center will not have this deficiency. Quality assurance The maintenance staff will do monthly rounds for six months using an audit tool to make sure that all fire doors have latches and the QAPI committee will inspect this annually and if there are any deficiencies to be found it reported to the administrator so immediate action can be taken.	

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K 311	Continued From page 2 of observations. The MD indicated he was not sure who removed the latch mechanisms throughout the facility. The Administrator was informed of the findings at the Life Safety Code exit conferenceon 12/12/23. Fire Safety Hazard. NJAC 8:39- 31.2(e)	K 311		
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) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces	K 321		1/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315375	A. BUILDING **01** B. WING _____	**12/12/2023**

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K 321	Continued From page 3 (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview on 12/12/23, in the presence of the Maintenance Director (MD) it was determined that the facility failed to provide a fire barrier with one hour fire resistance rating in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1 and 8.7.1. The deficient practice was evidenced in 4 of 10 areas observed. 1). At 10:55 AM, the surveyor and MD observed in the basement corridor that an approximately 6' area of the steel beam was missing fire-rated material by the employee lunch room. 2). At 11:00 AM, the surveyor and MD observed in the basement corridor that an approximately 2' area of the steel beam was missing fire-rated material by the exit and lockers. 3). At 11:18 AM, the surveyor and MD observed in the basement that an approximately 5' area of the steel beam was missing fire-rated material in the main electrical room. 4). At 11:27 AM, the surveyor and MD observed in the basement corridor that an approximately 5' area of the steel beam was missing fire-rated material by elevator's #1 & #2. The findings were verified by the Maintenance Director at the time of the observation's. The Administrator was informed of the finding's at	K 321	Corrective action The maintenance director reached to the vendor to receive a proposal to have the beams be placed with fire rated material the company came to look at all the work that needs to be done. Identification of other resident of the deficient practice The maintenance staff did rounds around the whole center from inside the building and in the parking lot where there is steal beams and there were no other beams that were found to be missing the fire rated material. Preventive measures The maintenance staff was in serviced as per policy that all steal beams need to have fire rating material to ensure the fire protection of the steel beams and an audit tool was created to ensure that all steel beams will have fire protection Quality assurance The maintenance staff will do monthly rounds on all the steel beams for 6 months to ensure that there is no steel beams that don't have fire protection by using an audit tool that will signed by the	

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K 321	Continued From page 4 the Life Safety Code Exit Conference on 12/12/23. NJAC 8:39-31.2(e)	K 321	maintenance staff and the QAPI committee will inspect annually to make sure that there are no deficiencies and if there are any deficiencies it will be reported to the administrator so immediate corrective action will be taken the maintenance director will make sure that this will be followed up on and will be completed by 01/026/2024 completion the beams are being protected by fire rated material as per nfpa on 1/18/2024	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review on 12/11/23 and 12/12/23, in the presence of the Maintenance Director (MD), the facility failed to ensure: a.) that their fire alarm system was inspected semi-annually as per NFPA 70 and 72. b.) smoke detection sensitivity testing were completed of the facility smoke detectors in accordance with NFPA 72 (2010 edition) section 14.4.5.3.2. The deficient practice was identified for 3 of 3 inspection reports and was evidenced by the following:	K 345	Corrective action Maintenance director reached out to the fire alarm vendor for the fire alarm inspection which came to the facility on 12/19/2023 completed the fire alarm inspection and to check all the batteries and ran the smoke detector sensitivity report. identification	1/26/24

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K 345	Continued From page 5 On 12/11/23 at 9:15 AM, the surveyor and MD observed the most recent "Fire Alarm & Testing form" that was dated:12/9/22. The facility did not have any further inspection documentation. The facility did not have their fire alarm system inspected in 2023. The current fire alarm system has sealed lead acid batteries and requires a semi-annual inspection as stated on the 12/9/22 report. The MD indicated he was aware the system was not inspected for 2023 and he stated it maybe due to a payment issue. b). On 12/11/23 at 9:48 AM, the surveyor and MD observed that no fire alarm smoke detector sensitivity report was provided in the Life Safety Code Inspection book. The last report was dated: 12/9/22 and did not indicate when the last smoke detector sensitivity test was conducted in accordance with NFPA 72 (2010 edition) section 14.4.5.3.2. The MD was interviewed during the document review, where he stated currently that no smoke detector sensitivity report was performed and he could not provide any documentation on when it was last conducted. The Administrator was informed of the findings at the Life Safety Code Exit conference on 12/12/23. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 70, 72	K 345	Maintenance director did rounds in the facility and there was no other deficiency found at the center Preventive measures The maintenance director was in serviced on reaching out to the vendor in setting up the inspection and getting the proper documentation an audit was created so fire alarm will not be missed in the future Quality assurance The maintenance director will keep a log of the quarterly inspection and will review the log quarterly for 1 year to ensure that the quarterly is not missed the QAPI committee will inspect annually and if there are any deficiency found it will be reported to the administrator to take immediate corrective action.	
K 353	Sprinkler System - Maintenance and Testing	K 353		1/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 353 SS=F	Continued From page 6 CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/11/23 and 12/12/23 in the presence of the Maintenance Director (MD).it was determined that a).The facility failed to maintain the sprinkler system, by ensuring that the ceiling was smoke resistant and fire rated in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. b). The facility failed to provide 2 of 4 quarterly fire sprinkler inspections from the facility vendor. c).The facility failed to ensure the fire sprinkler pipe was in optimal condition. d). The facility failed to ensure fire sprinkler deficiencies from the facility vendor inspection	K 353	Corrective action The maintenance director reached out to the sprinkler to come down for an inspection they will come in January 2024 and they will replace the 2 risers 2 mains and 1 valve face plate and they will replace the rusted and leaking 1.25 inch pipe after the itv and they will fix the two dry sprinkler heads in the coolers in the 3rd floor kitchen and they will replace the outdated water gauges and they will do an internal cleaning to remove all foreign materials which are in the pipe and they will replace the escutcheon plate by the nurses station the maintenance staff	

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K 353	Continued From page 7 reports were repaired as per NFPA 25. a). During a building tour on 12/11/23, from 9:30 AM, to 12:25 PM, the Surveyor and MD, observed 3 of 15 verticle ceiling openings in the following areas of the facility: 1). At 11:18 AM, the surveyor and MD observed in the IT closet by the administrative offices, that a drop ceiling tile, approximately 4" x 2' was not in place. The open area was observed to have wires running through the opening and above the drop ceiling. 2). At 11:27 AM, the surveyor and MD observed in the (east) physical therapy closet, that the drop ceiling was missing two tiles. 3). At 12:40 PM, the surveyor and MD observed that outside the nurse station the fire sprinkler head was missing its escutcheon plate. The opening around the sheetrock ceiling was approximately 1" around the missing plate. The MD in an interview confirmed the above observations. b). At 09:50 AM, the surveyor reviewed the quarterly fire sprinkler inspection reports from the facility vendor. The reports provided were dated: 11/29/23 and 1/6/23, the sprinkler system was not inspected for the 2nd and 3rd quarter of 2023. The MD stated the inspections may not have been completed due to a payment issue. c). At 10:10 AM, the surveyor reviewed the 5-year internal obstruction investigation of the pipe document, dated: 10/18/22 the report	K 353	replaced the ceiling tiles in the IT room and in the physical therapy room on 12/14/2023 Other residents are affected by the deficient practice. Maintenance staff did rounds around the center for missing tiles and any other issues regarding the pipes and there were no other deficiencies found. Preventive measures Maintenance director was in serviced that he needs to reach out to the vendor to schedule all the inspections and a log was created for the quarterly inspections and a log for any work orders that are not completed, and maintenance staff were in serviced that there can□t be any missing tiles. Quality assurance Monthly rounds for the next 6 months will be inspected if there any missing tiles and the log will be checked if there are any work orders that are not followed up on and if there any missing inspections and it will be inspected by the members of the QAPI committee annually and if there is found to be any deficiencies it shall be reported to the administrator to take corrective action immediately. completion the sprinkler company came down to the center on january 8th and completed all	

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K 353	Continued From page 8 indicated 2-risers, 2-mains and 1-valve face plate were examined. The results of the initial examination: -The interior of the sprinkler appear in satifactory condition: NO -The sprinkler systems are in need of internal cleaning. Some of the pipes were found to be partially full of foreign materials. (specifically nature of internal stoppage): SILT The MD stated he was aware of the report and confirmed the condition indicated on the report as stated above. d). At 10:30 AM, the surveyor reviewed all fire sprinkler documentation provided by the MD. The inspection repair proposal: 12-502 dated: 12/7/23 indicated that the following deficiencies be corrected in order for the automatic sprinkler system to operate as originally designed: coordinate system shutdown with building facilities. replace rusted and leaking 1.25" pipe after the ITV in the maintenance shop. replace (2) dry sprinkler heads in coolers of the 3rd floor kitchen that are dated from 2004. replace a total of (4) outdated water guages for the standpipes. One is located in the basement, and three are located on the tops of the standpipe risers. The Administrator was informed of the findings at	K 353	the work	

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FOREST HILLS CENTER FOR REHABILITATION AND HEALING	**497 MT PROSPECT AVE** **NEWARK, NJ 07104**

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K 353	Continued From page 9 the Life Safety Code Exit Conference on 12/12/23. NJAC 8:39-31.2(e) NFPA 25	K 353		
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that electrical equipment had approved wiring and electrical outlets in accordance with NFPA 70, 2011 Edition, Section 19.5.1.1, 9.1.1 and 9.1.2. The deficient practice was evidenced for 1 of 10 electrical outlets observed by the following: At 11:10 AM, the surveyor and MD observed in the physical therapy room, that the portable hydrocollator was full of water and plugged into a standard electrical outlet. The Maintenance Director stated that the current electrical duplex outlet could not be identified as a ground-fault circuit interrupter (GFCI).	K 511	Corrective action a work order was placed and the maintenance staff replaced a gfci outlet for the hydrocollator on 12/14/2023 identification The maintenance director did rounds to make sure all equipment in close proximity to water was plugged in with a gfci outlet using an audit tool and there were no other deficiency found at the center Preventive measures The maintenance staff was in serviced regarding facility policy that all equipment	1/26/24

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K 511	Continued From page 10 The Administrator was informed of the finding at the Life Safety Code exit conference on 12/12/23. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 511	in close proximity to water be plugged into a gfci outlet. Quality assurance Maintenance staff will do a monthly audit for 6 months to ensure compliance with equipment in close proximity to water the QAPI committee will inspect this annually and if there are any deficiencies found they will report it to the administrator for immediate corrective action	
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: During record review on 12/11/23, in the presence of the Maintenance Director (MD), it	K 531	Corrective action	2/9/24

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K 531	Continued From page 11 was determined that the facility failed to test and inspect the elevator's annually with the New Jersey Department of Community Affairs Division of Codes and Standards Elevator Safety Division and/or AHJ. This deficient practice was evidenced by the following: At 10:45 AM, a review of the facility's elevator inspection certificate's, revealed that 3 of 3 elevator devices #1, #2 and #3, were last inspected 12/13/19 and were good for use until 12/13/20. The annual elevator inspection was conducted by the authority having jurisdiction (AHJ) and was over 3 years overdue. In an interview, at 11:00 AM, the facility's MD, stated they will communicate with their contracted elevator vendor AHJ to schedule an inspection as soon as possible. The observation of the signed off elevator certificate in the elevator room confirmed, the inspection was not up to date and last inspected: 12/13/19. No further documentation was provided. The Administrator was informed of the findings at the Life Safety Code exit conference on 12/12/23. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3.	K 531	The administrator reached out to the elevator vendor who contacted the inspector of Newark new jersey elevator to set up an inspection . Identification of other residents affected by the deficient practice. The maintenance staff did rounds of the center on all the elevators that had this deficient practice and there were no other elevators that had this deficient practice. Preventive measures The maintenance Director were in serviced by the administrator on how to set up the inspection with the elevator inspector of Newark new jersey, which is to call the facility elevator company who will set up a date and time with the inspector of Newark new jersey. An audit tool using a log was created which the maintenance director will go over each month with the administrator for 6 months in order not to miss the annual elevator inspection. Quality insurance Monthly for the next 12 months shall inspect the log and have the proper paperwork of the annual inspection of the elevators and it will be inspected annual by the members of the QAPI committee if it is found to be not inspected it shall be reported to the administrator for	

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K 531	Continued From page 12	K 531	immediate corrective action completion the administrator reached out the facility elevator company who contacted the newark elevator inspector who gave a date to come out to inspect the elevator by 02/08/2024	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: . Based on observation and interview on 12/12/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that the fire doors were inspected annually by an individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15.	K 761	Corrective action The maintenance director reached out to the fire alarm vendor which inspected all the fire doors which were all in compliance on 12/19/2023. Identification of other residents affected by the deficient practice. The maintenance director and fire alarm	1/26/24

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K 761	Continued From page 13 This deficient practice was evidenced for 12 of 12 doors observed by the following: At 09:00 AM document review indicated that the fire door assemblies were not inspected and tested annually in accordance with NFPA 80 Standard for fire doors. The Maintenance Director was interviewed at the time of the document review and he confirmed the fire doors were not inspected annually and could not provide a log indicating so. The MD indicated that a facility door vendor will perform the fire door inspections from now on. The Administrator was informed of the findings at the Life Safety Code exit conference on 12/12/23. NJAC 8:39-31.1(c), 31.2(e) NFPA 80 .	K 761	vendor did rounds on all the fire doors of the center and there were no other deficiencies founds that affected any residents Preventive measures The center created an audit tool and the maintenance director will check monthly and annualy using a log for the fire door inspection done. the administrator in serviced the maintenance staff that the fire door needs to be inspected annually. Quality insurance Monthly for the next 6 months shall inspect the log that the annual inspection is being done for the fire doors and it will be inspected annually by the members of the QAPI committee if this found to not be followed it shall be reported to the administrator for immediate action.	
K 911 SS=E	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/12/23, in the presence of the Maintenance Director (MD), it was determined that the facility	K 911	Corrective action The maintenance staff removed gallons of	1/26/24

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K 911	Continued From page 14 did not maintain the required clearance around electrical panels 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 was evidenced for 1 of 10 areas observed by the following: At 11:50 AM, the surveyor and Maintenance Director observed in the floor #1 water/storage area that 40-5 gallon water bottles were blocking access to 4-large electrical wall panels, that would prevent staff and emergency personnel from disconnecting the electrical power quickly. The observations were confirmed by the Maintenance Director during the observations. The Administrator was informed of the above observations at the Life Safety Code exit conference on 12/12/23. NJAC 8:39-31.2(e) NFPA 70, 99	K 911	water from the 4 large electrical panels that would prevent staff and emergency personnel from disconnecting the electrical power quickly on 12/13/2023. identification of other residents affected by the deficient practice. The maintenance staff did rounds on the center to make sure there were no obstacles in the way of any electrical panels and there was no deficient found around the center and there were no other residents that were affected by this deficient practice. preventive measures the maintenance staff and housekeeping staff were in-service that no obstacles be placed in the way of any electrical panels and an audit tool was created for monthly rounds to make sure that there are no obstacles in the way of any electrical panels and the maintenance director will do rounds monthly with the log to make sure that this deficient practice does not happen quality insurance monthly for the next 6 months the maintenance staff shall do rounds and inspect if there are any obstacles blocking the electrical wall panels and It will be inspected by the members of the QAPI committee annually if there any obstacles	

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K 911	Continued From page 15	K 911	found it shall be reported to the administrator for corrective action immediately	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, interview and documentation review on 12/11/23 and 12/12/23, in the presence of the facility's Maintenance Director (MD), it was determined that the facility failed to functionally test electrical receptacles in residents' rooms that had non-hospital grade outlets annually for grounding, polarity, and blade tension in accordance with NFPA 99.	K 914	Corrective action The maintenance director reached out to the vendor for the inspection for the electrical receptacles which was inspected on 12/19/2023 and everything was in working condition. identification of other residents affected	1/26/24

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K 914	Continued From page 16 This deficient practice was evidenced for 50 of 50 resident rooms observed by the following: On 12/12/23 from approximately 10:30 AM to 1:30 PM, the surveyor and MD, observed that resident rooms were provided with electrical receptacles that were less than hospital grade and required an annual electrical inspection. The MD, confirmed that the facility had non-hospital outlets installed in resident rooms, but could not provide any documentation or logs indicating the annual inspection was conducted for the current year. The last document provided for the electrical inspection from the facility vendor was dated: 12/07/21, but the provided document with that date did not have a company name, NJ electrical license and what was inspected as the document was not legible to read. The MD confirmed the electrical inspection was not conducted after 12/07/21, and he indicated the electrical inspection report provided was not legible to read. The Administrator was informed of the findings at the Life Safety Code exit conference on 12/12/23. NJAC 8:39-31.2(e) NFPA 99	K 914	by the deficient practice. the center maintenance director checked that no other areas of the center were affected by the deficient practice and no other areas were found to be affected by the deficient practice there was no issues preventive measures a log was created using an audit tool to ensure that the annual inspection for the electrical receptacles will not be missed, the maintenance director will be responsible for monthly rounds that the facility is in compliance, and the maintenance director will meet monthly with the administrator and show him the log to make sure that this deficient practice does not happen again . and maintenance director was in serviced of this deficient practice by the administrator. quality insurance monthly for the next 6 months the log will be checked, and the center plant supervisor will check that the log is up to date for the inspection, and it will be reviewed by the QAPI committee if there any issues. it will be reported to the administrator so immediate action can be taken	
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 916		1/26/24

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K 916	Continued From page 17 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview conducted on 12/12/23, it was determined that the facility failed to ensure that the facility's emergency generator annunciator panel was properly installed as per NFPA 99 and 72. This deficient practice was evidenced for 1 of 1 annunciator panels by the following: At 11:50 AM, the surveyor, in the presence of the Maintenance Director, observed that the generator annunciator panel was installed on the wall at the first floor security desk. The MD indicated that the facility had security 24 hours, but recently the over night shift was eliminated. The generator annunciator panel if activated from 8:00 PM, to 7:00 AM, would now not be observed by any operating personnel. The Maintenance Director confirmed in an interview, that the security nightshift tour was eliminated and now the generator annunciator panel would now not be observed by any operating personnel, as no one would be in that	K 916	Corrective action The maintenance director called the vendor for a proposal to move the generator annunciator panel which currently located in the front lobby to be moved to the nurse□s station which will be under 24hr surveillance. Identification of other residents affected by the deficient practice. The center physical plant manager inspected the other areas of the building to identify other areas that could be affected by this deficient practice and there were no other areas affected by this deficient practice. Due to this the only annunciator panel for the center Preventive measures The maintenance staff was in serviced that the annunciator panel needs to be on	

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K 916	Continued From page 18 area of the building during the 8:00 PM, to 7:00AM, shift. The Administrator was informed of the above observation at the Life Safety Code exit conference on 12/12/23. NJAC 8:39-31.2(e) NFPA 99 Health Care Facilities Code NFPA 72 National Fire Alarm and Signaling Code	K 916	24hr surveillance in case of an emergency and the policy was updated that the annunciator panel has to be under 24hr surveillance Quality insurance Monthly for the next 6 months the designee shall inspect that the annunciator panel for the generator will be placed in an area of the center that is on 24 hour watch and will be inspected annually by the member of the qapi committee if it needs repair or needs to be replaced it will be reported to the administrator for immediate corrective action completion the administrator reached out to the vendor and received confirmation that the annunciator panel will be moved on 1/22/2024 so it will be under 24hr surveillance	
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.	K 918		1/26/24

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K 918	Continued From page 19 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 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, interview and record review on 12/12/23, in the presence of the Maintenance Director (MD), A). it was determined that the facility failed to ensure a remote manual stop station for 1 of 1 outside diesel generators (800 KW) was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. B). it was determined that the facility failed to certify the time needed by their generator to transfer power to the building was within the required 10-second time frame, in accordance with NFPA 99 for emergency electrical generator systems.	K 918	Corrective action The maintenance director reached out to the vendor to receive a proposal to install a remote manual stop station for the generator to be installed at least 6 feet from the generator. The low load test was done on the generator immediately and the generator went on within 10 seconds. Identification of other residents affected by the deficient practice.	

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K 918	Continued From page 20 C). it was determined that the facility failed to provide any documentation for a load bank test as per NFPA 110 standards. These deficient practice's were evidenced by the following: A). On 12/12/23 at 11:05 AM, the surveyor and MD observed the exterior 800 KW (kilowatt) diesel generator. The observation indicated that there was no remote manual stop station observed outside the area of the generator location. It was observed that the current generator had a manual push/stop button installed on the front and back of the cabinet by the vents, but did not provide a "remote" manual push/stop. An interview was conducted during the time of the observation with the MD, who stated and confirmed that the exterior generator did not have a remote manual stop station to prevent inadvertent or unintentional operation that was located outside the area of the enclosure housing the prime mover for the current generator in service. B). On 12/11/23 At 9:44 AM, a review of the generator records for the previous twelve (12) months, did not reveal documented certification that the generator would start and transfer power to the building within ten seconds for only 10 of 10 times on the provided generator log. Currently, the MD was performing monthly generator load testing, but did not indicate the required transfer times on the provided log dates: 1/9/23, 2/6/23, 3/6/23, 4/3/23, 5/1/23, 5/29/23, 6/23/23, 7/24/23, 8/21/23,	K 918	The maintenance staff did rounds to check that no other areas were affected by this deficient practice and nothing else was found due to this is the only generator of the building. preventive measures the maintenance staff was in-service regarding the load test requirements and the remote manual stop station for the generator and the policy was updated to ensure that the low load test is being included in the generator testing using an audit tool Quality insurance Monthly for the next 6 months the designee shall inspect the load test for the generator and the remote manual stop station is at least 6 feet from the generator and will be inspected annually by the members of the QAPI committee if it is found to be replaced or repairs it shall be reported to the administrator for immediate corrective action. completion the administrator reached out to the vendor and received confirmation that the vendor will be coming out on the 01/22/2024 to install the remote stop generator	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315375	A. BUILDING **01** B. WING _____	**12/12/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILLS CENTER FOR REHABILITATION AND HEALING	**497 MT PROSPECT AVE** **NEWARK, NJ 07104**

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K 918	Continued From page 21 9/18/23, 10/11/23 and 11/13/23. An interview was conducted with the MD during document review, where he stated that currently he was not putting the transfer time on the provided generator monthly load test log. C). On 12/11/23 at 11:10 AM, the surveyor and MD confirmed that the facility could not provide any documentation on the last load bank test for their current 800 KW generator as per NFPA 110. In an interview during the documentation review, The MD indicated he was not sure when the last load bank test was performed, and that he will call his generator vendor to see if it was performed. No further documentation was provided. The Administrator was informed of the findings at the Life Safety Code exit conference on 12/12/23. NJAC 8:39-31.2(e), 31.2(g) NFPA 99 NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. NFPA 101 Life Safety Code 2012 edition 9.1.3.1 Standard for Emergency and Standby Power Systems	K 918		
K 923 SS=F	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.	K 923		1/26/24

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	315375	A. BUILDING **01** B. WING _____	**12/12/2023**

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K 923	Continued From page 22 >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 12/11/23 and 12/12/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to store cylinders of	K 923	Corrective action A call was placed immediately to the vendor for the oxygen cylinders and holders for the pt rooms and it was	

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	315375	A. BUILDING **01** B. WING _____	**12/12/2023**

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K 923	Continued From page 23 compressed oxygen in a manner that would protect the cylinders against tipping, rupture and damage in accordance with NFPA 99. This deficient practice was identified for 14 of 45 portable oxygen cylinders observed and was evidenced by the following: 1). On 12/11/23 at 9:32 AM, the surveyor and MD, observed in the clean utility linen closet across from resident rooms: 511 &512 that 2 oxygen cylinders were observed to be freestanding. 2). On 12/12/23 at 11:42 AM, the surveyor and MD, observed in the floor #1 oxygen storage room that 12 of 43 cylinders were observed to be freestanding. It was observed that cylinders were stored in four (4) green milk crates that did not have the ability to store cylinders individually. An interview was conducted with the MD, during the observations,where he stated that the portable oxygen cylinder's observed, must be secured from tipping, rupture and damage at all times in the facility. He indicated that he would notify the facility vendor for proper cylinder storage racks. The Administrator was informed of the finding's at the Life Safety Code exit conference on 12/12/23. NJAC 8:39-31.2(e) NFPA 99	K 923	delivered on 12/14/2023 the next day and all the oxygen cylinders were placed in the holders. Identification of other residents affected by the deficient practice. The maintenance and nursing staff did rounds that all the oxygen cylinders as per policy were placed in in the correct holders this deficiency was not found anywhere else in the center Preventive measures The policy of forest hill is that all oxygen cylinders need to be placed in its proper holders and stored properly,. All staff were in serviced of the oxygen cylinders proper holders as per policy . Quality insurance The maintenance staff will do monthly rounds for six months to maintain the oxygen cylinders are properly stored and will be inspected annually by the QAPI committee if it is found to be out of order it will be reported to the administrator for corrective action immediately. this will be completed by February 7th 2024	

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
315375 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/12/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILLS CENTER FOR REHABILITATION AND HEALING	497 MT PROSPECT AVE NEWARK, NJ 07104

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 K0311	01/26/2024	LSC K0321	01/26/2024	LSC K0345	01/26/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	01/26/2024	LSC K0511	01/26/2024	LSC K0531	02/09/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0761	01/26/2024	LSC K0911	01/26/2024	LSC K0914	01/26/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0916	01/26/2024	LSC K0918	01/26/2024	LSC K0923	01/26/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/12/2023	☐ YES ☐ NO