STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	151 NINTH AVENUE LITTLE EGG HARBOR TW, NJ 08087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is not in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
E 030 SS=D	Names and Contact Information CFR(s): 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff.	E 030		11/23/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/24/2022

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

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	151 NINTH AVENUE LITTLE EGG HARBOR TW, NJ 08087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 030	Continued From page 1 (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the	E 030		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	151 NINTH AVENUE LITTLE EGG HARBOR TW, NJ 08087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 030	Continued From page 2 following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on review of the facility's Emergency Preparedness Plan and interview on 11/02/22, it was determined that the facility failed to ensure that their communication plan included an updated emergency contact list as evidenced by the following: At 10:15 AM, the surveyor reviewed the facility's emergency contact list section and observed that it did not include the names of staff, resident's physicians, other facilities and volunteers. The contact list section of the binder was empty and did not contain any documents. During an interview with the surveyor on 11/02/22 at 10:53 AM, the Director of Nursing (DON) stated they kept the list of department heads and other numbers at the front desk. During an interview with the Maintenance Director (MD) on 11/02/22, and in the presence of the	E 030	An updated facility contact listing have been placed in the facility Emergency Plan Binder All residents residing in the facility have the potential to be affected by this practice Director of Maintenance and or his/her designee will maintain Emergency Plan Binder, weekly to assure that all mandatory documentation and information are current and accurate. He/She shall document his/her findings in the Emergency Plan Binder Director of Maintenance or designee will submit his/her findings of these audits to the Quality Assurance Committee, which will monitor these findings on a monthly basis for a period of six (6) months.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	151 NINTH AVENUE LITTLE EGG HARBOR TW, NJ 08087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 030	Continued From page 3 DON and survey team, the MD stated the staff and resident's physician number list was not kept in the Emergency Preparedness binder and that it was kept at the front desk. NJAC 8:39-31.2(e)	E 030		
F 000	INITIAL COMMENTS Survey Date: 11/02/22 CENSUS: 102 SAMPLE SIZE: 25 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine.	F 636		11/28/22

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	151 NINTH AVENUE LITTLE EGG HARBOR TW, NJ 08087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 4	F 636		

(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	151 NINTH AVENUE LITTLE EGG HARBOR TW, NJ 08087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 5 following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to accurately complete an Annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care for a resident. This deficient practice was identified for 1 of 25 residents reviewed (Resident #73) and was evidenced by the following: Review of the 08/07/22 Annual MDS for Resident #73 reflected in Section C "Cognitive Patterns", that Subsections C0100, C0200, C0300, C0400, C0500 C0600, C0700, C0900, and C1000 were not assessed. The MDS further reflected in Section Q "Participation and Goal Setting" that Subsections Q0100, Q0300, Q0490, Q0500, Q0550 were not assessed. Review of Section Z "Assessment Administration in subsection" that Subsection Z0400 "Signature of Persons Completing the Assessment" reflected that the MDS Coordinator completed Sections C and Q. During an interview with the surveyor on 11/01/22 at 9:01 AM, the MDS Coordinator stated that at the time the MDS assessment was completed, the facility did not have a Social Worker who would usually completed Sections C, D and Q of each MDS. The MDS Coordinator reviewed Resident #73's 08/07/22 Annual MDS, in the presence of the surveyor, and stated that Sections C, D and Q should have been completed. The MDS Coordinator added that she was working remotely and could not complete the resident interview. The MDS Coordinator stated	F 636	Resident #73 has had an updated Cognitive assessment completed and has had no change in cognition that would require new intervention. Resident #57's current Minimum Data Assessment (MDS) has been completed and accurately reflects resident's cognitive status. All residenst have the potential to be affected by this practice. An Audit of current residents with annual MDS assessments has been completed by the MDS Coordinator and they all have Section C and Section Q completed as required by the appropriate Staff members The MDS coordinator has been educated by the Regional MDS Coordinator on the requirements to ensure that section C and Section Q are completed during appropriate timeframe The MDS Coordinator has educated the Social Services Director and the Director of Nurses to ensure timely completion of Section C and Section Q of the annual MDS to accurately reflect the current cognitive status of the residents The MDs coordinator or designee will conduct weekly audits for a period of three months of current residenst with annual MDS Assessments due to ensure Section C and Section Q are completed in	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	151 NINTH AVENUE LITTLE EGG HARBOR TW, NJ 08087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 6 that it was the responsibility of each department to complete their assigned sections; and if not completed, she gave them reminders to complete them. The MDS Coordinator further stated that each department should be looking daily at MDS "in progress tabs" to make sure their sections were completed. She added that the MDS program did not alert her when a section was not assessed. During an interview with the surveyor on 11/01/22 at 10:50 AM, the Social Worker stated that she started her position as Social Worker on 08/08/22. She confirmed that she did not complete this assessment and normally she completed Sections C, D and Q of each MDS. During an interview with the surveyor on 11/02/22 at 11:25 AM, the Director of Nursing (DON), in the presence of the Regional Director of Clinical Services, stated the MDS Coordinator was working remotely and was ultimately responsible for the completion of the MDS. The DON added that sections C and Q were normally done by Social Worker but the Unit Manager was new and completed those sections. The DON stated that she expected the MDS Coordinator to let her know that the sections were not assessed. The DON further stated she expected the Sections of the MDS to be completed. Review of the facility's RAI Process Operational Manual - Administrative Policies policy, reviewed 03/22, reflected that the facility will utilize the Resident Assessment Instrument (RAI) process as the basis for the accurate assessment of each resident's functional capacity and health status, as outlined in the CMS [Centers for Medicaid] RAI MDS 3.0 Manual. The policy further reflected	F 636	the required timeframe The MDS Coordinator will present the results of the audits to the facility Quality Assurance Committee monthly for review for a period of six months.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	151 NINTH AVENUE LITTLE EGG HARBOR TW, NJ 08087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 7 that all information recorded within the MDS Assessment must reflect the resident's status.	F 636		
F 658 SS=E	NJAC 8.39 - 11.1 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 interview and record review, it was determined that the facility failed to consistently document the administration of a treatment in the electronic Treatment Administration Record (eTAR) in accordance with the facility policy. This deficient practice was identified for 1 of 2 residents (Resident # 29) reviewed for nutrition and for 2 of 3 residents (Residents #90 and #195) reviewed for EX Order 26 § 4b1 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 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,	F 658	Residents #29,#90,#195 had treatments administered as per the physician's orders but the nurses failed to sign the Treatment Administration Record (TAR) on multiple occasions, on all shifts dating back to 8/10/2022 through 10/30/2022. These treatments include but are limited to; change [redacted] bottle/filter wash, change and date [redacted], water bottle if applicable, wash filter every shift every [redacted], monitor tab alarms for placement/function every shift for [redacted]; [redacted] apply to [redacted] topically every shift for [redacted], [redacted] while in bed every shift; apply skin prep to [redacted] to [redacted] every shift, [redacted] to [redacted] every shift [redacted] output every shift and monitor [redacted] output evey shift. all resident with treatment orders have the	11/28/22

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	151 NINTH AVENUE LITTLE EGG HARBOR TW, NJ 08087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 8 and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. According to the Admission Record, Resident #29 was admitted to the facility with diagnoses that included EX Order 26 § 4b1 [redacted] According to the Quarterly Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care dated 09/02/22, Resident #29 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident was EX Order 26 § 4b1 [redacted]. The MDS further reflected that Resident #29 was at risk for skin breakdown, sustained [redacted] with no injury since the last MDS assessment and received [redacted]. A review of Resident #29's electronic medical record revealed the following physician orders (PO):	F 658	potential to be affected by this practice. An audit has been conducted on residenst with treatments for the past 30 days and all residenst in the facility have had their treatment administered and signed for by the licensed staff. All current licensed staff have been educated by the Director of Nursing on the procedure of signing for all treatments upon completion to properly document administration of teh Treatment and to check their documentation before the end of their shift to ensure no treatments have been missed Daily audits of treatment administration will be conducted by the Director of Nursing or designee x3 months to ensure compliance with TAR documentation. Ongoing monitoring will be conducted during the dily clinical meeting. All missing Treatment entries will be investigated to determine if the treatment was omitted or if the nurse failed to sign for the treatment administration. The Director of Nursing or designee will report findings of the daily treatment administration audits at the monthly Quality Assurance Meeting for review and any necessary adjustments to maintain continued compliance.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	151 NINTH AVENUE LITTLE EGG HARBOR TW, NJ 08087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 9 - An order dated 04/10/22 EX Order 26 § 4b1 bottle/wash filter: change and date EX Order 26 §, water bottle if applicable, wash filter every night shift every [redacted] - An order dated 04/11/22 to monitor tab alarm for placement/function every shift for fall risk. - An order dated 09/26/22 for EX Order 26 § 4b1 Apply to [redacted] topically every shift for redness. - An order dated 06/23/33 to [redacted] while in bed every shift for [redacted]. - An order dated 06/23/ to apply skin prep for [redacted], [redacted]. Discontinued 10/30/22. - An order dated 04/08/22 for EX Order 26 § 4b1 to EX Order 26 § 4b every shift for preventative - An order dated 07/07/22 for EX Order 26 § 4b1 EX Order 26 § 4b1 apply to EX Order 26 § 4b1 topically every shift to promote skin integrity due to [redacted]. A review of Resident #29's August, September and October 2022 eTAR reflected blanks for the following POs, indicating that the nurse did not document in the eTAR when the treatment was rendered: - For the order dated 04/10/22 EX Order 26 § 4b [redacted] filter: change and date EX Order 26 § 4b1 if applicable, wash filter every night shift [redacted] order, blanks were noted on 08/10/22, 08/31/22 and 10/12/22 for night shift. - For the order dated 04/11/22 monitor tab alarm for placement/function every shift for EX Order 26 § 4b order, blanks were noted on 09/09/22, 10/26/22 evening shift, and on 08/10/22, 08/31/22, 09/13/22, and 10/12/22 night shift.	F 658		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	151 NINTH AVENUE LITTLE EGG HARBOR TW, NJ 08087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 10 - For the order dated 09/26/22 for EX Order 26 § 4b1 Apply to EX Order 26 § 4b topically every shift for EX Order 26 § 4b1 order, blanks were noted on 10/26/22 evening shift and on 10/12/22 night shift. - For the order dated 06/23/22 to while in bed every shift for blanks were noted on 09/09/22 and 10/26/22 on evening shift and on 08/10/22, 08/31/22, 09/13/22 and 10/12/22 on night shift. - For the order dated 06/23/22 to apply skin prep for EX Order 26 § 4b1, blanks were noted on 09/09/22, 10/26/22 and 10/30/22 on evening shift and on 08/10/22, 08/31/22, 09/13/22, and 10/12/22 on night shift. Order was discontinued 10/30/22. - For the order dated 04/08/22 for to EX Order 26 § 4b every shift for preventative, blanks were noted on 09/12/22 on day shift, 09/09/22 and 10/26/22 on evening shift, and 08/10/22, 08/31/22, 09/13/22, and 10/12/22 on night shift - For the order dated 07/07/22 for EX Order 26 § 4b1 apply to EX Order 26 § 4b1 every shift to promote skin integrity due to blanks were noted on 09/09/22 and 10/26/22 on evening shift, and on 08/10/22, 08/31/22, 09/13/22 and 10/12/22 on night shift. During an interview with the surveyor on 11/01/22 at 9:16 AM, Licensed Practical Nurse #1 (LPN) stated that after she provided a treatment to a resident, she signed the eTAR. LPN #1 stated that it was important to sign the eTAR so that everyone would know that a treatment was completed and that the resident would not receive	F 658		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	151 NINTH AVENUE LITTLE EGG HARBOR TW, NJ 08087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 11	F 658		

duplicate treatments.

During an interview with the surveyor on 11/01/22 at 10:23 AM with the Director of Nursing (DON) and Regional Director of Clinical Services (RDCS), the DON stated that blanks in the electronic Medication Administration Records (eMAR) and eTARs were reviewed during the clinical meeting held Monday through Friday, by Nursing Management, consisting of the Unit Managers and the DON, where they will review for any missing documentation in the eMARs and eTARs. We try to address each concern and call each nurse who had missed documentation and tell them they have 24 hours to enter the documentation. We do not have a policy to this effect. The RDCS stated that the electronic medical record computer program will allow you 30 days to make corrections; but the facility tells nurses that they only have 24 hours to complete the documentation.

During a follow up interview with surveyor on 11/02/22 at 11:55 AM, the DON, in the presence of the RDCS, stated that she expected that the eMARs and eTARs should be signed by the end of the shift.

2. On 10/21/22 at 12:13 PM, the surveyor observed Resident #90 awake and alert sitting in a wheelchair in his/her room. The surveyor observed a [redacted] in a blue privacy bag attached to the wheelchair.

According to the Admission Record, Resident #90 was admitted to the facility with diagnoses that included EX Order 26 § 4b1 [redacted]

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	151 NINTH AVENUE LITTLE EGG HARBOR TW, NJ 08087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658		F 658		

Continued From page 12

and [redacted]

According to the most recent MDS, dated 10/08/22, Resident #90 had a BIMS score of [redacted], which indicated the resident had [redacted] [redacted]. Section H reflected that Resident #90 had an [redacted].

A review of Resident #90's PO dated 09/23/22 revealed an order for [redacted] every shift.

A review of Resident #90's October 2022 eTAR revealed a PO for [redacted] every shift with a start date of 09/23/22.

A review of Resident #90's Care Plan (CP), initiated 09/23/22, included a focus that "I have a [redacted] to [redacted]." The CP included interventions, initiated on 09/23/22, to "Monitor and document intake and output as per facility policy."

A review of Resident #90's October 2022 eTAR revealed that the aforementioned PO, with the administration time of day, evening, and night shifts. The TAR reflected no documentation for the [redacted] output on the following dates and times:

Day shift:10/10/22,
Evening Shift:10/08/22, 10/12/22, 10/14/22, 10/15/22
Night Shift: 10/02/22, 10/08/22, 10/11/22, 10/12/22,10/16/22, 10/17/22, 10/18/22

3. On 10/21/22 at 12:13 PM, the surveyor observed Resident #195 in bed watching

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	151 NINTH AVENUE LITTLE EGG HARBOR TW, NJ 08087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 13	F 658		

television. The surveyor observed a [redacted] covered with a blue flap, attached to the resident's bed. When interviewed, Resident #195 had no concerns with the care being provided for his/her EX Order 26 § 4b1.

According to the Admission Record, Resident #195 was admitted with diagnoses that included, but were not limited to, EX Order 26 § 4b1 [redacted]

A review of the Admission MDS, dated 10/20/2022, revealed Resident #195 had a BIMS score of EX Order which indicated that the resident's cognition was EX Order 26 § 4b1. Further review of the MDS revealed the resident had a EX Order 26 § 4b1 and required extensive assistance with [redacted]

A review of Resident #195's CP, initiated 10/14/22, included a focus that "I have an EX Order 26 § 4b1 due to obstructive EX Order 26 § 4b1. The CP included interventions, initiated on 10/14/22, to "Monitor and document intake and output as per facility policy" and 'EX Order 26 § 4b1."

Review of Resident #195's October Order Summary Report (OSR), for active orders as of 10/28/22, revealed an PO, dated 10/14/22, to 'EX Order 26 § 4b1 output every shift. every shift for monitoring."

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	151 NINTH AVENUE LITTLE EGG HARBOR TW, NJ 08087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 14	F 658		

Review of Resident #195's October 2022 eTAR revealed the aforementioned PO, with the administration time of day, evening, and night shifts. The eTAR reflected no documentation for the EX Order 26 § 4b1 on the following dates and times:

Day shift: 10/17/22, 10/18/22 and 10/24/22
Evening Shift: 10/25/22 and 10/26/22
Night Shift: 10/16/22, 10/17/22, 10/18/22, 10/20/22, and 10/25/22.

During an interview with the surveyor on 10/27/22 at 12:27 PM, the Certified Nursing Assistant (CNA) stated she would empty the EX Order 26 § 4b1 and give the amount to the nurse who would document the amount in the electronic medical record (EMR).

During an interview with the surveyor on 10/28/22 at 11:01 AM, LPN #2 stated the nurse should add up the resident's for their shift and document the total amount in the eTAR by the end of their shift. The LPN further stated is was important to monitor and record the resident's output to ensure the resident was not and was getting enough fluids.

During an interview with the DON on 11/01/22 at 10:23 PM, the DON stated that she reviewed the resident's EMR and confirmed the blanks noted in the October 2022 eTAR. The DON stated the CNAs documented the resident's output on their assignment sheet, which were kept in a binder on the unit. The DON added that she expected the nurse to communicate with the CNA to get the resident's output and then document the output amount in the eTAR by the end of their shift. The DON added that late documentation should be

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	151 NINTH AVENUE LITTLE EGG HARBOR TW, NJ 08087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 15 completed within 24 hours. The surveyor reviewed the facility's "Documentation of Treatment Administration" policy, revised April 2022, revealed that a nurse or Certified Aide (where applicable) shall document all treatments administered to each resident on the resident's TAR. The policy further reflected that administration of a treatment must be documented after (never before) it is given. Documentation of procedures and treatments will include care-specific details, including g: the signature and title of the individual documenting. NJAC 8:39-11.2 (b); 27.1(a)	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	656004	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	151 NINTH AVENUE LITTLE EGG HARBOR TW, NJ 08087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments The facility is 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 interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the day shifts. The facility was deficient in CNA staffing for residents on 12 of 14 day shifts. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	Efforts to hire facility staff will continue until there is adequate staff to serve all residenst. Until that time, facility will utilize staffing agencies to fill any open spots in the schedule. All residenst have the potential to be affected by this practice Contracts with additional staffing agencies have been secured to supplement facility staff. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, on line job listings, job fairs and referral bonuses are being utilized to become more competitive in the area marketplace.	11/28/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	656004	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	151 NINTH AVENUE LITTLE EGG HARBOR TW, NJ 08087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 nursing homes. "Direct care staff member" means any registered professional nurse, licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021: One CNA to every eight residents for the day shift. 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 CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and 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 CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 10/02/22 to 10/08/22 and 10/09/22 to 10/15/22, the staffing-to-resident ratios did not meet the minimum requirement of 1 CNA to 8 residents for the day shift, The facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows: -10/02/22 had 10 CNAs for 96 residents on the day shift, required 12 CNAs. -10/03/22 had 9 CNAs for 96 residents on the day shift, required 12 CNAs. -10/04/22 had 10 CNAs for 96 residents on the day shift, required 12 CNAs. -10/05/22 had 10 CNAs for 96 residents on the day shift, required 12 CNAs.	S 560	The Administrator and or his/her designee will review staffing schedules weekly to ensure adequate staffing for all shifts. The results of these reviews will be submitted to the Quality Assurance Committee for a period of three (3) months , then quarterly at the scheduled monthly Quality Assurance Meetings x3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	656004	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	151 NINTH AVENUE LITTLE EGG HARBOR TW, NJ 08087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 -10/06/22 had 10 CNAs for 99 residents on the day shift, required 12 CNAs. -10/07/22 had 11 CNAs for 95 residents on the day shift, required 12 CNAs. -10/08/22 had 9 CNAs for 92 residents on the day shift, required 11 CNAs. -10/09/22 had 8 CNAs for 92 residents on the day shift, required 11 CNAs. -10/10/22 had 10 CNAs for 92 residents on the day shift, required 11 CNAs. -10/11/22 had 9 CNAs for 92 residents on the day shift, required 11 CNAs. -10/14/22 had 11 CNAs for 98 residents on the day shift, required 12 CNAs. -10/15/22 had 10 CNAs for 98 residents on the day shift, required 12 CNAs. During an interview with the surveyor on 11/01/22 at 11:20 AM, the Human Resources/Staffing Coordinator/CNA stated that she was in charge of recruiting new staff, trying to meet the quota, and cover any call outs or no shows. The Staffing Coordinator further stated that she was aware of the mandated staffing ratios.	S 560		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315456		2/8/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	151 NINTH AVENUE LITTLE EGG HARBOR TW, NJ 08087

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 E0030 Reg. # 483.73(c)(1) LSC	Correction Completed 11/23/2022	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	
11/2/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315456	A. Building B. Wing	2/8/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	151 NINTH AVENUE LITTLE EGG HARBOR TW, NJ 08087

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 F0636 Reg. # 483.20(b)(1)(2)(i)(iii) LSC	Correction Completed 11/28/2022	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 11/28/2022	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 11/2/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
656004	A. Building B. Wing	2/8/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	151 NINTH AVENUE LITTLE EGG HARBOR TW, NJ 08087

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 11/28/2022	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	
11/2/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING **02** B. WING _____	**11/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	**151 NINTH AVENUE** **LITTLE EGG HARBOR TW, NJ 08087**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 11/02/22, and Mystic Meadows Rehabilitation and Nursing Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy Mystic Meadows Rehabilitation and Nursing Center is a single-story building that was built in the January 1995. It is composed of Type V protected construction. The facility is divided into nine smoke zones.	K 000		
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/02/22, in the presence of facility management, it was determined that the facility failed to ensure that all means of egress were provided with continuous lighting with two lamps for 2 of 8 exit discharge doors. This deficient practice was evidenced by the following:	K 281	Supplemental lighting has been installed outside the designated exit discharge near room# [redacted] and outside the designated discharge door near room [redacted] All residents residing in the facility have the potential to be affected by this practice.	12/28/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/24/2022

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING **02** B. WING _____	**11/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	**151 NINTH AVENUE** **LITTLE EGG HARBOR TW, NJ 08087**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 281	Continued From page 1 Starting at 9:59 AM, in the presence of the facility's Maintenance/Environmental Services Director (MESD), a tour of the building was conducted. During the building tour, the surveyor observed outside two (2) designated exit discharge doors (illuminated exit signs above the doors) failed to be equipped with two lamps. The surveyor observed only a single bulb light fixture in the following locations: 1. At 9:17 AM, outside the designated exit discharge door near resident room [redacted]. 2. At 11:32 AM, outside the designated exit discharge door near resident room [redacted] There was no supplemental light to ensure the area was illuminated should the single bulb or single bulb light fixture have failed. The MESD confirmed the findings at the time of observations. The Administrator was informed of the deficiency at the Life Safety Code exit conference on 11/02/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.8	K 281	An inspection was conducted by the Director of Maintenance on all exit doors to ensure they are all equipped with two (2) working lamps, for a period of three months A weekly inspection of supplemental exit discharge door lighting wil be conducted by the Director of Maintenance (DOM) or his designee Results of the inspections will be submitted to the facility Quality Assurance Committee monthly, for a period of three months.	
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1	K 293		11/28/22

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING **02** B. WING _____	**11/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	**151 NINTH AVENUE** **LITTLE EGG HARBOR TW, NJ 08087**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 293	Continued From page 2 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility provided documentation on 11/02/22, in the presence of facility management, it was determined that the facility failed to ensure that illuminated exit signs were in four (4) locations to clearly identify the exit access path to reach an exit discharge door. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 During the survey entrance at 8:37 AM, a request was made to the Administrator and Maintenance/Environmental Service Director (MESD) to provide a copy of the facility layout which identified the various rooms and smoke compartments in the facility. A review of the facility provided layout identified that there were two (2) center court yards located in the facility. During a tour of the building starting at 8:59 AM with the MESD, the surveyor observed four areas	K 293	All four (4) areas that failed to have illuminated exit signs that clearly identify exit access, have had illuminated exit signage installed in "Courtyard A" and "Courtyard B" All residenst who use the facility courtyards have the potential to be affected by this practice. All areas of the facility have been inspected by the Director of Maintenance and have illuminated exit signs, that clearly identify the exit path to reach the exit discharge door. A weekly inspection of all outdoor areas will be conducted by the Director of Maintenance or his designee withh a special focus on exit signage illumination for a period of three months Results of the inspections will be submitted to the facility Quality Assurance Committee monthly for a period of three months.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING **02** B. WING _____	**11/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	**151 NINTH AVENUE** **LITTLE EGG HARBOR TW, NJ 08087**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 293	Continued From page 3 that failed to have illuminated exit signs to clearly identify the exit access route to reach an exit in the following locations: 1) At 10:08 AM, the surveyor observed no evidence of two (2) illuminated exit signs inside the enclosed "Courtyard B" that were on opposite sides of the courtyard. 2) At 10:43 AM, the surveyor observed no evidence of two (2) illuminated exit signs inside the enclosed "Courtyard A" that were on opposite sides of the courtyard. The MESD confirmed the findings at the time of observations. The Administrator was informed of the deficiency at the Life Safety Code exit conference on 11/02/22. Fire Safety Hazard. NJAC 8:39 -31.1 (c) NFPA Life Safety Code 101	K 293		
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders,	K 341		12/15/22

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING **02** B. WING _____	**11/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	**151 NINTH AVENUE** **LITTLE EGG HARBOR TW, NJ 08087**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 341	Continued From page 4 and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility provided documentation on 11/02/22, in the presence of the facility management, it was determined that the facility failed to provide fire alarm notification by audible and visible signals for 2 of 2 outside enclosed courtyards in accordance with NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9. The deficient practice was evidenced by the following: During the survey entrance at 8:37 AM, a request was made to the Administrator and Maintenance/Environmental Service Director (MESD) to provide a copy of the facility layout which identified the various rooms and smoke compartments in the facility. A review of the facility provided layout identified that there were two (2)outside enclosed center court yards located in the facility. During a tour of the building starting at 8:59 AM with the MESD, the surveyor observed two (2) locations that failed the have an audio and visual alarm to notify residents, staff and visitors of an activation of the building's fire alarm system in the following locations:	K 341	Fire alarm notification by audio and visual alarm notification (horn/strobe)equipment for both courtyards have been ordered from the manufacturer, expected delivery date is Mid-December All residents who use the courtyards have the potential to be affected by this practice. All areas of the facility that require fire alarm notification by audio or visual alarm notification (horn/strobe)have been inspected by the Director of Maintenance (DOM) and are in place and are functional. All staff have been educated that in case of a fire, they will check both courtyards to ensure all residents have been evacuated An inspection will be conducted by the Director of Maintenance (DOM) or his designee to ensure compliance of having fire alarm notification by audio and visual alarm notification (horn/strobe) inspections will be scheduled for aperiod of three months Results of the inspections will be submitted to the facility Quality Assurance	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING **02** B. WING _____	**11/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	**151 NINTH AVENUE** **LITTLE EGG HARBOR TW, NJ 08087**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 341	Continued From page 5 1) At 10:08 AM, the surveyor observed no evidence of an audio and visual alarm notification (horn/strobe) inside the enclosed "Courtyard B." At that time, the surveyor asked the MESD, "Do you have a horn and strobe out here." The MESD looked around and said, "No." 2) At 10:43 AM, the surveyor observed no evidence of an audio and visual alarm notification (horn/strobe) inside the enclosed "Courtyard B." At that time, the surveyor asked the MESD, "Do you have a horn and strobe out here." The MESD looked around and said, "No." The MESD confirmed the findings at the time of observations. The Administrator was informed of the deficiency at the Life Safety Code exit conference on 11/02/22. NJAC 8:39-31.2(a) NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9	K 341	Committee monthly for a period of three months.	
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	K 345		12/15/22

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING **02** B. WING _____	**11/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	**151 NINTH AVENUE** **LITTLE EGG HARBOR TW, NJ 08087**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on surveyor's observation and record review on 11/02/22, it was determined that the facility failed to ensure that their building's fire alarm system was maintained in accordance with the requirements of NFPA 70 and 72. This deficient practice had the potential to affect all residents and was evidenced by the following: On 11/02/22 during the survey entrance at 8:37 AM, a request was made to the facility Administrator and Maintenance/Environmental Service Director (MESD) to provide all mandatory inspections from January 1, 2021 through November 2, 2022. This would include the building's semi-annual fire alarm and detection system inspections. At 12:15 PM, the surveyor reviewed all facility provided fire alarm inspections dated: 04/25/22, 03/29/22, 04/29/21 and 10/01/20. The documentation reflected the "fire alarm inspection and testing report" indicated that the service was conducted annually. The current inspection reports were one year apart and not done on the required semi-annual basis. A review of the facility's annual inspections (mandatory inspections) spread sheet indicates that Fire Alarm System Testing and Inspections, Inspection Schedule: semi-annual. An interview was conducted with the MESD during the document review and he stated that the vendor did not come in due to COVID. 9.6.1.5* To ensure operational integrity, the fire alarm system shall have an approved	K 345	Semi Annual inspection of the fire alarm system have been scheduled with a licensed professional service All residents residing in the facility have the potential to be affected by this practice. Director of Maintenance or his designee will review and submit a report, every month on all Sate and Federal mandated inspections, the the Licensed Nursing Home Administrator or his/her designee for a period of three months Results of these reviews will be submitted to the facility Quality Assurance Committee meeting for a period of three months.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING **02** B. WING _____	**11/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	**151 NINTH AVENUE** **LITTLE EGG HARBOR TW, NJ 08087**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 7 maintenance and testing program complying with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. The Administrator was informed of the deficiency at the Life Safety Code exit conference on 11/02/22. NFPA 70 NFPA 72 NJAC 8:39-31.2(e)	K 345		
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations on 11/02/22, in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for 2 of 9 resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: During the survey entrance on 11/02/22 at 8:37	K 521	The Bathroom exhaust fan in room #[redacted] and inside the Day Room's resident bathroom (near resident room #[redacted]) that were found to be nonoperational were immediately repaired by Maintenance Staff. The residents in or near these areas had no adverse effects due to bathroom exhaust fans not functioning All residents residing in the facility have	11/28/22

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING **02** B. WING _____	**11/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	**151 NINTH AVENUE** **LITTLE EGG HARBOR TW, NJ 08087**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 521	Continued From page 8 AM, a request was made to the Administrator and Maintenance/Environmental Service Director (MESD) to provide a copy of the facility layout which identified the various rooms and smoke compartments in the facility. Starting at 8:59 AM, in the presence of the facility's MESD, during the building tour, an inspection of nine (9) resident bathrooms was performed. The surveyor observed that the bathroom exhaust systems were independent exhaust fans. This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 2 of 9 resident bathrooms in the following locations: 1. At 10:25 AM, inside resident room #[redacted] bathroom, when tested, the exhaust system did not function properly. At that time, the surveyor informed the MESD that the exhaust system did not function properly. 2. At 11:10 AM, inside the Day Room's resident bathroom (near resident room #[redacted], when tested, the exhaust system did not function properly. At that time, the surveyor informed the MESD that the exhaust system did not function properly. The surveyor observed that all the bathrooms had no windows with an area that would open and the bathrooms would rely on mechanical ventilation. This findings were verified by the facility's MESD at the time of inspection.	K 521	the potential to be affected by this practice. All residents areas that have external exhaust fans have been identified and have been inspected, and have bathroom exhaust fans that are functioning properly. The fans are now being inspected daily by Maintenance Staff for proper function, for a period of three months. Results of these inspections will be submitted to the Licensed Nursing Home Administrator or his/her designee for review Results of the inspections will be submitted the the facility Quality Assurance Committee monthly, for a period of three months.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING **02** B. WING _____	**11/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	**151 NINTH AVENUE** **LITTLE EGG HARBOR TW, NJ 08087**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 521	Continued From page 9 The Administrator was informed of the deficiency at the Life Safety Code exit conference on 11/02/22. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and	K 918		12/15/22

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING **02** B. WING _____	**11/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	**151 NINTH AVENUE** **LITTLE EGG HARBOR TW, NJ 08087**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 10 separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/02/22, in the presence of facility management, it was determined that the facility failed to ensure a remote manual stop station for 1 of 1 emergency generator was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice was evidenced by the following: On 11/02/22 during the survey entrance at 08:37 AM, a request was made to the facility Administrator and Maintenance/Environmental Service Director (MESD) if the facility had an emergency generator. The MESD said, "Yes, we have an emergency generator." During the building tour on 11/02/22 with the facility MESD at approximately 11:42 AM, an inspection outside of the building, where the Diesel Emergency Generator was located, was performed. At that time, the surveyor asked the MESD, where is the remote emergency shut off for the generator. The MESD told the surveyor, "There is no remote emergency shut off." The surveyor observed that the emergency shut off was located on the generator's control panel. The MESD confirmed the findings at the time of observation. The Administrator was informed of the deficiency	K 918	Contractor has been contacted regarding the installation of a remote shut off for the facility generator All residenst residing in the facility have the potential to affected by this practice. Contractor to install remote switch in addition to reviewing and inspecting facility generator to assure compliance will all mandatory standards. Licensed Nursing Home Administrator or his/her designee will review all inspection reports regarding the facility generator on a monthly basis, for a period of three months Results of the inspections will be submitted to the facility Quality Assurance Committee monthly for a period of three months.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING **02** B. WING _____	**11/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	**151 NINTH AVENUE** **LITTLE EGG HARBOR TW, NJ 08087**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 11 at the Life Safety Code exit conference on 11/02/22. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315456 Y1	A. Building 02 - BUILDING B. Wing Y2	2/8/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHAB & NURSING CENTER	151 NINTH AVENUE LITTLE EGG HARBOR TW, NJ 08087

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0281	12/28/2022	LSC K0293	11/28/2022	LSC K0341	12/15/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0345	12/15/2022	LSC K0521	11/28/2022	LSC K0918	12/15/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
11/2/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO