STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315061	A. BUILDING _____ B. WING _____	C 06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	99 MANHEIM AVENUE BRIDGETON, NJ 08302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint #'s: NJ 167157, 167901, 1672004, 174146 Census: 85 Sample Size: 20 + 2 Closed Records THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. 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 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that	F 550		7/19/24

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

Electronically Signed | 07/11/2024

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F 550	Continued From page 1 promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review it was determined that the facility failed to ensure a resident room and the resident environment was [redacted], and that staff addressed a resident in a dignified manner. This deficient practice occurred for 1 of 20 residents reviewed (Resident #55) and was evidenced by the following:	F 550	1. The deficiency occurred when the facility failed to ensure the residents room was free of [redacted]. The deficiency occurred when a staff member spoke about a resident to a surveyor in an undignified manner. 2. The Administrator, Director of	

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F 550	Continued From page 2 On 06/13/24 at 10:28 AM, Surveyor #1 observed Resident #55 in bed and there was a noticeable NJ Ex Order 26.4(b)(1) in the room and the resident's NJ Ex Order 26.4(b)(1) was lying on the bed. Resident #55 stated, he/she was waiting for coffee at that time and acknowledged there was NJ Ex Order 26.4(b)(1). NJ Ex Order 26.4(b)(1) were noted scattered throughout the room and when asked the resident about the NJ Ex Order 26.4(b)(1) the resident confirmed he/she was aware of the NJ Ex Order 26.4(b)(1) Resident #55 then stated "the NJ Ex Order 26.4(b)(1) isn't from me." On 06/13/24 at 2:01 PM, Surveyor #1 and #2 observed the resident in bed on top of a pink bedspread, with the NJ Ex Order 26.4(b)(1) also on the bed and the bed remote next to it. The surveyors observed NJ Ex Order 26.4(b)(1) on the bedspread, one on the remote and observed NJ Ex Order 26.4(b)(1) in the room. The surveyors requested the U.S. FOIA (b) (6) to accompany the surveyors to the room. The U.S. FOIA (b) (6) stated Resident #55 was NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) and was NJ Ex Order 26.4(b)(1) with care. When asked the U.S. FOIA (b) (6) about the NJ Ex Order 26.4(b)(1) and if having NJ Ex Order 26.4(b)(1) on the bed and in the room was okay, she stated, "it is not okay, it is not clean". The U.S. FOIA (b) (6) stated then stated she never saw NJ Ex ONJ Ex Order 26.4(b)(1) before. On 06/14/24 at 9:07 AM, Surveyor #2 observed NJ Ex Order 26.4(b)(1) inside of Resident #55's room while resident was eating a meal. A NJ Ex Order 26.4(b)(1) was on top of the burgundy meal tray lid that was on the bed next to the resident. Surveyor #2 requested the nurse (LPN #2) to come to the resident's room. The surveyor showed the nurse the flies and LPN #2 stated Resident #55 was NJ Ex Order 26.4(b)(1) and "he/she is a NJ Ex Order 26.4(b)(1) " and walked away from the surveyor	F 550	Maintenance, Housekeeping Director and Unit Manager inspected Resident #55 room on 6/13/24. All open food items and containers were removed. All linens and soiled personal clothing were removed and laundered. All surfaces and floors were cleaned and disinfected. Resident was showered, a NJ Ex Order 26.4b1 was replaced and clean clothing provided. The Social Worker interviewed Resident #55 on 6/14/24 and asked if NJ Ex Order 26.4(b)(1) felt NJ Ex Order 26.4(b)(1) was treated in a dignified manner by all staff members. NJ Ex Order 26.4(b)(1) stated that NJ Ex Order 26.4(b)(1) was treated well by the staff. NJ Ex Order 26.4(b)(1) was asked if NJ Ex Order 26.4(b)(1) had any concerns to report and NJ Ex Order 26.4(b)(1) stated “No.” U.S. FOIA (b) (6) was re-educated by the social worker that if NJ Ex Order 26.4(b)(1) ever feels NJ Ex Order 26.4(b)(1) is treated in an undignified manner to report this to anyone from facility management. An audit was also conducted by the DON on 6/14/24 to determine if all residents were addressed in a dignified manner by LPN #2. 3. On 6/13/24 the Administrator increased the facility pest control visits, implemented flying insect lights and a fan at smoking area door to deter flying insects from entering the building. The Administrator and/or assigned designee will conduct facility audits to inspect for flying insects daily times 2 weeks, weekly times 4 weeks then monthly starting on 6/13/24. The Administrator will report all findings to the QA team during quarterly meetings. On 6/14/24 the DON re-educated all staff on communication, dignity and respect for	

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F 550	Continued From page 3 and exited the room. Surveyor #2 interviewed LPN #2 at the nursing station about Resident #55 and the NJ Ex Ord LPN #2 stated, Resident #55 was a "NJ Ex Order 26.4(b)(1)]. Surveyor #2 asked LPN #2 if that is what she called her residents and she stated he/she was NJ Ex Order 26.4(b)(1). On 06/14/24 at 10:08 AM, the U.S. FOIA (b) (6) provided a Promoting/Maintaining Resident Dignity Policy, implemented 01/09/24 which revealed: Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. 10. Speak respectfully to residents; avoid discussions about residents that may be overheard. On 06/14/24 at 11:01 AM, Surveyor #2 in the presence of another surveyor interviewed the U.S. FOIA (regarding the observations of NJ Ex Or and how LPN #2 spoke about Resident #55 at the nursing station as others walked by. Surveyor #2 then asked if what LPN #2 referred to the resident as was okay. The U.S. FOIA stated, "no, that was not okay" and stated that she heard about what happened and that the LPN #2 was "trying to be cute" and it was a dignity issue. On 06/17/24 at 10:35 AM, Surveyor #1 observed Resident #55 in bed, and the NJ Ex Order 26.4(b)(1) was observed on the floor and NJ Ex Order 26.4(b)(1) were observed in the room. On 06/19/24 at 11:34 PM, the survey team held an exit conference with the U.S. FOIA (b U.S. FOIA (b) (6) , and U.S. FOIA (b) (6)	F 550	all residents. All new hire employees will be educated on treating residents with dignity and respect during orientation. The DON and/or assigned designee will conduct audits of all residents to determine if they are being addressed with dignity and respect. These audits will be conducted weekly times 2 weeks, then twice a month for the next 2 months then monthly times 3 months starting on 6/14/24. The DON will report all findings to the QA team during quarterly meetings. 4. All audits will be reviewed by Administrator, DON and/or designee to ensure compliance daily, weekly and monthly thereafter per the audit timeframes listed in action #3 beginning on 6/13/24. These audits will be reviewed at the quarterly QA	

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F 550	Continued From page 4 U.S. FOIA (b) (6) to reviewed the above concerns. NJAC 8:39-4.1(11)(12)	F 550		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to ensure Resident #12	F 561	1. The deficiency occurred when the facility failed to ensure Resident #12 had	7/19/24

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F 561	Continued From page 5 preferences had been accommodated. This deficient practice occurred for 1 of 20 residents reviewed (Resident #12) for accommodation of needs and was evidenced by the following: During the initial tour on 6/14/24 at 10:31 AM, interview with Resident #12 revealed that would like to NJ Ex Order 26.4(b)(1) at a certain time and their wishes had not been honored. On 6/17/24 at 10:14 AM surveyor #2 followed up with Resident #12 regarding their concerns. The observation of Resident #12 revealed that Resident #12 was in bed dressed in a hospital gown. Resident #12 was NJ Ex Order and was NJ Ex Order to the surveyor and stated that he/she had not been able to NJ Ex Order 26.4(b)(1). Resident #12 further stated that their NJ Ex Order 26.4(b)(1) were still at the other facility and could not get in touch with the U.S. FOIA (b)). When inquired if the resident enlisted the assistance of the U.S. FO at the current facility, Resident #12 stated, "yes but nothing had been done." On 6/17/24 at 12:30 PM, the surveyor reviewed Resident #12 admission record. The admission face sheet reflected that Resident #12 had diagnoses which included but were not limited to; U.S. FOIA (b) (6), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). Review of the 2/16/24 Quarterly Minimum Data Set Assessment in the Electronic Medical Recort (EMR) for Resident #12 revealed that Resident #12 had NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) NJ Ex Order 2 NJ Ex Order 26.4(or NJ Ex Order 26.4(b)(1). Resident #12 received a score of NJ Ex /15 on the Brief	F 561	NJ Ex O preferences met with NJ Ex Order 26.4(b)(1) at a certain time and having NJ Ex O personal clothing brought to facility from NJ Ex O previous nursing facility. 2. On 6/17/24 Resident #12's care plan and Kardex were updated to reflect NJ Ex O wishes to get out of bed prior to 10am. On 6/17/24 Social worker called previous facility and left another message regarding residents personal clothing. On 6/19/24 Social worker also drafted a letter to the previous facilities Administrator requesting Resident #12's personal clothing and letter was mailed. On 6/18/24 the DON re-educated all nursing staff on resident preferences and their right to choose what time they get out of bed and what clothing they choose to wear. On 6/18/24 Administrator also educated nurse managers and the U.S. FOIA (b) (6) on using multiple communication tools to facilitate acquiring residents' belongings from previous facilities. 3. The Unit managers will meet with all new admissions to determine their personal preferences related to what time they wish to get out of bed and what clothing they would like to wear. The DON and/or designee will conduct audits of all residents to determine if their personal preferences are being met and care planned. The Social worker will meet with all new admissions to ensure they have their personal effects they wish to have during their stay in our facility. The Social Worker and/or assigned designee will conduct audits on all new admissions to	

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F 561	Continued From page 6 Interview for Mental Status (BIMS) which indicated the resident was NJ Ex Order 26.4(b)(1). Resident #12 reported to the surveyor that it was very important for him/her to: NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) . Review of Resident's #12 comprehensive care plan addressed, "ADLs Self Care Performance Deficit with the goal to maintain a sense of dignity by being clean, dry odor free and well groomed. NJ Ex Or , but did not specify their choice for their time to get out of bed. Review of the progress notes from social services dated NJ Ex Order 26.4 revealed that she attempted to call the U.S. FOIA (b) (6) at the prior facility regarding Resident #12's belongings, but was unsuccessful. No other attempts were documented in the EMR. On 6/17/24 at 9:30 AM, the surveyor met with the U.S. FOIA (b) (6) , to inquire regarding Resident #12's personal belongings. The U.S. FO informed the surveyor that she called the prior facility several times and could not reach the U.S. FOIA While in her office she called the facility, and she was prompted to leave a message or to call later. The surveyor then asked the U.S. FO what other methods could have been used to communicate with the facility, the U.S. FO stated that she could have sent a letter to the facility but had not done so. On 06/18/24 the surveyor met again with the U.S. FO and inquired regarding if she was able to contact the prior facility, she stated no. The surveyor then inquired if she discussed the concerns with the facility's U.S. FOIA (b) (6) for further guidance she replied, "No".	F 561	ensure they have their personal belongings from previous facilities. These audits will be conducted weekly times 2 weeks, then twice a month for the next 2 months then monthly times 3 months starting on 6/17/24. The DON and Social worker will report all findings to the QA team during quarterly meetings. 4. All audits will be reviewed by Administrator, DON and/or designee to ensure compliance daily, weekly and monthly thereafter per the audit timeframes listed in action #3 beginning on 6/17/24. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback. The Administrator and DON will be responsible for implementing this plan of correction.	

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F 561	Continued From page 7 On 06/18/24 at 10:30 AM, the surveyor observed the resident sitting at the nursing station, dressed in a hospital gown and was seated in a recliner chair. The resident stated, "[he/she] would feel much better", wearing their own personal clothing. On 6/19/24 at 12:30 the survey team presented the above concerns to the facility and requested any documentation regarding how Resident #12's concerns were addressed by the facility. On 6/19/24 at 2:30 PM the U.S. FOIA (b) (6) provided a letter dated NJ Ex Order 26.4 that will be forwarded to the facility on behalf of Resident #12. Resident #12 had been at the facility since U.S. FOIA (b) (6) The surveyor contacted the facility on 6/19/24 and left a message with the U.S. FOIA (b) (6) for the U.S. FOIA (b) (6) and the U.S. FOIA The facility's U.S. FO returned the call and informed the surveyor that she never received any correspondence from the U.S. FOIA The U.S. FO further stated that she was informed only on NJ Ex Order 26.4 that Resident #12 was trying to locate their personal belongings. The U.S. FO went on to state that Resident #12's family could not be contacted. A review of the Resident's rights policy dated, last revised. NJAC 8:39-27.1(a)	F 561		
F 570 SS=F	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced	F 570		7/19/24

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F 570	Continued From page 8 by: Based on interview and document review it was determined that the facility failed to ensure a Surety Bond was in place to provide coverage to protect resident personal needs account funds held by the facility. The deficient practice effected all residents who had personal needs funds held by the facility and was evidence by the following: On 06/13/24 at 2:00 PM. and again on 06/14/24 at 9:00 AM, the surveyor requested a facility Surety Bond from the U.S. FOIA (b) (6) [redacted] On 06/14/24 at 9:30 AM, the U.S. FOIA (b) provided a Funds Balance Report for 06/03/24 which listed 48 active residents with a combined balance of $20,829.05. The surveyor again requested a Surety Bond from the U.S. FOIA (b) [redacted] On 06/14/24 at 12:20 PM, the U.S. FOIA (b) provided a "Commercial Crime Policy" effective: July 24, 2023- July 24, 2024, for a Bond Limit: $90,000. The policy did not specify any coverage to secure resident funds. On 06/14/24 at 11:37 AM, during an interview with the U.S. FOIA (b) [redacted] in the presence of four surveyors, the U.S. FOIA (b) [redacted] provided a copy of a surety bond, effective June 14, 2024 for $100,000. The surveyor inquired to the U.S. FOIA (b) why the surety bond was effective the same day and the U.S. FOIA (b) stated he told the "new business office" that he needed the surety bond as soon as possible and he was provided the copy on June 14, 2024 and the surety bond was effective the same day. The surveyor requested the prior surety bond. On 06/17/24 at 9:12 AM, the U.S. FOIA (b) provided a	F 570	1. The deficiency occurred when the facility failed to ensure a Surety Bond was in place. All residents have the potential to be affected by this deficient practice. 2. The facility obtained the Resident Trust Fund Surety Bond 6/14/24. The Resident Trust Fund Surety Bond will ensure the residents funds in the sum of $100,000 and will remain in place until the renewal date of 6/14/27. 3. The Administrator will meet with the business office manager monthly to ensure the residents trust fund balance does not exceed the amount of the Surety Bond. The Administrator or assigned designee will complete monthly audits for 90 days then annually to ensure that the resident trust fund balance does not exceed the amount of the surety bond. The Administrator will report all findings to the QA team during quarterly meetings. 4. All audits will be reviewed by Administrator and/or designee to ensure compliance monthly then annually thereafter per the audit timeframes listed in action #3 beginning on 6/19/24. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback. The Administrator and DON will be responsible for implementing this plan of correction.	

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F 570	Continued From page 9 copy of a Certificate of Property Insurance, dated 06/14/24. The document revealed the Type of Policy: "Crime", Limits: $90,000. The U.S. FOIA (b) then stated that was the surety bond policy. On 06/17/24 at 11:01 AM, the U.S. FOIA (b) (6) provided the Surety Bond Requirements, Policy dated 11/01/23. The Policy Explanation and Compliance Guidelines: revealed 1. The facility must be able to show proof that it has a surety bond, or another alternative to a surety bond, a crime policy etc. 3. Reasonable alternatives to a surety bond must: a. Designate the oblige (depending on State law, the resident individually or in aggregate, or the Stte on behalf of each resident) who can collect in case of a loss; B. Specify that the oblige may collect due to any failure by the facility, when by omission, bankruptcy, or omission, to hold, safeguard,, manage, and account for the residents' funds; and ac. Be managed by a third party unrelated in any way to the facility or its management. 4. Self insurance is not an acceptable alternative to a surety bond. On 06/19/24 at 1:39 PM, during the exit conference, the surveyor asked the U.S. FOIA (b) why the surety bond was effective after surveyor inquiry. The U.S. FOIA (b) stated, he cannot speak to the "old" owners, and did not respond as to why the bond was not in place prior to surveyor inquiry. The facility had no additional information to provide. NJAC 8:39-9.5(d)1	F 570		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		7/19/24

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	315061	A. BUILDING _____ B. WING _____	C 06/19/2024

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SOUTH JERSEY EXTENDED CARE	99 MANHEIM AVENUE BRIDGETON, NJ 08302

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§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable

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F 584	Continued From page 11 sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to maintain all resident rooms and common areas in a clean and sanitary manner. The deficient practice occurred on 1 of 3 units and in the Sub-Acute smoking courtyard and was evidenced by the following: On 6/13/24 at 10:41 AM, two surveyors toured the Sub-Acute smoking courtyard and observed cigarette butts were located throughout the lawn area surrounding the gazebo, on top of a garbage can and partially filling the inside of an open bucket that rested on the ground which included empty cigarette packages. There were signs posted to utilize cigarette disposal not the ground. On 06/17/24 at 9:39 AM, the surveyor observed Resident #47 in bed and observed the privacy curtain was stained in several areas, there was soiled areas on several walls and a broken window blind with NJ Ex Or in the room. The surveyor asked about the NJ Ex Or and the resident confirmed there were NJ Ex Or in the room. On 06/19/24 at 11:13 AM, the surveyor, in the presence of the survey team informed the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) of the above findings. NJSA 8:39-4.1(11)	F 584	1. The deficiency occurred when the facility failed to ensure cigarette butts were not on the ground in the designated NJ Ex Order 26.4b1 and in Resident #47's room had a privacy curtain and wall with a stain and window blind was broken. Resident #47 was affected by this deficient practice. All residents have the potential to be affected when the facility is not maintained in a clean, comfortable and homelike environment. 2. On 6/19/24 a complete inspection of the facility smoking area was completed and all cigarette butts were removed from the ground, the lawn and in the gazebo area. On 6/19/24 Resident #47 privacy curtain was removed and new curtain replaced, wall was cleansed and window blind repaired. Also, on 6/19/24 an inspection of resident rooms was conducted for soiled curtains and/or broken blinds non were found to be soiled or in disrepair. On 6/19/24 Administrator re-educated all staff on reminding residents to use designated cigarette butt disposal containers and not disposing of cigarette butts on the ground. Housekeeping was also educated on removing soiled curtains and cleaning walls if soiling is noted. On 6/19/24 Administrator re-educated all staff on use of maintenance logbook for any needed resident room repairs as well. On 6/13/24 the Administrator increased the facility pest control visits, implemented flying	

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insect lights and a fan at smoking area door to deter flying insects from entering the building.

3. The Maintenance Director or assigned designee will conduct maintenance rounds monthly within the facility to observe any physical environmental areas that need attention such as broken blinds. All staff will document any maintenance concerns in the maintenance logbook kept at each nurses station. Maintenance staff will review the logbooks daily and address maintenance issues accordingly. The Housekeeping Director or assigned designee will conduct daily rounds within the facility and facility grounds to observe for any cigarette butts or trash improperly disposed of. The Administrator and Housekeeping Director reviewed the current curtain cleaning schedule and revised curtain cleaning to be done during monthly carbolization of each room. The Administrator and/or designee will conduct facility audits to inspect designated smoking area and resident rooms daily times 2 weeks, monthly for 2 months then quarterly. The Administrator will also conduct facility audits to inspect for flying insects daily times 2 weeks, weekly times 4 weeks then monthly starting on 6/13/24. The Administrator will report all findings to the QA team during quarterly meetings.

4. All audits will be reviewed by Administrator, DON and/or designee to ensure compliance daily, weekly and monthly thereafter per the audit

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F 584	Continued From page 13	F 584	timeframes listed in action #3 beginning on 6/13/24. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback. The Administrator and DON will be responsible for implementing this plan of correction.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to conduct a new Preadmission Screening and Resident Review (PASARR) NJ Ex Order 2 assessment after a resident was newly diagnosed with a NJ Ex Order 26.4(b)(1). This deficient practice was identified in 1 of 2 residents reviewed for	F 644	1. On 6/17/24 the facility failed to refer Resident #44 to a NJ Ex Order 26.4(b)(1) for a PASRR NJ Ex Order 26.4 review. Resident #44 was NJ Ex Order 26.4(b)(1) by this deficient practice. 2. A complete audit of all active residents	7/19/24

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F 644	Continued From page 14 Preadmission Screening and Resident Review PASARR (Resident #44) and was evidenced by the following: Resident #44 was a resident of the facility. On 06/13/2024 at 11:43 AM the surveyor reviewed the NJ Ex Order 26 PASARR (a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) for Resident #44 dated NJ Ex Order 26.4(b) which was NJ Ex Order 26.4(b) meaning the resident NJ Ex Order 26.4(b)(1) diagnoses that could lead to a NJ Ex Order 26.4(b)(1). The surveyor reviewed the quarterly Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4(b)(1). The MDS reflected that Resident #44 was NJ Ex Order 26.4(b)(1) and had a diagnosis of NJ Ex Order 26.4(b)(1) On 06/13/24 at 1:49 PM the surveyor reviewed the Annual MDS dated NJ Ex Order 26.4(b)(1), which reflected that Resident #44 was not currently considered by the state NJ Ex Order 2 PASARR process to have NJ Ex Order 26.4(b)(1) and/or NJ Ex Order 26.4(b)(1) or a related condition. It reflected that Resident #44 had diagnoses which include but are not limited to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)((NJ Ex Order 26.4(b)(1)). On 06/17/2024 at 9:36 AM the surveyor reviewed the NJ Ex Order 26.4(b)(1) consult for Resident #44 dated NJ Ex Order 26.4(b). The consult included a new diagnosis of NJ Ex Order 26.4(b)(1) During an interview with the surveyor on 06/17/2024 at 9:52 AM, the U.S. FOIA (b) (6)) who began working at the facility in NJ Ex Order 26.4(b)(1) and stated that when a resident was diagnosed with a new NJ Ex Order 26.4(b)(1) disorder, it would prompt an interdisciplinary	F 644	with newly evident serious mental disorder, intellectual disability or related condition who were admitted with a positive or negative PASRR level I was completed on 6/18/24 by the facility social worker. This audit included ensuring these residents have proper diagnosis on their PASRR level I and any resident requiring a PASRR level II have a proper level II completed. 3. On 6/18/24 the Administrator and DON met with the Interdisciplinary team and re-educated them on when a resident exhibits a newly evident mental disorder, intellectual disability or related condition the resident should be referred to a mental health authority for a PASRR level II review. An audit will be conducted by the Social worker and/or designee on all residents starting on 6/18/24 to check for proper PASRR assessments and diagnosis. These audits will be monthly x 2 months, then quarterly for 6 months then annually thereafter. 4. All audits will be reviewed by Administrator, DON and/or designee to ensure timely compliance monthly, quarterly and annually thereafter per the audit timeframes listed in action #3 beginning on 6/18/24. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback. The Administrator and DON will be responsible for implementing this plan of correction.	

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F 644	Continued From page 15 conference for the resident. She would request that a [NJ Ex Order 26.] PASARR be completed. The [U.S. FO] stated she does not have a PASARR [NJ Ex Order 26.4] for Resident #44 since the new [NJ Ex Order 26.4(b)(1)] diagnosis on [NJ Ex Order 26.4(b)]. During an interview with the surveyor on 06/17/24 at 10:22 AM, the U.S. FOIA (b) (6) stated that a new [NJ Ex Order 26.4(b)(1)] diagnosis should have triggered a PASARR [NJ Ex Order 26.] The surveyor reviewed the facility policy titled, "Resident Assessment-Coordination with PASARR Program", with a date implemented on 1/10/24. The policy reflected that any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level ii resident review. Examples include A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis). NJAC 8:39-27.1 (a)	F 644		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning	F 660		7/19/24

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process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-
(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who

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F 660	Continued From page 17 made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Complaint # NJ 00167157 Based on interview and rerecords review, it was determined that the facility failed to address Resident #194's (Activities of Daily Living) ADLs care needs by ensuring that the resident was NJ Ex Order 26.4(b)(1) prior to discharge. The facility did not have a care plan that addressed discharge. The facility discharged Resident #194 without addressing and acknowledging family members voiced concerns of the resident being NJ Ex Order 26.4(b)(1) for himself/herself.	F 660	1. On 6/20/24 resident #194 discharge form was completed and signed by the attending Physician and a verbal order stating resident was ok to discharge home was received by same physician. 2. A complete audit of all active residents who have the potential for discharge was conducted by the DON and Social Worker. All Physicians have been notified to review their resident charts to ensure physician orders and progress notes have	

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F 660	Continued From page 18 This deficient practice was identified for 1 of 2 residents reviewed for discharge and was evidenced by the following: On 6/17/24 at 10:30 AM, the surveyor reviewed Resident #194's closed medical record. Resident #194 was admitted to the facility on [redacted] and discharged on [redacted]. Resident #194's diagnoses included but were not limited to; [redacted], NJ Ex Order 26.4(b)(1), [redacted], NJ Ex Order 26.4(b)(1), [redacted] and NJ Ex Order 26.4(b)(1). A review of the Discharge Minimum Data Set (MDS) Assessment dated [redacted], indicated Resident #194 had NJ Ex Order 26.4(b)(1). Resident #194 scored [redacted] out of 15 on the Brief Interview For Mental Status (BIMS). Resident #194 required [redacted] with [redacted] and [redacted] Resident #194 needed [redacted] with [redacted] A review of the comprehensive care plan dated [redacted] did not include a care plan for discharge planning. Review of a progress notes dated [redacted], revealed Resident #194 was [redacted]. The progress note further indicated that Resident #194 was to return to the facility on [redacted] for discharge and the note continued and indicated that Resident #194 was previously notified via care conference (no date). On 6/18/24 at 9:30 AM, the surveyor interviewed the U.S. FOIA (b) (6) [redacted] regarding the facility's discharge protocol. The [redacted] stated that the discharge planning must be initiated on admission. The resident's goals for discharge must be discussed	F 660	been entered in the medical record addressing the resident's potential for discharge. 3. On 6/20/24 the Administrator and DON met with the Attending Physician to determine the root cause of why discharge orders and progress notes were not entered in a timely manner. It was determined that the Physician was not completely aware of the facility policy and procedures regarding the Discharge Policy which includes timeliness of writing progress notes and orders in the resident chart. A copy of the facility policy was given to the attending Physician for review. The Interdisciplinary team consisting of US FOIA (b)(6) [redacted] and nursing staff including US FOIA (b)(6) were also in-serviced on discharge summary completion and following facility discharge policy. All new hire staff will be in-serviced at orientation by DON/designee. An audit will be conducted by the DON and/or designee on all residents starting on 6/20/24 to check for timeliness of Physician progress notes addressing discharge and writing orders for discharge. These audits will be monthly times 2 months, then quarterly for 6 months then annually thereafter. 4. All audits will be reviewed by Administrator, DON and/or designee to ensure timely compliance monthly, quarterly and annually thereafter per the audit timeframes listed in action #3 beginning on 6/20/24. These audits will be reviewed at the quarterly QA meetings for	

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F 660	Continued From page 19 and reviewed by all involved with the resident's care. Prior to discharge, the Interdisciplinary team will convene to review the plan and formulate the discharge summary. The surveyor showed a copy of the discharge paperwork to the U.S. FO who confirmed that the discharge was incomplete and there was no physician order for the discharge. On 6/18/24 at 10:30 AM, the surveyor reviewed the NJ Ex Order 26.4(b)(1) Evaluation completed on NJ Ex Order 26.4 which indicated that Resident #194 demonstrated NJ Ex Order 26.4(b)(1) as evidenced by ability to NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(and NJ Ex Order 26.4(b)(1). The NJ Ex Order 26.4(b)(1) Evaluation also completed and signed on NJ Ex Order 26.4 revealed that Resident #194 demonstrates NJ Ex Order 26.4(b) as evidenced by ability to NJ Ex Order 26.4(b)(1) and ability to NJ Ex Order 2 with a target date of NJ Ex Order 26.4. There were no further entries from NJ Ex Order 26 included in the medical record indicated resident #194 met the goals. The NJ Ex Order 26.4(screen completed upon admission did not include the goal for discharge and the level of care that would be required upon discharge. On 6/18/23 at 11:00 AM, the surveyor attempted to contact via telephone, and then left a message for the U.S. FOIA (b) (6)). The U.S. FO returned the call on 6/24/24 and requested to be called later. On 6/24/24 at 7:14 PM, during a telephone interview with the surveyor, the U.S. FO revealed that the resident was discharged NJ Ex Order despite NJ Ex Order 26.4(b)(1) for discharge. The facility informed the resident that he/she was being discharged because the NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) their stay. The U.S. FO further stated that she had informed the facility	F 660	recommendations and/or feedback. The Administrator and DON will be responsible for implementing this plan of correction.	

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F 660	Continued From page 20	F 660		

that Resident #194 still NJ Ex Order 26.4(b)(1) with care and NJ Ex Order 26.4(b)(1) discharged.

An interview on June 19, 2024 at 12:30 PM, with the nurse who initiated the discharge summary, revealed that she was not familiar with the resident's care. She was employed by an agency at that time and was not familiar with paperwork to be completed prior to discharge. The nurse revealed she had completed the discharge paperwork on NJ Ex Order 26.4(b)(1), for Resident #194. The surveyor showed the incomplete discharge paperwork to the nurse, who then stated she was instructed to complete the paperwork. The nurse further stated that day was the only day she had worked with this resident, and she really didn't know much about the resident.

An interview with the U.S. FOIA (b) (6)) on June 18, 2024, at 11:30 AM, who was then the U.S. FOIA (b) (6), revealed that the discharge summary was incomplete and there was not much she could do about it as she was not the physician.

On June 19, at 1:30 PM, an interview with the U.S. FOIA (b) (6)) who was at the facility to assist with the survey, revealed that moving forward, the facility would develop a discharge planning and all the disciplines will be involved with the discharge planning.

A review of the facility's policy titled, " Discharge Planning" last reviewed, 2/16/24 included the following:
Objective: To evaluate each resident relative to their potential for discharge to a least restrictive environment and to make recommendations to

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	99 MANHEIM AVENUE BRIDGETON, NJ 08302

(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 660	Continued From page 21 facilitate that goal. Goal: The discharge plan utilizes the interdisciplinary approach to plan for care in an attempt to bring all disciplines together to formulate individual goals and a personalized plan of care for each resident. All disciplines interact to establish objectives in order to provide this continuity of care. Within 7 days of admission, each discipline must enter on the Discharge planning form their discharge plan. The attending physician of each resident must estimate how long the resident will stay and record the resident's potential for discharge. Each discipline, including the resident and/ or their family, shall have input into their own formulation of the most appropriate treatment and discharge goal. Discharging Procedure: Residents are usually discharge only upon the written order of the attending physician. Or the sponsor may sign a form for discharge against medical advice. The facility failed to follow their own policy. The discharge summary revealed that the discharge form must be completed within 30 days of discharge. The discharge Form provided by the facility on 06/13/24 was not completed and not signed by the physician. NJAC 8:39-5.4 (b)(c)	F 660		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677		7/19/24

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F 677	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of records, and review of pertinent documents, it was determined that the facility failed to provide appropriate NJ Ex Order 26.4(b)(1) care, and NJ Ex Order 26.4(b) care for 1 of 2 residents. (Resident #12) reviewed for activities of daily living. The deficient practice was evidenced by the following: On 06/17/24 at 9:24 AM, the surveyor observed Resident #12 in bed. Resident #12 was NJ Ex Or and stated that NJ Ex Order 26.4(b)(1) care was not provided in a timely manner. When asked to elaborate, Resident #12 stated he/she was assisted with NJ Ex Order 26.4(b)(1) care at 11:00 PM and again this morning at 3:00 AM. Upon inquiry, the resident stated that he/she had not received care yet. The resident further stated that he/she NJ Ex Order 26.4(b)(1) and would like to NJ Ex Order 26.4(b)(1). The surveyor left the room and informed the U.S. FOIA (b) (6). The U.S. FOI provided the surveyor with the assignment sheet and identified the U.S. FOIA (b) (6)) assigned to the resident. On 06/17/24 at 9:44 AM, the surveyor interviewed the U.S. FOIA who had Resident #12 on her assignment. The U.S. FOIA revealed that she had 10 residents on her assignment of which seven of them required total assistance with care. The U.S. FOIA confirmed that she had not yet provided NJ Ex Order 26.4b1 to Resident #12. The U.S. FOIA stated that by 11:00 AM she would complete her first round and provide NJ Ex Order 26.4b1 to all. On 06/17/24 at 10:00 AM the surveyor asked the U.S. FOIA if she can check Resident #12. Resident	F 677	1. The deficiency occurred when the facility failed to ensure Resident #12 was provided with appropriate NJ Ex Order 26.4(b)(1) care and NJ Ex Order 26.4(b)(1). All dependent residents have the potential to be affected by this deficiency. 2. On 6/17/24 the CNA provided Resident #12 with NJ Ex Order 26.4(b)(1) care and NJ Ex Order 26.4(b) . The Unit Manager and CNA's checked all residents on the unit and provided incontinence care and hygiene if needed to each resident. 3. On 6/17/24 the DON re-educated nursing staff on providing incontinence care every 2 hours, personal hygiene and not double diaper any resident. All new hire nursing staff will be educated on ADL care, incontinence care and personal hygiene during orientation. Staff nurses will be responsible for checking their assigned residents to ensure proper ADL care has been performed. CNA's who are unable to provide ADL care within the appropriate time frame are to inform the staff nurse and/or nurse manager for assistance. The DON and/or designee will complete random audits for incontinence care and personal hygiene on dependent residents weekly times 2 weeks, monthly times 3 months then quarterly for 2 quarters thereafter for dependent residents to monitor compliance. The DON or designee will also audit CNA assignment workloads to balance the resident's who are dependent on total	

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F 677	Continued From page 23 #12 agreed to NJ Ex Order 26.4(b)(1). The surveyor and the CNA observed that Resident #12 wore NJ [redacted] which were NJ Ex Order 26.4(b)(1). The NJ Ex Order 26.4(b)(1) the resident was also NJ Ex Order 2[redacted] The CNA indicated that was not the first time she observed the residents with NJ Ex Order 26.4(b)(1). The surveyor then left the room and accompanied the U.S. FOIA (b) (6) to the room. At the surveyor's request, the resident's NJ Ex Order 26.4(b)(1) was checked by staff, and we all observed Resident #12 with NJ Ex Or[redacted] which were NJ Ex Order 26.4(b)(1). When asked about her expectations, the U.S. FC replied, " the resident should not have NJ Ex Order 26[redacted] ". The U.S. FC further stated that the concerns with NJ Ex Order 26.4(b)(1) were addressed sometimes this year and the staff was in-serviced. On 06/17/24 at 11:55 AM, the surveyor again with the U.S. FC regarding NJ Ex Order 26.4(b)(1) care. The U.S. FC stated that the facility's protocol was to provide [redacted] care every 2 hours and as needed. The U.S. FC further stated that the concerns with NJ Ex Order 26.4b1 was discussed at morning meeting and in-service education was provided this year. On 06/18/24 at 10:45 AM, the surveyor reviewed Resident #12's electronic medical record. Resident #12's Admission Record (AR) revealed, Resident #12 was admitted to the facility with diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) [redacted], and NJ Ex Order 26.4(b)(1). The Admission Minimum Data Set (MDS) assessment tool used by the facility to prioritize care, dated NJ Ex Order 26.4(b[redacted], revealed that Resident #12 scored NJ Ex[redacted]/15 on the Brief Interview for Mental Status (BIMS) and indicated the resident was	F 677	care. The DON will report all findings to the QA team during quarterly meetings. 4. All audits will be reviewed by Administrator and DON and/or designee to ensure compliance weekly, monthly then Quarterly thereafter per the audit timeframes listed in action #3 beginning on 6/17/24. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback. The Administrator and DON will be responsible for implementing this plan of correction.	

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NJ Ex Order 26.4(b)(1). Section NJ Ex C of the MDS which referred to Activities of Daily Living (ADLs) revealed that Resident #12 was NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4 and NJ Ex Order 26.4(b)(1).

Review of the Care Plan for Resident #12 initiated on NJ Ex Order 26.4(b), included a "Focus" for ADL Self Care Performance Deficit and is at risk for not having their needs met in a timely manner related to: NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1)., NJ Ex Order 26.4(b)(1) NJ Ex Orde The goal was for Resident #12 will maintain a sense of dignity by being clean dry, odor free, and well groomed through the next review date. Resident #12 had a focus for NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4 related to NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b), NJ Ex Order 26.4(b)(1). The interventions were to check frequently for NJ Ex Order 26.4(and NJ Ex Order 26 NJ Ex Order 26.4 as needed. Initiated NJ Ex Order 26.4(b). Resident #12 wears NJ Ex Order 26.4(b)(1) at night to assist in NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) care. The care plan did not specify the frequency for staff to provide NJ Ex Order 26.4(b)(1) care to the resident. Resident #12 was provided with NJ Ex Order 26.4(b)(1) care at 3:00 AM and then seven hours later at the surveyor's request 10:30 AM.

On 06/18/24 at 7:16 AM, the surveyor interviewed the 11:00 AM- 7:00 AM U.S. FOIA regarding NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) care. The U.S. FOIA stated that care was to be provided every 2 hours depending on the level of resident NJ Ex Order 26.4(b)(1) The U.S. FOIA further stated that all residents were to be NJ Ex Order 26.4(b) x 2 during the shift. When inquired regarding residents NJ Ex Order 26.4 and stated, "that was not the practice."

On 06/19/24 at 11:30 AM, the facility was made

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F 677	Continued From page 25 aware of the above concerns and requested the facility policy for incontinence care and Activity of daily living. On 06/19/24 at 3:00 PM, during the exit conference that was held with the survey team, the U.S. FOIA (b) (6)), U.S. FOIA (b) (6) and the U.S. FOIA (b) (6)), the U.S. stated, "that staff should not use NJ Ex Order 26.4(b)(1) on the residents." A review of the facility's policy titled, "Activities of Daily Living (ADLs) implemented 3/5/24 revealed the following: Policy The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: Bathing dressing, grooming and oral care. Policy Explanation and compliance Guidelines Guideline #3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene. A review of a form titled, " Resident Care-Certified Nursing Assistant Responsibilities provided by the facility on 6/17/24, indicated the following: All residents must be properly dressed, clothes neat and clean, females must have bra and proper unclothes. Residents must be assisted with toileting as	F 677		

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F 677	Continued From page 26 needed. Any resident on bowel and bladder training must be toileted every 2 hours and as needed. All residents must be treated with dignity and respect. NJAC 8:39-27.1 (a)2(h)	F 677		
F 678 SS=D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and pertinent facility documentation it was determined that the facility failed to identify conflicting physician's orders for emergency treatment on the medical record for 1 of 1 resident reviewed for NJ Ex Order 26.4(b)(1) resident #49. This deficient practice was evidenced by: A review of Resident #49's Order Summary Report in the Electronic Medical Record (EMR) revealed that, resident #49 had a NJ Ex Order 26.4(b)(1) with a start date of NJ Ex Order 26.4(b)(1), and a (NJ Ex Order 26.4(b)(1)) order with a start date of NJ Ex Order 26.4(b)(1).	F 678	1. Resident #49 was NJ Ex Order 26.4(b)(1) by this deficient practice when the facility failed to identify conflicting physician's orders for emergency treatment in the medical record. Resident #49 medical record was updated to reflect accurate emergency treatment order. 2. A complete audit of all active residents with a POLST was conducted on 6/19/24 by the DON to determine accurate emergency treatment orders. An admissions check list was created which included POLST forms to alert nursing staff to check orders for code status accuracy. 3. On 6/19/24 the DON re-educated all nursing staff on checking POLST forms prior to getting physician orders for	7/19/24

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F 678	Continued From page 27 A review of Resident #49's New Jersey Practitioner Orders for Life-Sustaining Treatment (POLST) dated [NJ Ex Order 26.4(b)(1)], contained the following order: "NJ Ex Order 26.4(b)(1), allow [NJ Ex Order 26.4(b)(1)], and [NJ Ex Order 26.4(b)(1)]". On 06/17/2024 at 12:33 PM, during an interview with the surveyor, the U.S. FOIA (b) (6) [U.S. FOIA (b) (6)], stated that Resident #49 was a [NJ Ex Order 26.4(b)(]. The surveyor reviewed the [NJ Ex Order 26.4(b)(], and the (POLST) with the [U.S. FOIA (b) (6)] the [U.S. FOIA (b) (6)] confirmed it was a conflicted order, she stated that the order should not say, '[NJ Ex Order 26.4(b)] as well." On 06/19/2024 at 11:34 AM, during an interview with the U.S. FOIA (b) (6)), [U.S. FOIA (b) (6)] and the U.S. FOIA (b) (6) the surveyor asked if Resident #49 should have both [NJ Ex Order 26.4(b] and [NJ Ex Order 26.4(b)(1] status. The [U.S.] stated, "no". Review of the facility's "POLST/Advanced Directive" policy dated 11/13/23, the policy revealed under "#5 the following: " Upon, a quarterly basis or significant change, code status will be reviewed with the resident or health care representative."	F 678	emergency treatment so orders reflect accurately. The DON or designee will conduct audits of all residents who have a POLST and confirm accurate physician orders weekly times 2 weeks, then twice a month for the next 2 months then quarterly for 2 quarters starting on 6/19/24. Resident charts will be reviewed for accuracy of physician orders and care plans. The DON will report all findings to the QA team during quarterly meetings. 4. All audits will be reviewed by Administrator, DON and/or designee to ensure compliance weekly, twice a month and monthly thereafter per the audit timeframes listed in action #3 beginning on 6/19/24. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback. The Administrator and DON will be responsible for implementing this plan of correction.	
F 684 SS=D	NJAC 8:39-9.6 (b) Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684		7/19/24

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F 684	Continued From page 28 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review it was determined that the facility failed to ensure that a system was in place and followed to review and notify physicians of NJ Ex Order 26.4(b)(1). This deficient practice occurred for 1 of 20 residents reviewed (Resident #47) and was evidenced by the following: On 06/17/24 at 9:39 AM, observed resident in bed and respond "NJ Ex Order 26.4(b)(1)" when asked how was doing. A review of the electronic medical record revealed resident was discharged to the hospital and admitted for NJ Ex Order 26.4(b) and a discharge summary from the hospital, revealed the discharge diagnoses that included NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). A NJ Ex Order 26.4(b Note dated: NJ Ex Order 26.4(b, timed 17:15 [5:15 PM] that was completed by the U.S. FOIA (b) (6) , revealed: Assessment and Plans: Resident is on a NJ Ex Order 26.4(b)(1) . NJ Ex Order 2 varies. Is supplemented with NJ Ex Order 26.4(b)(1) daily NJ Ex Order 26.4(b)(1) . NJ Ex Order 26.4(b)(1) . Was NJ Ex O past NJ Ex Order 26.4(b)(. NJ Ex Order 26.4(b)(1 still uncontrolled NJ Ex Orc NJ Ex Order 26.4(b)(	F 684	1. The deficiency occurred when the facility failed to ensure that a system was in place to notify physicians of NJ Ex Order 26.4(b)(1) Resident #47 was NJ Ex Order 26.4(b)(1) by this practice. 2. On 6/17/24 the Physician was notified of Resident #47 NJ Ex Order 26.4(b)(1) which included NJ Ex Order 26.4(b)(1) and the physician stated there were no new orders at this time. 3. On 6/17/24 the DON re-educated all nursing staff on procedure to contact the physician and/or the nurse practitioner when new labs are received daily. Education was also provided to all nursing staff on writing a progress note regarding the lab values after speaking to the practitioner and writing new orders if appropriate. The facility policy was updated to reflect the need to contact the physician in a timely fashion and write a nursing progress note stating physician recommendations. All nursing staff were educated by the DON regarding the policy change. The DON and/or designee will complete audits weekly times 2 weeks, monthly times 3 months then quarterly for 2 quarters thereafter for residents receiving labs. The DON will report all	

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F 684	Continued From page 29 NJ Ex Order 26.4(b)(1)] NJ Ex Or ." Monitor NJ Ex Order 26 NJ Ex Order 2 and NJ Ex Order 26.4(b)(1) Reviewed NJ Ex O Result which was located in a tab in the Electronic Medical Record which revealed NJ Ex Order 26.4 Collection Date: NJ Ex Order 26.4(b ; 03:15 Received Date: NJ Ex Order 26.4(b 15:05 Reported Date: NJ Ex Order 26.4(b 16:35 NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)) NJ Ex Order 26.4(b)(1)] FinalReport contains NJ Ex Order 26.4(b)(results (results NJ Ex Order 26.4(b)(1) text). The surveyor reviewed the Electronic Medical Record from NJ Ex Order 26.4(b through current and did not locate any documentation where the NJ Ex Order 26.4 was referred to the physician or the physician reviewed the NJ Ex Order 26.4(b)(1) that was identified by the U.S. FOIA (b) (6) as the resident had NJ Ex Order 26.4(b)(1). On 06/17/24 at 11:43 AM, the surveyor interviewed the U.S. FOIA (b) (6)) regarding physician coverage and the U.S. FOIA stated the U.S. FOIA (b) (6) came to the facility twice weekly, and completed progress notes. 06/17/24 at 11:53 AM, the surveyor interviewed the U.S. FOIA (b) (6) for Resident #47. The surveyor asked about the process when receiving NJ Ex Or and the U.S. FOIA (b) (6) stated the NJ Ex Or would pop up under each resident in a tab, and the nurse or U.S. FOIA (b) (6) would check it and notify the physician or U.S. FOIA (b . The surveyor asked about the NJ Ex Order 26.4(b)(1) and the U.S. FOIA (b) (6) reviewed the NJ Ex in the computer in the presence of the surveyor. The surveyor asked if the physician was notified of the NJ Ex Order 26.4(b)(result as the surveyor could not locate any documentation. The U.S. FOIA (b) (6) reviewed the progress notes and stated, "I don't	F 684	findings to the QA team during quarterly meetings. 4. All audits will be reviewed by Administrator and DON and/or designee to ensure compliance weekly, monthly then Quarterly thereafter per the audit timeframes listed in action #3 beginning on 6/17/24. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback. The Administrator and DON will be responsible for implementing this plan of correction.	

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F 684	Continued From page 30 see anything either". On 06/17/24 at 12:12 PM, the surveyor conducted a telephone interview with the U.S. FOIA (b) (6) [redacted] /Resident #47's physician, regarding when he should be notified of NJ Ex Order 26.4(b)([redacted] and he stated the same day. NJAC 8:39-27.1(a)	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to obtain a Physician's Order (PO) for an NJ Ex Order 26.4(b)(1) for 1 of 1 resident (Resident#14) reviewed for	F 688	1. Resident #14 was NJ Ex Order 26.4(b)(1) [redacted] by this deficient practice when the facility failed to obtain a physician order for a NJ Ex Order 26.4(b)(1).	7/19/24

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	315061	A. BUILDING _____ B. WING _____	C 06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	99 MANHEIM AVENUE BRIDGETON, NJ 08302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 31 NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(On 06/13/2024 at 10:04 AM, the surveyor observed Resident #14 in the bed. An NJ Ex Order 26. was observed near Resident #14's NJ Ex Or . According to the Admission Record, Resident #14 was admitted to the facility with a diagnosis including but not limited to; NJ Ex Order 26.4(b)(1) (NJ E), NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)) and NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)). Review of the Annual Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care, dated NJ Ex Order 26.4(b)(1), reflected that the resident was NJ Ex Order 26.4(b)(1) and had NJ Ex Order 26.4(b)(1) of the NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b . Review of the Order Summary Report with active orders as of NJ Ex Order 26.4(b)(1) did not reveal an order for Resident #14's NJ Ex Order 26.4(b)(1) for the NJ Ex Ord . Review of Resident #14's current Care Plan reflected that Resident #14 required NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1). The interventions included to encourage use of the NJ Ex Order 26.4(b)(1). Review of Resident #14's NJ Ex Order 26.4(b)(1) discharge summary from NJ Ex Order 26.4(b)(1) reflected recommendations for a NJ Ex Order 26.4(b)(1) as tolerated. During an interview with the surveyor on 06/18/2024 at 7:47 AM, the U.S. FOIA (b) (6)) stated that there should	F 688	2. A complete audit of all active residents who use an orthotic device was conducted on 6/19/24 by the DON to determine if they had a physician□s order and care plan in place. 3. On 6/20/24 the DON re-educated nursing and therapy staff on obtaining physician orders for orthotic devices and following the facility ROM, Splinting, Bracing policy. Weekly audits by the DON and/or assigned designee of all residents who have a orthotic device will be conducted weekly times 2 weeks, then twice a month for the next 2 months starting on 6/20/24. Resident charts will be reviewed for accuracy of physician orders and care plans. The DON will report all findings to the QA team during quarterly meetings. 4. All audits will be reviewed by Administrator, DON and/or designee to ensure compliance weekly, twice a month and monthly thereafter per the audit timeframes listed in action #3 beginning on 6/20/24. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback. The Administrator and DON will be responsible for implementing this plan of correction.	

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F 688	Continued From page 32 be an order for Resident #14's NJ Ex Order 26.4(b)(1) [redacted] The surveyor and the U.S. FOIA (b) reviewed the physician orders for Resident #14 together. The U.S. FOIA (b) acknowledged that there was no physician order for the NJ Ex Order 26.4(b)(1). During an interview with the surveyor on 06/18/2024 at 10:19 AM, the Licensed Practical Nurse #1 stated that there should be a physician order for an NJ Ex Order 26.4(Review of the facility policy titled "Range of Motion, Splinting, Bracing" implemented 1/10/24 reflected that a physician's order must be obtained for use of equipment such as splints, braces, handrolls. NJAC 8:39-27.1 (a)	F 688		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. 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 and document review it was determined that the facility failed to ensure the NJ Ex Order 26.4(b) policy was followed to ensure the safety for residents who NJ Ex Order 26.4(and held their own NJ Ex Order 26.4(b)(1 and NJ Ex Order 26.4(This deficient practice occurred for 2 of 2 residents who held their own NJ Ex Order 26.((Resident #22 and #25) and	F 689	1. Resident #22 and resident #25 were NJ Ex Order 26.4(b)(1) by this deficient practice. Residents #22 and #25 have since been assessed by nursing staff to ensure safety during NJ Ex Order 26.4(b) activities. Both residents were re-educated on the facility [redacted] policy and not keeping	7/19/24

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F 689	Continued From page 33 was evidenced by the following: a. During the initial tour on 6/13/2024 at 09:49 AM, the surveyor observed Resident #22 in their room. Upon inquiry, Resident #22 informed the surveyor that he/she was [redacted]. On 06/17/2024 at 10:38 AM, the surveyor observed Resident #22 in the designated [redacted] area and was [redacted] On 06/18/2024 at 09:00 AM, the surveyor observed Resident #22 in their room. Resident #22 informed the surveyor that they held their own [redacted] and [redacted] The resident showed to the surveyor their [redacted] and [redacted] and stated that the facility was aware. On 6/18/24 at 10:30 AM, the surveyor reviewed Resident #22's medical record. The Admission Summary reflected that Resident #22 was admitted to the facility with diagnoses which included but were not limited to; [redacted] A review of the Annual Minimum Data Set (MDS) dated [redacted], an assessment tool used to facilitate resident care, revealed that Resident b#22 had [redacted]. Resident #22 scored [redacted]/15 on the Brief Interview for Mental Status (BIMS). A review of a Care Plan with an initiated date of [redacted], revealed a focus area for [redacted] The goal was for Resident #22 will abide by the	F 689	[redacted] materials on their person and they must be secured and kept by the [redacted] monitor or designated staff member. Both residents care plans were updated to reflect their re-education and knowledge of the facility [redacted] policy. 2. A complete audit for all active residents who smoke was conducted on 6/20/24 by the social worker to ensure proper smoking assessments, smoking evaluations and smoking care plans were complete. All active smokers will be re-educated on the facility smoking policy and job description of the smoking monitor. 3. The Administrator, DON and/or designee will in-service nursing staff on the importance of the smoking assessment and smoking care plan to be completed on admission, yearly and with a significant change starting on 6/20/24. All smoking monitors will be re-educated on the smoking policy and smoking paraphernalia procedure for all residents who smoke. All new hire nursing or smoke monitors will be educated regarding smoking policy and procedure during orientation. Residents found to have lighting materials will have them confiscated and they will be re-educated on the facility smoking policy. Unit managers and social worker will be responsible for reviewing admission documentation and assessments plus conducting a resident interview to verify resident is a smoker and has the proper smoking assessments, evaluations and	

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F 689	Continued From page 34 facility's NJ Ex Order 26.4(b) policy and remain safe during NJ Ex Order 26.4(b) times through the next review. The interventions included to remind residents and their family that all NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4 NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1) must be kept at the nurses station. On 6/18/24 at 9:14 AM, the surveyor interviewed the U.S. FOIA (b) (6) who informed the surveyor that NJ Ex Or residents could hold their own NJ Ex Order 26.4(b)(1 and NJ Ex Order 26.4 On 06/18/2024 at 11:33 AM, the surveyor interviewed the U.S. FOIA (b) (6) who stated, " We don't allow residents to have their own NJ Ex Order 26. for safety reasons." On 06/18/24 at 12:37 PM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated, if residents were care planed as an NJ Ex Order 26.4(b)(1) , they could hold their own NJ Ex Order 26.4(b)(1 and NJ Ex Order 26 The surveyor reviewed with the U.S. FO Resident #22's care plan. The U.S. FO stated then, "No, they should not have their NJ Ex Order 26.4 On 06/18/2024 at 12:41 PM, during an interview with the surveyor, on the U.S. FOIA (b) (6) confirmed that residents should not hold their NJ Ex Order 26. because it was a hazard. A review of an undated smoking policy provided by the facility policy titled "Smoking Policy" revealed under subsection "procedure" that "8. The smoking monitor will be assigned to observe the courtyard to monitor all smokers. All residents will have their products lit by the smoking monitor or designated staff.	F 689	care plans in place. Audits by the SW and/or assigned designee of all residents who currently smoke will be conducted once in September then once again in December then continue on admission, annually and significant changes starting on 6/20/24 to check for care plan accuracy, smoking assessments and evaluations and make sure all new admissions are educated on the current facility smoking policy. 4. All audits will be reviewed by Administrator, DON and/or designee to ensure timely compliance weekly, twice a month and monthly thereafter per the audit timeframes listed in action #3 beginning on 6/20/24. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback. The Administrator and DON will be responsible for implementing this plan of correction.	

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F 689	Continued From page 35	F 689		

b. On 06/14/24 at 11:50 AM, five surveyors were in the conference room and observed Resident #25 walk past the back of the building by the Sub Acute area bordering the woods, was on a path and was observed NJ Ex Order 26.4(b)(1).

At that time, the surveyor reviewed the electronic Medical Record (EMR) for Resident #25 which revealed the following Care Plan:

Focus
NJ Ex Order 26.4(b)(
Resident is NJ Ex Order 26.4(b)(and is at risk for injury.
Resident is an NJ Ex Order 26.4(b)(1)
and does not require direct supervision to NJ Ex Order 26.
Date Initiated: NJ Ex Order 26.4(b)(1)
Revision on: NJ Ex Order 26.4(b)(1)
Goal:
-Resident will abide by facility's NJ Ex Order 26.4(policy and remain safe during NJ Ex Order 26.4(times through the next review.
Date Initiated: NJ Ex Order 26.4(b)(1)
Revision on NJ Ex Order 26.4(b)(1)
Target Date: NJ Ex Order 26.4(b)(1)
- Resident will NJ Ex Order 26 in designated areas without occurrence of injury through the next review.
Date Initiated: NJ Ex Order 26.4(b)(1)
Revision on: NJ Ex Order 26.4(b)(1)
Target Date: NJ Ex Order 26.4(b)(1)
Interventions
- Perform NJ Ex Order 26.4(assessment according to facility policy.
Date Initiated: NJ Ex Order 26.4(b)(1)
- Educate resident on NJ Ex Order 26.4(policy.
Date Initiated NJ Ex Order 26.4(b)(1)
-NJ Ex Order 26.4(b)(1): Resident is an NJ Ex Order 26.4(b)(1) and does not require the use of a NJ Ex Order 26.4(b)(1) or direct staff supervision

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F 689	Continued From page 36 during [NJ Ex Order 26.4(b)] breaks. Date Initiated: [NJ Ex Order 26.4(b)(1)]. (The Care Plan did not indicate the resident was able to hold own [NJ Ex Order 26.4(b)] material and [NJ Ex Order 26.4(b)] and walk around the building [NJ Ex Order 26.4(b)(1)] Resident #25's most recent [NJ Ex Order 26.4(b)] assessment, dated [NJ Ex Order 26.4(b)] revealed #3 Is resident physically capable of holding a [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4(b)(1)], and [NJ Ex Order 26.4(b)] and [NJ Ex Order 26.4(b)(1)] own [NJ Ex Order 26.4(b)] without assistance; "[NJ Ex Order 26.4(b)] Has resident been instructed in facility policy regarding safety of himself/herself or others; [NJ Ex Order 26.4(b)] Has resident signed the "[Facility Name]" [NJ Ex Order 26.4(b)] agreement and [NJ Ex Order 26.4(b)] release of responsibility form, "[NJ Ex Order 26.4(b)] On 06/14/24 at 11:58 AM, a surveyor observed Resident #25 entering the building from the main entrance. The surveyor inquired as to what the resident did outside and the Resident stated was outside walking the parameter of the building and [NJ Ex Order 26.4(b)(1)]. Resident #25 stated he/she NJ Ex Order 26.4(b)(1) and stated kept a personal [NJ Ex Order 26.4(b)] to [NJ Ex Order 26.4(b)] his/her own [NJ Ex Order 26.4(b)(1)] The Smoking Policy, provided on 06/13/24 at 12:00 by the [U.S. FOIA (b)] revealed "Safe smoking assessment and smoking rules". Purpose to determine a resident's level of ability to smoke safely. Procedure: 1. Upon admission, the social worker or admitting nurse will determine if the resident is a smoker. 6. Residents are only permitted to smoke in the designated smoking area. 8. The smoking monitor will be assigned to observe the courtyard to monitor all smokers. All residents will have their products lit by the smoking monitor or	F 689		

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F 689	Continued From page 37 designated staff member. On 06/18/24 at 11:30 AM, the surveyor conducted an interview with the [U.S. FOIA (b)] in the presence of the survey team, regarding the [NJ Ex Order 26.4(b)] policy. The [U.S. FOIA (b)] confirmed the policy was the current policy and asked per the policy could a resident hold their own [NJ Ex Order 26.4(b)(1)] and light there own [NJ Ex Order 26.4(b)(1)] The [U.S. FOIA (b)] stated, "we don't allow them to have [NJ Ex Order 26.4(b)] and asked why not and the [U.S. FOIA (b)] stated, "safety".	F 689		
F 695 SS=D	NJAC 8:39-31.6 (e) Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to follow the physician orders related to the use of [NJ Ex Order 26.4(b)(1)] for 1 of 1 resident (Resident #42) reviewed for the use of [NJ Ex Order 26.4(b)(1)] This deficient practice was evidenced by the following: On 06/13/2024 at 9:44 AM, the surveyor	F 695	1. Resident #42 was [NJ Ex Order 26.4(b)(1)] by this deficient practice. Resident #42□s [NJ Ex Order 26.4(b)(1)] was replaced, [NJ Ex Order 26.4(b)(1)] was dated [NJ Ex Order 26.4(b)(1)] and placed in a [NJ Ex Order 26.4(b)(1)] for both the [NJ Ex Order 26.4(b)(1)] and the [NJ Ex Order 26.4(b)(1)] in the room. Resident #42 [NJ Ex Order 26.4(b)(1)] was placed back on properly after [NJ Ex Order 26.4(b)(1)] and the residents [NJ Ex Order 26.4(b)(1)] was taken by the LPN UM which she recorded a reading of [NJ Ex Order 26.4(b)(1)].	7/19/24

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F 695	Continued From page 38 observed a staff member assisting Resident #42 via a recliner chair, into the common area of the facility. The surveyor observed Resident #42 was wearing a NJ Ex Order 26.4(b)(1) attached to a [redacted] and the [redacted] was set at NJ Ex Order 26.4(b)(1) [redacted]. On 06/14/2024 at 8:43 AM, the surveyor observed the resident's privacy curtain drawn around the bed and could hear a staff member assisting the resident. At that time, the surveyor observed the resident's recliner chair in the hallway. The NJ Ex Order 26.4(b)(1) was on the back of the chair and there was [redacted] with the [redacted] wrapped around [redacted]. The [redacted] was not in a NJ Ex Order 26.4(b)(1) and was exposed to the environment. On 06/14/2024 at 8:59 AM, the surveyor returned and observed Resident #42 in bed with his/her eyes closed. There was [redacted] being administered and the NJ Ex Order 26.4(b)(1) was tucked under the NJ Ex Order 26.4b1 that was under the resident. A review of Resident #42's hybrid (both paper and electronic) medical records revealed an Admission Record with diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1), [redacted]), [redacted] and [redacted]. A review of the most recent Quarterly Minimum Data Set (MDS) an assessment tool used to prioritize care, dated [redacted], included but was not limited to; Section B the resident was coded a 'NJ Ex Order 26.4(b)(1) when considering ability to express ideas; Section C the Brief Interview for Mental Status (BIMS) was coded '[redacted] for NJ Ex Order 26.4(b)(1)	F 695	Education was provided by the DON to the nursing staff on 6/14/24 regarding facility Oxygen Administration policy, Infection Control specifically addressing oxygen tubing and placing tubing in a protective covering when not in use and replacing nasal cannula after resident has received care. 2. A complete audit for all active residents who have a Physicians order for oxygen was done on 6/14/24 by the DON to ensure oxygen tubing was dated and placed in clear plastic bags. All tubing that was found unbagged was discarded and new tubing was applied, dated and bagged. A complete audit for all active residents who have a Physicians order for oxygen was done on 6/14/24 by the DON to ensure physicians orders are accurate, facility Oxygen policy was being followed and oxygen tubing was being administered correctly. 3. On 6/14/24 the DON re-educated nursing staff on infection control as related to proper storage of Oxygen tubing, dating tubing and placing tubing in bags when not in use. This education also included following facility Oxygen policy and administering oxygen appropriately as ordered by the attending physician. Audits will continue by the DON and/or assigned designee on all residents who have Physician Oxygen orders starting on 6/14/24. These audits will be weekly for 4 weeks, then twice a month for 2 months then monthly for 2 months.	

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F 695	Continued From page 39 NJ Ex Order 26.4(b)(1) as the resident was NJ Ex Order 26.4(b)(1) ; Section GG indicated the resident was dependent on staff for Activities of Daily Living (ADL); and Section O indicated the resident required NJ Ex Order 26.4(b)(1). A review of the Order Summary Report included but was not limited to; NJ Ex Order 26.4(b)(1) via NJ Ex Order 26.4(b)(1) every shift dated NJ Ex Order 26.4(b)(1). A review of the resident-centered, on-going Care Plan included but was not limited to; a focus area of NJ Ex Order 26.4(b)(1) related to NJ Ex Order 26.4(b)(1) with interventions including to anticipate and meet needs; and NJ Ex Order 26.4(b)(1) and is at risk for NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1)) with interventions including to administer medications NJ Ex Order 26.4 and to monitor the resident's NJ Ex Order 26.4(b)(1) status. On 06/14/2024 at 9:02 AM, the U.S. FOIA (b) (6)) was in the hallway by the resident's room. The surveyor asked the U.S. FOIA to come to the resident's room. The U.S. FOIA acknowledged the resident was not NJ Ex Order 26.4 his/her NJ Ex and stated he/she should be NJ Ex Order 26.4 "so the resident NJ Ex Order 26.4(b)(1)." The U.S. FOIA also acknowledged that the NJ Ex Order 26.4(b)(1) on both the room NJ Ex Order 26.4(b)(1) and the recliner chair NJ Ex Order 26.4(b)(1) were both uncovered and exposed to the environment. The U.S. FOIA asked the U.S. FOIA (b) (6) to come to the room. The U.S. FOIA (b) (6) acknowledged the resident was not being administered his/her NJ Ex Order 26.4(b)(1) as ordered and assessed Resident #42's NJ Ex Order 26.4 . The U.S. FOIA obtained new NJ Ex Order 26.4(b)(1) and NJ Ex Orde to administer the physician ordered NJ Ex Order 26.4(b)(1) to the resident.	F 695	4. All audits will be reviewed by Administrator, DON and/or designee to ensure timely compliance weekly, twice a month and monthly thereafter per the audit timeframes listed in action #3 beginning on 6/14/24. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback. The Administrator and DON will be responsible for implementing this plan of correction.	

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	315061	A. BUILDING _____ B. WING _____	C 06/19/2024

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SOUTH JERSEY EXTENDED CARE	99 MANHEIM AVENUE BRIDGETON, NJ 08302

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F 695	Continued From page 40 A review of the facility provided, "Oxygen Administration" policy revised 10/2010, included but was not limited to; Purpose: ... to provide guidelines for safe oxygen administration. Preparation: ... verify that there is a physician's order. Steps in the Procedure: ... 9. Place the appropriate oxygen device (i.e. nasal cannula) on the resident. 10. Adjust the oxygen delivery device ... proper flow of oxygen is being administered. 13. Observe the resident ... and periodically to be sure oxygen is being tolerated. On 06/19/2024 at 11:13 AM, the above concern was addressed with the U.S. FOIA (b) (6) [redacted] the U.S. FOIA (b) and a Corporate nurse who was the facility interim U.S. FOIA (b) (6) [redacted]. The facility stated the NJ Ex Order 26.4 [redacted] policy provided was the only one the facility had and also provided in-servicing and education that was started with the staff regarding the use of NJ Ex Order 26.4 [redacted] NJAC 8:39-11.2(b); 27.1(a)	F 695		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve	F 727		7/19/24

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F 727	Continued From page 41 as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and review of Nursing Staffing Report sheets, Payroll Based Journal (PBJ) Reports and facility provided documents, it was determined that the facility failed to ensure the U.S. FOIA (b) (6) served as a US FOIA (b)(6) only when the facility has an average daily occupancy of 60 or fewer residents for 7 of 16 days reviewed The deficient practice was evidenced by the following: A review of the Nurse Staffing Reports completed by the facility for 05/07/2023 through 05/13/2023 revealed the facility had one RN for the day shift on 05/12/2023. On 05/12/2023, the census was 100 residents. A review of the Nurse Staffing Reports completed by the facility for 05/26/2024 through 06/01/2024 revealed the facility had one RN for the day shift on 05/26/2024 and 05/27/2024. On 05/26/2024, the census was 92 residents. On 05/27/2024, the census was was 91 residents. A review of the Nurse Staffing Reports completed by the facility for 06/02/2024 through 06/08/2024, revealed the facility had one RN for the day shift on 06/08/2024. On 06/08/2024. the census was 90 residents. On 06/17/2024 at 1:24 PM, during an interview with the surveyor, the U.S. FOIA (b) (6) told the surveyor that the U.S. FOIA (b) (6) worked the specified days above as the	F 727	1. The facility failed to have scheduled a Registered Nurse for at least 7 out of 16 days. (1/27, 1/28, 2/24, 2/25, 3/10, 3/23 and 3/24/24.) No residents were negatively affected by this deficient practice. 2. An audit of the RN staffing coverage was reviewed for the rest of the schedule with the staffing coordinator to ensure there was at least 8 consecutive hours a day for 7 days a week of RN staff. 3. On 6/20/24 the Administrator and DON met with the staffing coordinator to determine the root cause of the facilities failure to have RN coverage 8 hours a day 7 days a week. It was determined that the staffing coordinator was not aware that the DON cannot act as the Registered Nurse for the facility when the census is over 60 residents. The staffing coordinator was given a copy and educated on the facility Nursing Services/RN policy. It was determined that the DON, staffing coordinator and Administrator will audit the daily schedule to ensure RN coverage for at least 8 hours daily. These audits will be daily for a month, then bi monthly and quarterly thereafter. 4. All audits will be reviewed by Administrator, DON and/or designee to ensure timely compliance daily, twice a month and quarterly thereafter per the	

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F 727	Continued From page 42 Registered Nurse. At that time, the surveyor requested time sheets that show when the [redacted] arrived to the facility. At that time, the [redacted] stated that the [redacted] is a salaried employee and does not record the time of arrival to the facility. On the same date at 2:05 PM, the surveyor received an email from the [redacted] titled, "RN Coverage Schedule." The email contained an attached document with the heading, "The following RN rotation coverage for May 2024-June 2024 is completed by Salaried RN's". The email showed the that the dates mentioned above were covered by the [redacted] On 06/18/2024 at 9:59, AM during an interview with the [redacted] the surveyor asked, How were you acting as the RN when you are [redacted] and had census over sixty residents. The [redacted] replied, "we had a weekend supervisor and she quit. We had to implement something for the time being." A review of the Payroll Based Journal (PBJ) Report for fiscal year quarter 2, 2024 (January - March) revealed that the facility triggered for no RN (Registered Nurse) hours. The infraction dates, as reported by the facility were: 01/27/2024 01/28/2024 02/24/2024 02/25/2024 03/10/2024 03/23/2024 03/23/2024 Upon request of the census and employees who	F 727	audit timeframes listed in action #3 beginning on 6/20/24. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback. The Administrator and DON will be responsible for implementing this plan of correction.	

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F 727	Continued From page 43 worked those days, it was determined that the facility's previous U.S. FOIA (b) (6), as identified by the U.S. FOIA (b) (6)), worked as the only RN on the following days: 02/24/2024 02/25/2024 03/10/2024 The resident census was provided to the surveyor through email from the U.S. FOIA (b) (The resident census on 02/24/2024 was 96. The resident census on 02/25/2024 was 95, and the resident census on 03/10/2024 was 92. On 06/19/2024 at 11:13 AM during an interview with the surveyor, The U.S. FOIA (b) replied, "I'm not quite sure. I'd have to look back at that." when the surveyor asked what was the reason the U.S. FOIA (worked as the facility's only Registered Nurse on days when the daily census was over 60. On 06/19/2024 at 1:39 PM during an interview with the surveyor, the U.S. FOIA (told the surveyor she became the U.S. FOIA (in April, 2024. A review of the facility-provided policy titled, "Nursing Services-Registered Nurse (RN)" with an implemented date of 11/14/23 revealed but was not limited to, "1. The facility will utilize the services of a Registered Nurse for at least 8 consecutive hours per day, 7 days per week." NJAC 8:39-25.2(h)	F 727		
F 730 SS=F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review	F 730		7/19/24

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F 730	Continued From page 44 of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documents, it was determined that the facility failed to provide Certified Nurse Aides (CNA) regular in-service education based on the outcome of employee job performance appraisals. The deficient practice was identified for 3 of 10 CNAs reviewed. The deficient practice was evidenced by the following: A review of the facility provided documents titled, "Employee Job Performance Appraisals" revealed eleven measurable attributes such as but not limited to, Job Expectations, Adaptability, Leadership, and Dependability. Each attribute also has a comments section and a goal section. Each attribute can be scored with a numeral revealing the following: 0 - Fails to Meet Expectations 1 - Needs Immediate Improvement 2 - Meets Expectations 3 - Above Average 4 - Excellent A review of CNA # 1's Employee Job Performance Appraisal revealed a score of 1 under Adaptability. Number 1 indicated, "Needs Immediate Improvement." The comments and goal section were left blank. On the reverse side of the document under Leadership, the score was 1. The comments and goal section was left blank.	F 730	1. The facility failed to provide CNA regular in-service education based on the outcome of employee job performance appraisals. No resident was negatively affected by this deficient practice. 2. The facility implemented a policy for conducting yearly performance evaluations and the education needed based off of scores received on the evaluation. On 6/19/24 the [redacted] was educated on nursing staff evaluations for proper scoring and re-education of staff where needed. On 6/19/24 an audit of the CNA job performance evaluations was completed by the DON and any aide scoring a 1 or below in any area was educated on that category by the DON. The goal as communicated to the CNA was to improve scoring above a 2 which “Meets Expectations.” 3. The DON and/or assigned designee will complete audits starting on 6/19/24 on job performance appraisals bi weekly, monthly then quarterly thereafter to ensure education was provided to any CNA who scored a 1 or below on the appraisal. The facility put in to place a procedure that after the Performance evaluations are completed by the DON, the Staffing Coordinator will review for	

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F 730	Continued From page 45 Further, under Dependability, the score was 1 and a hand written note revealed that CNA # 1, "Requires to improve attendance call outs." The document was signed by the employee on NJ Ex Order 26.4b1. A review of CNA # 2's Employee Job Performance Appraisal document revealed a score of 1 under Leadership. A handwritten note revealed, "Area requires improvement." The document was signed by the employee but no date was indicated. A review of CNA # 3's Employee Job Performance Appraisal document revealed a score of 1 under Adaptability. A handwritten note revealed, "Improve Attendance." The document was signed by the employee on NJ Ex Order 26.4b1 On 06/18/2024 at 9:59 AM, during an interview with the U.S. FOIA (b) (6)), the surveyor asked how an area that needs immediate improvement can be left blank. The U.S. FOIA stated, "not that it's supposed to happen but we go case by case." The U.S. FOIA then stated, "No" when the surveyor asked if she was ever trained on completing employee appraisals. The U.S. FOIA said that at the time of the appraisal, the employee signed the document and the concerns were verbally discussed with them. Lastly, the U.S. FOIA confirmed the document was blank stating, "I provided what I had". On 06/19/2024 at 9:21 AM, the U.S. FOIA informed the surveyor that the facility does not have a policy on Employee Job Performance Appraisal and that it was at U.S. FOIA discretion. On 06/19/2024 at 11:13 AM, during an interview	F 730	education if applicable before filing evaluation in employee HR file. The DON will report all findings to the QA team during quarterly meetings. 4. All audits will be reviewed by Administrator, DON and/or designee to ensure timely compliance bi weekly, monthly and quarterly thereafter per the audit timeframes listed in action #3 beginning on 6/19/24. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback. The Administrator and DON will be responsible for implementing this plan of correction.	

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F 730	Continued From page 46 with the surveyor, the U.S. FOIA (b) (6)) interim infection preventionist replied, "No", when the surveyor asked if the comments and goal section should be left blank. The U.S. FOIA (b) replied "I'd have to look at specific case." when the surveyor asked if employees who scored a one or zero receive education based on the outcome of the review. The surveyor asked how should the in-service be documented. The U.S. FOIA (b) replied, "We do education with them and they would have to sign the education." The surveyor then asked if someone scored poorly, what would be the procedure from that point. The U.S. FOIA (b) replied, "They would receive an education and they would have to sign it." On the same date at 1:39 PM, the U.S. FOIA (b) confirmed the facility did not have a policy on Performance Evaluations. A review of the Facility Assessment titled, revealed under section, "J." but not limited to, "Training/education and competencies/skill checks are generally provided upon hire, during monthly in-servicing/training, annual in-servicing/training, whenever an area of concern is identified, new areas or new situations/developments evolved are identified based on resident diagnoses and/or clinical condition." The document further revealed, "Address areas of weakness as determined in nurse aides' performance reviews and facility assessment and may address the special needs of residents as determined by the facility staff." A review of the facility-provided document titled, "Director of Nursing-Job Description" revealed under, "Major Duties and Responsibilities" that	F 730		

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F 730	Continued From page 47 the DON, "Interprets and communicates policies and procedures to nursing staff, and monitors staff practices and implementation." The document also revealed that the DON, "Evaluates work performance of all nursing personnel and implements discipline according to operational policies." Lastly, the documented revealed, "Individual performance will be evaluated using the following scale: 1. Unsatisfactory: Achieves results which are far less than the standards identified for performance factors rated. 2. Needs Improvement: Achieves results which are less than the standards identified for the performance factors rates. Exhibits the potential to become a competent performer. May be new to job or need skill development." N.J.A.C. 8:39-43.17	F 730		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		7/19/24

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F 812	Continued From page 48 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and other facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe consistent manner. This deficient practice was evidenced by: On 06/13/24 between 09:24 AM until 10:01 AM, the surveyor observed the following in the kitchen in the presence of the U.S. FOIA (b) (6)): 1. On 06/13/24 at 9:25 AM, the surveyor observed a U.S. FOIA (b) (6) preparing food during the initial tour of the kitchen and was noted not wearing a beard guard. The U.S. FO stated that all staff have been trained according to the policy and procedure of the kitchen to wear proper attire while working in the kitchen. He confirmed that all staff must wear a hairnet and beard guard to prevent food contamination. The U.S. FO left the workstation and walked towards the entrance to put on his beard guard. 2. On 06/13/24 at 9:27 AM, the surveyor observed an opened package of hot dog buns containing 3 buns left in the package that was not dated with an opened date and use by date. The U.S. FO stated that items need to be dated when they are opened and dated with a use by date according to the facility policy. 3. On 06/13/24 at 9:35 AM, the surveyor observed 6 lbs (pound) can of diced potatoes in the dry storage area with a 2 inch dent located on the seam of the can. The U.S. FO confirmed that the canned diced potatoes should not be used and	F 812	1. The deficiency occurred when the facility failed to handle potentially hazardous foods and maintain sanitation in a safe consistent manner. This deficient practice has the potential to affect all residents in the facility. 2. On 6/13/24 the Food Service Director re-educated dietary staff on wearing hair and beard nets at all times while in the kitchen area. She also re-educated dietary staff on proper labeling, dating and storage of food items. All new hire dietary employees will receive this education during their orientation period. On 6/13/24 all undated and unlabeled food items were discarded by the Food Service Director. 3. On 6/13/24 the Food Service Director inspected all food areas in the kitchen to ensure proper labeling and dating. She also performed an audit of all shifts to ensure proper use of hair and beard nets by all dietary staff. The Food Service Director and Administrator implemented a check list sheet to ensure labels and dates on all appropriate food items daily. The Food Service Director will continue to audit these areas daily for 2 weeks, weekly times 4 weeks and monthly thereafter. The Food Service Director or Administrator will report all findings to the QA team during quarterly meetings. 4. All audits will be reviewed by	

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F 812	Continued From page 49 was removed. 4. On 06/13/24 at 9:40 AM, the surveyor observed dried spiced goods in the food preparation line that did not contain a date when the spices were opened, nor did it contain a use by date. These items consisted of grated cheese, adobo seasoning, paprika, black pepper, onion power and cinnamon. 5. On 06/13/24 at 9:43 AM, the surveyor observed 10 prepared salami sandwiches in the walk-in refrigerator. Only 1 out of 10 salami sandwiches had the prepared date labeled, and 10 out of 10 did not have a use by date. The [redacted] stated once the sandwiches were prepared, they were good for 3 days. The [redacted] confirmed that all food items should have a date of preparation and use by date labeled. 6. On 06/13/24 at 9:46 AM, the surveyor observed 15 dessert cups of diced pineapple on a tray in the walk-in refrigerator. Only 1 out of 15 pineapple cups had a prepared date labeled, and 15 out of 15 did not have a use by date. 7. On 06/13/24 at 9:48 AM, the surveyor observed 3 pitchers that contained dark liquid in the walk-in refrigerator, that the [redacted] verified was iced tea. The 3 pitchers of iced tea were not labeled with a preparation date and use by date. 8. On 06/13/24 at 9:50 AM, the surveyor observed a plate of leftover cheese ravioli with tomato sauce covered with a clear food service film in the walk-in refrigerator. The cheese ravioli was not labeled with a preparation date and use by date.	F 812	Administrator and/or designee to ensure compliance monthly then Quarterly thereafter per the audit timeframes listed in action #3 beginning on 6/13/24. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback. The Administrator and Food Service Director will be responsible for implementing this plan of correction.	

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SOUTH JERSEY EXTENDED CARE	99 MANHEIM AVENUE BRIDGETON, NJ 08302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 50 9. On 06/13/24 at 9:57 AM, the surveyor observed left over sauteed spinach in a stainless-steel pan covered with a clear food service film in the walk-in refrigerator. The sauteed spinach was not labeled with a preparation date and use by date. The surveyor reviewed the facility provided policy titled "Food Safety and Sanitation." The policy revealed the following: 2. Employees All staff will be in good health, will have clean personal habits and will use safe food handling practices. Hair restraints are required and should cover all hair on the head. Beard nets are required when facial hair is visible. 3. Food Purchasing Bulging or leaking cans, cans with severe dents on the seams, or broken containers of food will not be used. 4. Food Storage All time and temperature control for safety foods (including leftovers) should be labeled, covered, and dated when stored. When a food package is opened, the food item should be marked to indicate the open date. This is used to determine when to discard the food. Leftovers are used within 72 hours (or discarded) NJAC 8:39-17.2 (g)	F 812		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration.	F 835		7/19/24

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F 835	Continued From page 51 A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review it was determined that the U.S. FOIA (b) (6) failed to ensure that facility policies and procedures were developed and consistently implemented. This failure to ensure a system was in place for residents who NJ Ex Order 26.4 independently and held their own NJ Ex Order 26.4(material and NJ Ex Order 26 had the potential to effect all residents on 3 of 3 resident units and was evidenced by the following: On 06/13/24 at 2:03 PM, three surveyors observed a person walking behind the building on a path by the woods. The surveyors approached the person, who was by him/herself, to interview them, while the person was headed toward the road and then turned toward the parking lot. The person identified him/herself as Resident #25 and stated that he/she lived at the facility. The surveyors accompanied Resident #25 for the duration of the walk throughout the parking lot and into the main entrance and then asked the U.S. FOIA (b) (6) about the resident walking around the building. The U.S. FOIA (b) (6) stated, Resident #25 "signed the paper that if anything happened to him/her that we are not responsible" and handed the surveyor a "List of residents signed release of responsibility papers" that contained nine names. On 06/14/24 at 10:00 AM, the surveyor interviewed the U.S. FOIA (b) (6))	F 835	1. The facility LNHA failed to ensure that facility policies and procedures were developed and implemented. All residents have the potential to be affected by this deficient practice. 2. The Facility Administration will provide increased oversight on the facility smoking policy and procedure. On 6/20/24 the IDT members which included the Administrator met to discuss the smoking policy, the policy was updated to address independent residents who leave the facility with their own lighting materials and how those residents would return these lighting materials upon re-entry into the facility. On 6/20/24 all staff were educated by the LNHA on the facility smoking policy as it pertains to residents who sign themselves out of the facility and the procedure for when they re-enter the building. All staff were also educated on alerting the LNHA for any concerns or observations made for immediate corrective action. 3. The Administrator will monitor the residents who smoke and their ability to follow the smoking procedure for compliance. The Administrator will also review the smoking policy and procedure to ensure compliance with staff and	

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F 835	Continued From page 52 regarding the list of residents that signed the paper and asked about the paper related to Resident #25. The U.S. FOIA stated residents can walk around the building, and "yes" it is a paper, "we created a paper". The U.S. FOIA stated that she and the old U.S. FOIA (b) (6) "made up the paper". The U.S. FOIA was the U.S. FOIA (b) (6) at that time. The surveyor requested the "paper". The U.S. FOIA provided a copy of the "paper" which revealed: I, [Signed by Resident #25] am NJ Ex Ord and capable of NJ Ex Order 26.4(b)(1). It is my wish to be allowed to come and go in and out of this facility freely and at my own will and risk. I understand hat this is NJ Ex Order 26.4(b)(1) and policy of [facility name redacted] and it's staff and doctors. By signing this document I hereby release [facility name redacted] and all its employees, mangers and management companies of any responsibilities of injuries I might sustain while out of the building. This shall include leaving the building and moving about in the parking lot or the entire area outside of the building. Signed by Resident #25, dated NJ Ex Order 26.4(b. The document also revealed: "We hereby attest to the fact that [Resident #25] is NJ Ex Ord and NJ Ex Order 26.4(and capable of NJ Ex Order 26.4(b)(1) . Signed by the current U.S. FOIA (b and NJ Ex Order 26.4(b) and [Doctor], NJ Ex Order 26.4(b)(1 On 06/14/24 at 11:50 AM, five surveyors were in the conference room and observed Resident #25 walk past the back of the building by the Sub Acute area bordering the woods, was on a path and was also observed NJ Ex Order 26.4(b)(1). At that time, the surveyor reviewed the electronic Medical Record (EMR) for Resident #25 which revealed the following:	F 835	residents. The Administrator will audit the residents who sign out of the facility to see if they are adhering to the smoking policy and procedure starting on 6/20/24. The LNHA will also audit the staff knowledge and adherence to the smoking policy and procedure starting on 6/20/24. The LNHA will complete audits daily for 2 weeks, bi-monthly for 3 months and quarterly thereafter for 2 quarters. 4. All audits will be reviewed by Administrator, DON and/or designee to ensure timely compliance daily, bi-monthly and quarterly thereafter per the audit timeframes listed in action #3 beginning on 6/20/24. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback. The Administrator and DON will be responsible for implementing this plan of correction.	

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F 835	Continued From page 53 The Admission Record revealed diagnoses including NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)),NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) . A Quarterly Mimimum Data Set dated NJ Ex Order 26.4(b revealed the resident scored a NJ Ex /15 on the Brief Interview for Mental Status which indicated the resident was NJ Ex Order 26.4(b)(1). Section GG, section K revealed the resident required NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b in a NJ Ex Order 26.4 or similar space. Section J1300 NJ Ex Order 26.4(b)(1) was left blank, neither yes or know was checked. The Current nine page Care Plan included the following Focus areas: NJ Ex Order 26.4(b)(1) NJ Ex Orde NJ Ex Order 26.4(b)(1), NJ Ex Orde NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(NJ Ex Orde Nursing NJ Ex Order 26.4(b)(1) with daily NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(and NJ Ex Orr and NJ Ex Order 26.4(b)(The Focus for NJ Ex Order 26.4(b revealed: Resident is a NJ Ex Order 26.4 and is at risk for injury. Resident is an NJ Ex Order 26.4(b)(1) and does not require NJ Ex Order 26.4(b)(1) to NJ Ex Order 26. Date Initiated: NJ Ex Order 26.4(b)(1) Revision on: NJ Ex Order 26.4(b)(1) Goal: -Resident will abide by facility's NJ Ex Order 26.4(b policy and remain safe during NJ Ex Order 26.4(b times through the next review. Date Initiated: NJ Ex Order 26.4(b)(1) Revision on: NJ Ex Order 26.4(b)(1) Target Date: NJ Ex Order 26.4(b)(1)	F 835		

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F 835	Continued From page 54	F 835		

- Resident will [redacted] in designated areas without occurrence of injury through the next review.
Date Initiated: [redacted]
Revision on: [redacted]
Target Date: [redacted]
Interventions
- Perform [redacted] assessment according to facility policy.
Date Initiated: [redacted]
- Educate resident on [redacted] policy.
Date Initiated: [redacted]
- [redacted]: Resident is an [redacted] and does not require the use of a [redacted] or direct staff supervision during [redacted].
Date Initiated: [redacted]. The Care Plan did not indicate the resident was able to hold own [redacted] and [redacted] and walk around the building [redacted]

The Falls Care Plan Date Initiated: [redacted] The resident will be free from [redacted] and subsequent injuries through the review date.
Date Initiated: [redacted]
Revision on: [redacted]
Target Date: [redacted]
Resident's call light is within reach
Date Initiated: [redacted]

There was no Care Plan related to the document that the resident signed, the ability to hold a [redacted] and [redacted] and [redacted] at will around the building perimeter.

Resident #25's most recent [redacted] assessment, dated [redacted] revealed #3 Is resident physically capable of holding [redacted] and [redacted] and [redacted]

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F 835	Continued From page 55	F 835		

own [NJ Ex Order 26.4(b)] without assistance; "[NJ Ex Order 26.4] Has resident been instructed in facility policy regarding safety of himself/herself or others; "yes"; 10. Has resident signed the "[Facility Name]" [NJ Ex Order 26.4(b)] agreement and [NJ Ex Order 26.4] release of responsibility form, "yes".

On 06/14/24 at 11:58 AM, a surveyor observed Resident #25 entering the building from the main entrance. The surveyor inquired as to what the resident did outside and the Resident stated was outside walking the perimeter of the building and was [NJ Ex Order 26.4(b)]. Resident #25 stated he/she NJ Ex Order 26.4(b)(1) a day and stated kept a personal [NJ Ex Order 2] to [NJ Ex Or] his/her own [NJ Ex Order 26.4(b)(1)]

On 06/18/24 at 11:33 PM, the surveyor interviewed the U.S. FOIA (b) (6) in the presence of the survey team regarding what was his responsibilities. The [U.S. FOIA (b)] stated he was responsible for the oversight and care of all residents and all regulations in accordance with state and federal law since he had been hired on [NJ Ex Order 26.4]. The surveyor asked if he ensured policies were followed and he stated, "yes", and the surveyor asked if that included the [NJ Ex Order 26.4(b)] policy and he stated "yes". The surveyor asked how he would ensure that, the [U.S. FOIA (b)] stated through meeting, daily rounds, and walked through all three units, including the kitchen, maintenance shop and laundry. The surveyor asked the [U.S. FOIA (b)] if the [NJ Ex Order 26.4(b)] policy would allow residents held their own [NJ Ex Order 26.] to [NJ Ex Or] there own [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA (b)] stated,"we don't allow them to have [NJ Ex Order 26.4(b)]. The surveyor asked why not, and the [U.S. FOIA (b)] responded, for"safety". The surveyor asked if a resident chose to not follow

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F 835	Continued From page 56	F 835		

the policy what would happen, and the U.S. FOIA (b) stated, "we educate them". The U.S. FOIA (b) stated they are supposed to be NJ Ex Order 26.4(b) in the NJ Ex Order 26.4(b) area. The surveyor asked if residents were allowed to keep there own NJ Ex Order 26.4(b) and walk around the building NJ Ex Order 26.4(b)(1) The U.S. FOIA (b) then stated there were a handful of residents that were able to do that and "they signed a waiver". The U.S. FOIA (b) stated they sign themselves to go out on the property and they are more independent of ADLs [activities of daily living]. The U.S. FOIA (b) then stated "some NJ Ex Order 26.4(b)(1) there own NJ Ex Order 26.4(b)(1) outside" and they know they need to NJ Ex Order 26.4(b)(1) from the building. The surveyor asked how he would know that and he stated, "it's a building policy". The surveyor showed the U.S. FOIA (b) the document signed by Resident #25 and asked where the document came from and was it a legal document. The U.S. FOIA (b) stated he was not sure who made it up, and "I did not say it was legal". The surveyor asked what the policy was for use of the document and the U.S. FOIA (b) stated, "I would have to check." The surveyor asked if the resident could hold onto their own NJ Ex Order 26.4(b) and keep them with them. The U.S. FOIA (b) stated, "my original answer was for those residents that were in the designated NJ Ex Order 26.4(b) area" and he was not sure if there was a policy and stated independent residents had their own NJ Ex Order 26.4(b) The surveyor showed the U.S. FOIA (b) the document again and also showed him the list of residents that signed responsibility papers and asked what the documents were for since the documents did not have [redacted] listed. The U.S. FOIA (b) stated it was a "release of responsibility of their own risk" and the residents can be independent outside of the building and facility would not be responsible. The surveyor asked about a policy for residents who hold their own NJ Ex Order 26.4(b) inside the facility, come

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F 835	Continued From page 57	F 835		

and go as they wish to [NJ Ex Order 26] around the facility. The [U.S. FOIA (b)] stated "he doesn't know, I have to check" and not sure if there was a policy and would go check.

On 06/18/24 at 11:55 PM, the [U.S. FOIA (b)] returned and stated, there "was no specific policy for residents who [NJ Ex Order 26.4] outside" and there was no policy for the use of the waiver. The [U.S. FOIA (b)] stated the [NJ Ex Order 26.4(b)] [NJ Ex Order 26.4] policy only was for the residents that [NJ Ex Order 26.4] in the designated areas. The surveyor asked how do you protect other residents from gaining access to the [NJ Ex Order 26] and asked how many residents hold their own [NJ Ex Order 26.4] and the [U.S. FOIA (b)] [U.S. FOIA (b)] did not respond. The surveyor informed the [U.S. FOIA (b)] about the observations of Resident #25 smoking around the facility. The [U.S. FOIA (b)] confirmed he was aware. The surveyor asked if there was a policy to prevent other residents from gaining access to the [redacted] and the [U.S. FOIA (b)] stated, "I do not have an answer for that."

On 06/18/24 at 12:26 PM, the surveyor interviewed the facility [U.S. FOIA (b) (6)]) regarding the document Resident #25 signed. The [U.S. FO] stated the paper was for the residents who leave independently and so the resident can go to the store. The [U.S. FO] stated it was for the resident were pending Medicaid, but they they met criteria for residency in a long term care facility. The [U.S. FO] stated the paper allowed for people to go through the front door without somebody having to sign them out.

A review of the [U.S. FOIA (b) (6)] signed job description, dated 12/23/23 revealed Position Purpose: Leads, guides and directs the operations of the healthcare facility in accordance with local, state and federal regulations,

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F 835	Continued From page 58 standards and established facility policies and procedures to provide appropriate care and services to the residents. Major Duties and Responsibilities; Plans, develops, organizes, implements, evaluates and directs the overall operation of the facility as well as its programs and activities, in accordance with current state and federal laws and regulations. NJAC 8:39-9.2(a)	F 835		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing	F 851		7/19/24

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F 851	Continued From page 59 information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents it was determined that the facility failed to submit accurate "No RN [Registered Nurse] Hours" Payroll Based Journal (PBJ) Report to the Centers of Medicare and	F 851	1. The facility failed to submit accurate RN hours for 4 of 7 days. (1/27, 1/28, 3/23 and 3/24/24.) to the Payroll Based Journal Report for Fiscal Year Quarter 2 (Jan 1-Mar 31, 2024.) All residents have the	

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F 851	Continued From page 60 Medicaid Services (CMS). The deficient practice was identified for 4 of 7 infraction dates on the PBJ Report for Fiscal Year Quarter 2 January 1 - March 31. A review of the PBJ Report for Fiscal Year Quarter 2 2024 January 1 - March 31 revealed the following days as ,"Infraction Date" under the "No RN Hours" Metric: 01/27 01/28 02/24 02/25 03/10 03/23 03/24 A review of the facility provided document titled, "The Following RN rotation coverage" revealed that on 01/27/2024 and 01/28/2024, the facility's current U.S. FOIA (b) (6) worked as an RN. At that time, the U.S. FOIA was not promoted to the U.S. FOIA role. A review of the same document revealed that on 03/23/2024 and 03/24/2024 the U.S. FOIA (b) (6) worked as the RN. On 06/19/2024 at 1:57 PM during an interview with the surveyor, the current U.S. FOIA revealed she became the U.S. FOIA sometime in NJ Ex Ord of NJ Ex Order A review of the facility policy titled, "Nursing Services-Registered Nurse (RN)" implemented on 11/14/23, revealed under "Policy Explanation and Compliance Guidelines" that, "3. The facility is responsible for submitting timely and accurate staffing data through the CMS Payroll-Based Journal (PBJ) system."	F 851	potential to be affected by this deficient practice. 2. An audit of the electronic PBJ reporting was conducted by the Administrator and the HR Director/staffing coordinator and found no further errors for reporting of RN staff. 3. On 6/20/24 the Administrator and DON met with the HR Director/staffing coordinator to determine the root cause of the facilities failure to accurately report RN staffing to the Payroll Based Journal. It was determined that the HR Director/staffing coordinator was not aware that salaried Registered nurses had to be manually added to the report as they do not punch in on the time clock. The US FOIA (b)(6) was given a copy and educated on the facility Nursing Services/RN policy, how to manually input salaried employees and importance of accurate reporting. The Administrator and/or DON will receive an emailed report from the facility payroll company daily to review for accuracy against the PBJ report. The HR Director/staffing coordinator and Administrator will audit the daily payroll system to ensure RN coverage is being reported accurately. These audits will be weekly for 4 weeks, then bi monthly and quarterly thereafter for 2 quarters. 4. All audits will be reviewed by Administrator and/or designee, weekly for 4 weeks, twice a month and quarterly thereafter per the audit timeframes listed	

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	315061	A. BUILDING _____ B. WING _____	C 06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	99 MANHEIM AVENUE BRIDGETON, NJ 08302

(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 851	Continued From page 61 NJAC 8:39-41.1	F 851	in action #3 beginning on 6/20/24 to ensure PBJ requirements are met according to CMS regulations . These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback. The Administrator and HR Director will be responsible for implementing this plan of correction.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		7/19/24

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F 880	Continued From page 62 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 880	1. Resident #42 was NJ Ex Order 26.4(b)(1)	

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F 880	Continued From page 63 and review of pertinent documentation, it was determined that the facility failed to a.) appropriately don (put on) Personal Protective Equipment (PPE), and b.) store [redacted] to prevent contamination and exposure to the environment. This deficient practice was evidenced by the following: On 06/13/2024 at 9:44 AM, the surveyor observed a staff member assisting Resident #42 via a recliner chair, into the common area of the facility. The surveyor observed Resident #42 was wearing a NJ Ex Order 26.4(b)(1) attached to a NJ Ex Order 26.4([redacted] and the NJ Ex Order 26.4 was set at NJ Ex Order 26.4(b)(1) [redacted]. On 06/14/2024 at 8:43 AM, the surveyor observed Resident #42's NJ Ex Order 26.4(b)(1) was on the back of the recliner chair in the hallway. The surveyor observed that there was NJ Ex Order 2 with the NJ Ex Order 26.4(b)(1) wrapped around NJ Ex Order 26.4(. The NJ Ex Order 26.4(b)(1) was not in a NJ Ex Order 26.4(b)(1) and was exposed to the environment. On 06/14/2024 at 8:59 AM, the surveyor returned and observed Resident #42 in bed with his/her eyes closed and the NJ Ex Order 26.4(b)(1) with the NJ Ex Order [redacted] was not in a NJ Ex Order 26.4(b)(1) and was in direct contact with the NJ Ex Order 26.4(b)(1) that was under the resident. On 06/14/2024 at 9:02 AM, the U.S. FOIA (b) (6) [redacted]) was in the hall by the resident's room. The surveyor asked the U.S. FOIA to come to the resident's room. The U.S. FOIA acknowledged the resident was not wearing his/her NJ Ex [redacted] and stated he/she should be wearing the NJ Ex [redacted] "so the resident	F 880	NJ Ex Order 26.4(b) by this deficient practice. All residents who require Enhanced Barrier Precautions have the potential to be affected by this deficient practice. Resident #42□s NJ Ex Order 26.4b1 was replaced, NJ Ex Order 2 was dated 6/14/24 and placed in a clear plastic bag for both the NJ Ex Order 26.4b1 [redacted] in the room. Resident #42 NJ Ex Order 26.4b1 was placed back on properly after NJ Ex Order 26 [redacted] and the residents NJ Ex Order 26.4b1 was taken by the LPN UM which she recorded a reading o NJ Ex Order 2 Education was provided by the Infection Preventionist to the US FOIA (b)(6) on 6/14/24 regarding proper donning and doffing of PPE for residents who have physician orders for Enhanced Barrier Precautions. 2. A complete audit for all active residents who have a Physicians order for oxygen was done on 6/14/24 by the DON to ensure oxygen tubing was dated and placed in clear plastic bags. A complete audit for all active residents who have a Physician order for Enhanced Barrier Precautions was done by Infection Preventionist to ensure all staff were following facility policy regarding donning and doffing PPE correctly for these residents. 3. On 6/14/24 the DON re-educated all nursing staff on infection control as related to proper storage of Oxygen tubing, dating tubing and placing tubing in bags when not in use. On 6/14/24 the Infection Preventionist also re-educated	

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F 880	Continued From page 64 can [NJ Ex Order 26.4(b)] The [U.S. FOIA] also acknowledged that the [NJ Ex Order 26.4(b)(1)] on both the [NJ Ex Order 26.4(b)(1)] and recliner chair portable [NJ Ex Order 26.4(b)(1)] were both uncovered and exposed to the environment. At that time, the [U.S. FOIA] asked the [U.S. FOIA (b) (6)] to come to the room. The [U.S. FOIA (b) (6)] acknowledged the resident was not being administered his/her [NJ Ex Order 26.4(b)(1)] as ordered. The [U.S. FOIA (b) (6)] donned a PPE gown but failed to secure the tie around her waist. The [U.S. FOIA (b) (6)] donned gloves and entered Resident #42's room to apply a [NJ Ex Order 26.4] to his/her [NJ Ex Orde] and check the resident's [NJ Ex Order 26.4(b)(1)], and to apply a blood pressure cuff to the resident's arm to obtain a blood pressure reading. The [U.S. FOIA (b) (6)] also connected new [NJ Ex Order 26.4(b)(1)] to the [NJ Ex Order 26.4(b)(1)] and applied a new [NJ Ex Order 26.4(b)(1)] to the residents [NJ Ex Order 26.4] During that time, the PPE gown ties were dragging on the floor and when the [U.S. FOIA (b) (6)] leaned over the resident, the PPE gown was falling down. On 06/14/24 at 9:15 AM, two Certified Nursing Assistants (CNA) arrived at the resident's room to [NJ Ex Order] him/her via a [NJ Ex Order 26.4(b)(1)] into the recliner chair. CNA #1 donned the PPE gown but failed to secure the ties around her [NJ Ex Order] CNA #1 assisted with securing the resident to be [NJ Ex Ord] and moved and made the resident's bed. While [NJ Ex Order 26.4(b] the resident and making the bed, the PPE gown was [NJ Ex Order 26.4(b)(1)] and dragging on the floor. A review of Resident #42's hybrid (both paper and electronic) medical records revealed an Admission Record with diagnoses which included but were not limited to; [NJ Ex Order 26.4(b)(1)], [NJ Ex Order 26.4(b)(1)], [NJ Ex Order 26.4(b)] [NJ Ex Order 26.4(b)(1)]	F 880	all nursing staff on the facility policy on Enhanced Barrier Precautions and Donning and Doffing PPE. The facility will place signage for sequencing PPE donning and doffing procedures on top of PPE bins as visual reminders of proper donning and doffing. Audits will continue by the DON, Infection Preventionist and/or assigned designee on all residents who have Physician orders for Enhanced Barrier Precautions starting on 6/14/24. These audits will be weekly for 4 weeks, then twice a month for 2 months then monthly for 2 months. 4. All audits will be reviewed by Administrator, DON and/or designee to ensure timely compliance weekly, twice a month and monthly thereafter per the audit timeframes listed in action #3 beginning on 6/14/24. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback. The Administrator and DON will be responsible for implementing this plan of correction.	

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NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). A review of the most recent Quarterly Minimum Data Set (MDS) an assessment tool used to prioritize care, dated NJ Ex Order 26.4(b)(1), included but was not limited to; Section B the resident was coded a 'NJ Ex Order 26.4(b)(1) when considering ability NJ Ex Order 26.4(b)(1); Section C the Brief Interview for Mental Status (BIMS) was coded 'NJ E for no the interview should not be conducted as the resident was NJ Ex Order 26.4(b)(1); Section GG indicated the resident was dependent on staff for Activities of Daily Living (ADL); and Section O indicated the resident required NJ Ex Order 26.4(b)(1). A review of the Order Summary Report included but was not limited to; NJ Ex Order 26.4(b)(1) via NJ Ex Order 26.4(b)(1)) every shift dated NJ Ex Order 26.4(b)(1); and an order dated NJ Ex Order 26.4(b)(1), for NJ Ex Order 26.4(b)(1) every shift. A review of the resident-centered, on-going Care Plan included but was not limited to; a focus area that the resident requires NJ Ex Or with interventions which included to wear NJ Ex Order 2 and gloves during high-contact resident care activities.

On 06/14/2024 at 9:17 AM, the U.S. FOIA (b) (6) stated that the process was to put the PPE gown on over the head via the opening, put arms through the sleeves and tie the back of the PPE gown around the waist area. The U.S. FOIA (b) (6) stated that the PPE gown was to ensure she was "completely covered" and stated, "sorry it [the PPE gown] should be tied in back" to prevent contamination.

On 06/14/2024 at 9:21 AM, CNA #1 stated that the PPE gown should be put on over the head and the arms through the sleeves. She stated, "I forgot to tie it." CNA #1 further stated that it was

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important to be fully covered by the PPE gown "so there is no cross contamination".

On 06/14/2024 at 9:26 AM, the [U.S. FOIA] stated that the process was to put the PPE gown on over the head and to tie it around the back. She stated the purpose was, "to prevent the spread of infection". A review of the facility provided, "Inservice Attendance Sheet" dated [NJ Ex Order 26.4(b)(1)] revealed the subject of the in-service included PPE and that the [U.S. FOIA (b) (6)] and CNA #1 had attended the education which was provided by the previous [U.S. FOIA (b)]

A review of the facility provided, "Oxygen Administration" policy revised 10/2010, included but was not limited to; Purpose: ... to provide guidelines for safe oxygen administration. The policy failed to include how to store the oxygen delivery equipment.

A review of the facility provided, "Personal Protective Equipment" policy revised 04/10/2024, included but was not limited to; Policy: ... to prevent the transmission of pathogens to residents, visitors, and other staff. 1. "All staff who have contact with residents and/or their environments must wear personal protective equipment as appropriate during resident care activities and at other times in which exposure to blood, body fluids, or potentially infectious materials is likely." 4. Indications/considerations for PPE use: ... b. Gowns: i. wear to protect arms, exposed body areas, and clothing from contamination ... ii. Gowns should fully cover torso from neck to knees, ... wrap around the back. Fasten in back at neck and waist.

On 06/19/2024 at 11:13 AM, the above concern

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F 880	Continued From page 67 was addressed with the U.S. FOIA (b) (6) [redacted], the U.S. FOIA (b) and a Corporate nurse who was the facility interim U.S. FOIA (b) (6) [redacted] The facility provided in-servicing and education that was started with the staff regarding the use of NJ Ex Order 26. and appropriate PPE donning. The facility stated there were no other NJ Ex Order 26.4 policies to address the storage of NJ Ex Order 26.4(b)(1) equipment. NJAC 8:39-19.4(a)(c)(k); 27.1(a)	F 880		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Complaint # NJ 00167157 Based on interviews, record review and review of pertinent documentation provided by the facility, it was determined that the facility failed to ensure that the resident call system was maintained in operable condition as evidenced by the following: 1. On 06/17/24 at 11:30 AM, the surveyor entered a random resident's room and asked the resident to activate the call light in the room. The surveyor went into the hallway and observed that the light was flashing and an audible sound could be	F 919	1. The facility failed to ensure that the resident call system was maintained in operable condition. All resident safety has been maintained during this alleged deficient practice. 2. On 6/18/24 the Administrator and Maintenance Director completed an audit of the entire call bell system and all residents call bells are functioning properly. On 6/18/24 the LNHA and Maintenance Director re-educated all staff on notification procedure if a call bell is	7/19/24

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F 919	Continued From page 68 heard. During an interview with the residents, they indicated that the call light was working but staff would take time to answer the call light. One of the resident revealed that 30 minutes could elapsed before staff would answer the call light. The surveyor reviewed the Maintenance logs and observed on 2 of the 4 units the following entries: Unit CD: 4/14/23 outside call light broken, repaired 4/14/23 (Room [redacted] 4/18/23 light not working repaired 4/20/23. (Room [redacted] 5/23/23 call light knob broke,checked 5/23/23. (Room [redacted] 6/21/23 call light does not worked on the outside, repaired 6/21/23.(Room [redacted] 6/22/23 call light does not work, repaired 6/22/23. (Room [redacted] 7/2/23 light not working, repaired 7/3/23.(Room [redacted] 7/5/23 call light not working, repaired 7/5/23. (Room [redacted] 7/8/23, call light not working, repaired 7/10/23. (Room [redacted] Unit AB: 3/26/23 call bell not working, repaired 3/27/23. (Room [redacted] 4/5/23 call light broken, repaired 4/7/23. Room [redacted] 4/11/23 call bell not working on the outside, repaired 4/18/23.(Room [redacted] 4/24/23 call light not working at all., repaired 4/25/23. (Room [redacted] 6/23/23 red box at nurse's station system blinking" missing monitor company called., repaired 6/26/23. Nurse's station.	F 919	found to not be functioning properly. New hire staff will be educated on call bell system during orientation to facility. 3. The Administrator and/or assigned designee will audit starting on 6/18/24 the residents call bell system and maintenance logs to ensure proper function and prompt notification of any call bell system concerns. These audits will be completed daily for 2 weeks, bi-monthly for 3 months and quarterly thereafter. 4. All audits will be reviewed by Administrator, DON and/or designee to ensure timely compliance daily, bi-monthly and quarterly thereafter per the audit timeframes listed in action #3 beginning on 6/18/24. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback. The Administrator and DON will be responsible for implementing this plan of correction.	

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The resident who filed the complaint resided on another unit and the facility did not provide the maintenance log for that particular unit. The U.S. FOIA (b) (6) indicated that he could not locate the log for 2023.

On 06/18/24 at 09:51 AM, the surveyor interviewed the U.S. FOIA (b) (6)) in the presence of another surveyor. The surveyor reviewed the log with the (U.S. FOIA He stated that any issue with the resident call light system should be addressed immediately. However there would be a delay if the issue arose during the weekend as there was no maintenance service on the weekend. The surveyor showed the order for the call light repair on Unit AB dated 04/11/23 that was repaired 7 days later. The U.S. FO informed the surveyors that the call system was defective and could not be repaired immediately. The U.S. FO could not comment on what was done during the 7 days, whether or not the facility informed the Department of Health (DOH) of the concerns or if the residents were provided with other means to alert the staff of their needs.

On 06/18/24 at 11:30 AM, the surveyor asked the U.S. FOIA (b) (6)) for any Call Bell Audits that were completed at the facility since the last survey. The U.S. FOIA informed the surveyor there was no need to complete any call bell audits and none were provided.

On 06/18/24 at 1:30 PM, the surveyor discussed the concerns with the call light system with the U.S. FOIA (b) (6) and inquired regarding the protocol if the call light system was defective on all the units. The U.S. FOIA (b) (6) stated, "The State had to be notified, the residents were to be provided with a tap bell, staff were to monitor all the

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residents more often." The U.S. FOIA (b) (6) added that he could not comment further on the issue with the call light of NJ Ex Order 26.4 to NJ Ex Order 26.4 as he was NJ Ex Order 26.4(b)(1) by the facility. The surveyor asked for any invoice/ work order that was completed for that period, none was provided.

On 06/19/24 at 09:26 AM, the facility provided a policy titled, " Maintenance Inspection". The following were noted: It is the policy of this facility to utilize a maintenance inspection checklist in order to assure a safe functional sanitary, and comfortable environment for residents, staff, and the public.
Policy Explanation

1. The Director of Maintenance Services will perform routine inspection of the physical plant.
2. The Administrator or designee, will perform random inspections of the physical plant. z
3. Maintenance issues will be communicated through the maintenance log on each unit.
4. All opportunities will be corrected immediately by maintenance personnel.
5. The facility shall establish quality/ compliance thresholds as a benchmark for QA purposes.
6. Data recorded on the Maintenance log will be compared to establish thresholds, and actions plans will be generated as needed.
7. Maintenance Director will report to QA team Quarterly. Date implemented 11/15/23 with no revision date.
A review of the facility's policy titled, " Call lights: Accessibility and Timely Response revealed the following:
Call lights : Accessibility and Timely Response Policy
The purpose of this policy is to assure the facility is adequately equipped with a call light at each

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315061	A. BUILDING _____ B. WING _____	C 06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	99 MANHEIM AVENUE BRIDGETON, NJ 08302

(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 919	Continued From page 71 resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light.. The call system must be accessible to the resident at each toilet and bath or shower facility. The call system should be accessible to a resident lying on the floor. 8. Staff will report problems with a call light or call call system immediately to the supervisor and/ or maintenance director and will provide immediate or alternative solutions until the problem can be remedied include: (Examples include: replace " call lights, provide a bell or whistle, increase frequency of rounding, etc.) On 06/19/24 at 1:20 PM the U.S. FOIA provided one page of an invoice dated 4/18/23 that contained the following: Description: Room AB no light at doors of annunciator panel. 1/5/23 Front Door. 1/13/23 Lobby Door Wanderguard monitor. The facility was unable to provide any documentation regarding how the documented concern with the call light system had been addressed. NJAC 8:39-31.2(e), 31.8(c)9	F 919		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions	F 921		7/19/24

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F 921	Continued From page 72 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to maintain a resident bathroom toilet (Resident Room #[redacted] in a sanitary working condition for four days and was evidenced by the following: On 06/13/2024 at 9:58 AM, during initial tour of the facility, the surveyor observed the toilet in Resident Room #[redacted] The toilet bowl was observed with NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) in the bowl. There was no water observed in the toilet. The resident stated that the toilet does not work, and the facility was aware the toilet had been broken for a few days. On 06/13/2024 at 12:59 PM, the surveyor reviewed the unit maintenance log sheets. The toilet in Resident Room #[redacted] was not on the log sheets to be repaired since 5/24/24. There was a work order dated 6/12/2024 for the paper towel dispenser in Resident Room #[redacted] needing batteries which was completed the same day. On 06/13/2024 at 1:12 PM, the surveyor observed the toilet in Resident Room #[redacted] The toilet bowl was observed with NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) in the bowl. There was no water observed in the toilet. On 06/17/2024 at 8:08 AM, the surveyor observed the toilet in Resident Room #[redacted] The toilet bowl was observed with NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) in the bowl. There was no water	F 921	1. The facility failed to maintain a resident bathroom toilet in sanitary working condition. All residents have the potential to be affected by this deficient practice. 2. On 6/18/24 the Maintenance Director plunged the toilet in room #[redacted] and ensured that it is working properly, Housekeeping staff cleansed and disinfected the toilet and entire bathroom on 6/18/24 in room #[redacted]. On 6/18/24 an audit of all resident toilets was done by Maintenance Director and all other toilets are in working order. On 6/18/24 the Housekeeping Director audited all toilets and bathrooms for cleanliness. On 6/18/24 the DON re-educated all staff on proper notification of any maintenance issues so they can be addressed promptly. 3. The Maintenance Director will perform maintenance rounds and check functioning of resident toilets weekly. Housekeeping Director will also perform rounds and check cleanliness of residents bathrooms including toilets. Audits will be completed by the Maintenance Director and/or assigned designee to ensure prompt repair of any resident maintenance concern. These audits will be daily for 2 weeks, bi-monthly for 3 months and quarterly thereafter for 2 quarters.	

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F 921	Continued From page 73 observed in the toilet. At 8:44 AM, the resident stated that the toilet had not been repaired. During an interview with the surveyor on 06/17/2024 at 8:44 AM, the Certified Nursing Assistant #1 (CNA) stated that when items needed to be repaired, she informed the Unit nurse then completed a work order in the maintenance log located on the unit. The CNA stated that Resident Room #[NJ Ex]'s toilet was often out of order as the resident NJ Ex Order 26.4(b)(1) the toilet bowl. The CNA further stated that she believes the toilet was plunged on 06/10/2024. During an interview with the surveyor on 06/17/2024 at 8:48 AM, the Licensed Practical Nurse #2 (LPN#2) stated that Resident Room #[NJ Ex] toilet was "always messed up" because the resident NJ Ex Order 26.4(b)(1) the toilet. She stated it is usually unclogged every other day. When asked if she reported the clogged toilet recently, she replied, No. She stated that she had not been at the facility since NJ Ex Order 26.4b1. On 06/18/2024 at 8:55 AM, the surveyor interviewed the U.S. FOIA (b) (6) on the CD Unit. The [U.S. FO] confirmed that all equipments needed repair must generate a work order. The order would be placed in the book and the maintenance director would be verbally informed. The [U.S. FO] revealed that the concern with Resident #[NJ Ex]'s toilet was an ongoing issue. The surveyor then inquired if the toilet should be in disrepair, the [U.S. FO] stated, "No." On 06/18/2024 at 9:50 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who revealed that all work orders were entered in the maintenance log located on each unit and at times would verbally communicate the concern.	F 921	4. All audits will be reviewed by Administrator, DON and/or designee to ensure timely compliance daily, bi-monthly and quarterly thereafter per the audit timeframes listed in action #3 beginning on 6/18/24. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback. The Administrator and DON will be responsible for implementing this plan of correction.	

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F 921	Continued From page 74 The U.S. FO stated the toilet in Resident Room #[redacted] should not be clogged for 4 days. He stated that a toilet being clogged for 4 days was an inconvenience to the resident and unhealthy. A review of the facility policy titled "Maintenance Inspection" with an implemented date of 11/15/23 reflected that it is the policy of this facility to utilize a maintenance inspection checklist to assure a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. NJAC 8:39-31.4(a)	F 921		

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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 observation, interview, and review of pertinent facility documentation, it was determined the facility failed to ensure that two persons received the required training for LGBTQI+ (Lesbian, Gay, Bisexual, Transgender, Queer/questioning [one's sexual or gender identity], Intersex [person is born with a combination of male and female biological traits] positive) and HIV+ (Human Immunodeficiency Virus [a virus that attacks cells that help the body fight infection] positive) program, was provided by an entity that has demonstrated expertise in identifying the legal, social, and medical challenges faced by, and in creating safe and affirming environments for LGBTQI+ and HIV+, and there was documented evidence to ensure the required staff training was provided.	S 560	1. The facility failed to ensure that two persons received the required training for LGBTQI+ and HIV program and ensure the required staff training was provided. No residents were affected by this deficient practice. 2. On 6/20/24 the Administrator and DON contacted SAGEcare to inquire about receiving the Leadership and Staff training on LGBTQI+ and HIV+. The facility now employs a 2nd employee with training on LGBTQI+ and HIV+. All staff are now trained on LGBTQI+ and HIV+. The HR Director completed an audit of all staff to ensure they have the required training completed.	7/19/24

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

Electronically Signed | 07/11/24

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S 560	Continued From page 1 This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 04/19/22, "Statutory Amendments Regarding the Rights of LGBTQI+ and HIV+ Residents of Long-Term Care Facilities Pursuant to N.J.S.A. 26:2H-12.101-10 7." The memorandum concerned the rights of LGBTQI+ and HIV+ residents of long-term care facilities; N.J.S.A. 26:2G-12, 101-107 ("LGBTQI+ Law"), and a facility's responsibilities under the LGBTQI+ Law. The LGBTQI+ Law was signed on March 3, 2021 and took effect on August 30, 2021. The requirements of the LGBTQI+ Law will be included in N.J.A.C 8:39 in future rulemaking. Specifically, the LGBTQI+ Law establishes specific rights and protections for lesbian, gay, bisexual, transgender, undesignated/non-binary, questioning, queer, and intersex ("LGBTQI+) older adults and people living with HIV ("HIV+) in long-term care facilities ("Facilities"). The LGBTQI+ Law ensures that LGBTQI+ and HIV+ residents in facilities have equitable access to health care and provides the same legal protections as everyone else regardless of their sexual orientation or health status. Prohibited Actions The LGBTQI+ Law prohibits facilities from taking any of the following actions based on a person's sexual orientation, gender identity, gender expression, intersex status, or HIV status: 1. Denying admission to a facility, transferring or refusing to transfer a resident within a facility or to another facility, or discharging, or evicting a	S 560	3. The facility will employ two dedicated representatives who have had formal LGBTQ+ training. The facility will also add the required LGBTQ+ training to its orientation process for all new hires. The LGBTQI+ leadership employees or assigned designee will audit the staff training weekly times 2 weeks, monthly times 3 months then quarterly thereafter to ensure compliance with N.J. S.A. 26:2H-12.101-107. 4. All audits will be reviewed by Administrator, DON and/or designee to ensure timely compliance weekly, monthly and quarterly thereafter per the audit timeframes listed in action #3 beginning on 6/20/24. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback. The Administrator and DON will be responsible for implementing this plan of correction.	

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S 560	Continued From page 2 resident from a facility; 2. Denying a request by residents to share a room; 3. Where rooms are assigned by gender, assigning or reassigning a room based on gender, subject to the provisions of 42 C.F.R. 483.10 (e) (5); 4. Forbidding a resident from, or harassing a resident who seeks to use or does use, a restroom available to other residents of the same gender identity, regardless of whether the resident is making a gender transition, has taken or is taking hormones, has undergone gender affirmation surgery, or presents as gender-nonconforming. For the purposes of this paragraph, harassment includes, but is not limited to, requiring a resident to show identity documents in order to gain entrance to a restroom available to other persons of the same gender identity; 5. Repeatedly failing to use a resident's chosen pronouns or the name the resident chooses to be called, despite being clearly informed of the resident's choice; 6. Denying a resident from wearing preferred clothing, accessories, or cosmetics, or participating in grooming practices; 7. Restricting a resident's right to visit and have conversations with other resident's or with visitors including the right to have consensual sexual relations; 8. Denying, restricting, or providing unequal medical or non-medical care, which is appropriate	S 560		

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S 560	Continued From page 3 to the resident's bodily needs and organs, or providing medical or nonmedical care that, to a similarly-situated resident, causes avoidable discomfort or unfairly demeans the resident's dignity; and 9. Declining to provide any service, care, or reasonable accommodation requested by the resident, subject to the provisions of 42 C.F.R. 483.10(c)(6). Resident Records Additionally, facilities are required to ensure that resident records include the resident's gender identity and the resident's chosen name and pronouns, as indicated by the resident. Confidentiality The LGBTQI+ Law also requires facilities to maintain the confidentiality of certain resident information. Unless required by state or federal law, personal identifying information regarding a resident's sexual orientation, whether a resident is transgender or undesignated/non-binary, a resident's gender transition status, a resident's intersex status, or a resident's HIV status shall not be disclosed. Further, facilities are required to take appropriate steps to minimize the likelihood of inadvertent or accidental disclosure of such information to other residents, visitors, or facility staff, except to the minimum extent necessary for facility staff to perform their duties. Unless expressly authorized, facility staff not directly involved in providing direct care to a transgender, undesignated/non-binary, intersex, or gender-nonconforming resident, shall not be present during a physical examination of, or the	S 560		

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S 560	Continued From page 4 provision of personal care to, that resident if the resident is partially or fully unclothed. Doors, curtains, screens, or other effective visual barriers to providing bodily privacy, when partially or fully unclothed, shall be used. Informed consent is required in relation to any non-therapeutic examination or observation of, or treatment provided to, a resident of the facility. Facilities shall also provide transgender residents with access to transition-related assessments, therapy, and treatments as having been recommended by the resident's health care provider, including, but not limited to, transgender-related medical care, including hormone therapy and supportive counseling. Violations A facility or an employee of a facility that violates the requirements of the LGBTQI+ Law is subject to civil or administrative action. Training Facilities shall designate two employees, including on employee representing management at the facility and one employee representing direct care staff at the facility, to receive in-person training within six months after the effective date of the LGBTQI+ Law. The required training shall be provided by an entity that has demonstrated expertise in identifying the legal, social, and medical challenges faced by, and in creating safe and affirming environments for LGBTQI+ and HIV+ seniors who reside in long-term care facilities in New Jersey. The required training shall address: 1. Caring for LGBTQI+ seniors and seniors living with HIV;	S 560		

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S 560	Continued From page 5 2. Preventing discrimination based on sexual orientation, gender identity or expression of intersex status, and HIV status; 3. The definition of terms commonly associated with sexual orientation, gender identity and expression, intersex status, and HIV; 4. Best practices for communicating with or about LGBTQI+ and HIV+ seniors, including the use of a resident's chosen name and pronouns; 5. A description of the health and social challenges historically experienced by LGBTQI+ and HIV+ seniors, including discrimination when seeking or receiving care at long-term care facilities, and the demonstrated physical and mental health effects within the LGBTQ community; 6. Strategies to create a safe and affirming environment for LGBTQI+ and HIV+ seniors, including suggested changes to facility policies and procedures, forms, signage, communication between residents and their families, activities, and staff training and in-services; and 7. An overview of the provisions of LGBTQI+ Law. Facilities are responsible for maintaining records documenting the completion of the training, as well as the cost of providing the training. On 06/13/24 at 10:26 AM, the surveyor held an entrance conference with the facility U.S. FOIA (b) (6) , U.S. FOIA (b) (6) U.S. FOIA (b) (6)). The U.S. FOIA (b) stated that the U.S. FOIA (b) (6) received the training and the other person was no longer with the	S 560		

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S 560	Continued From page 6 facility. The surveyor asked if the staff had been trainied and the [U.S. FOIA] stated, there was a nurse who did inservices and that was the person who trained. The surveyor asked for the supporing doucuments. On 06/19/24 at 1:35 PM, during the exit conference held with the facility administration the facility was unable to provide any evidence to support that all staff were trained to meet the requirements. NJAC 8:39-5.1(a)	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
315061 Y1	A. Building B. Wing Y2	8/30/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	99 MANHEIM AVENUE BRIDGETON, NJ 08302

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0561	Correction	ID Prefix F0570	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(f)(1)-(3)(8)	Completed	Reg. # 483.10(f)(10)(vi)	Completed
LSC	07/19/2024	LSC	07/19/2024	LSC	07/19/2024
ID Prefix F0584	Correction	ID Prefix F0644	Correction	ID Prefix F0660	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.20(e)(1)(2)	Completed	Reg. # 483.21(c)(1)(i)-(ix)	Completed
LSC	07/19/2024	LSC	07/19/2024	LSC	07/19/2024
ID Prefix F0677	Correction	ID Prefix F0678	Correction	ID Prefix F0684	Correction
Reg. # 483.24(a)(2)	Completed	Reg. # 483.24(a)(3)	Completed	Reg. # 483.25	Completed
LSC	07/19/2024	LSC	07/19/2024	LSC	07/19/2024
ID Prefix F0688	Correction	ID Prefix F0689	Correction	ID Prefix F0695	Correction
Reg. # 483.25(c)(1)-(3)	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(i)	Completed
LSC	07/19/2024	LSC	07/19/2024	LSC	07/19/2024
ID Prefix F0727	Correction	ID Prefix F0730	Correction	ID Prefix F0812	Correction
Reg. # 483.35(b)(1)-(3)	Completed	Reg. # 483.35(d)(7)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	07/19/2024	LSC	07/19/2024	LSC	07/19/2024

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

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
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NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 F0835	Correction	ID Prefix F0851	Correction	ID Prefix F0880	Correction
Reg. # 483.70	Completed	Reg. # 483.70(q)(1)-(5)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	07/19/2024	LSC	07/19/2024	LSC	07/19/2024
ID Prefix F0919	Correction	ID Prefix F0921	Correction		
Reg. # 483.90(g)(1)(2)	Completed	Reg. # 483.90(i)	Completed		
LSC	07/19/2024	LSC	07/19/2024		

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	
6/19/2024	☐ 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 A. Building B. Wing Y2	DATE OF REVISIT Y3
060602		8/30/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	99 MANHEIM AVENUE BRIDGETON, NJ 08302

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 07/19/2024	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	
6/19/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315061	A. BUILDING **01** B. WING _____	**06/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	**99 MANHEIM AVENUE** **BRIDGETON, NJ 08302**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 6/17/24 and 6/18/24, South Jersey Extended Care 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 Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. South Jersey Extended Care is a Single-story, Type II unproctected building that was built in January 1946. The facility is divided into 6 smoke zones. The facility has an exterior 200 KW diesel generator, that does approximately 50 % of the building, as per the MD. * currently the CPCH wing is closed, but the exit/egress corridor is being maintained and include the following room numbers: E-2, E-3, E-4, E-5, E-6, E-7, & E-9, the Physical Therapy room is in that wing and is currently occupied by staff and residents. The building has a partial basement that houses: Housekeeping storage, Boiler room, & Dietary storage and has an ongoing K-241 for only one certified exit with a second exit that entails a steep step ladder leading to Bilko hatch doors. The facility has 167 certified beds and is currently occupying 85.	K 000		
K 241 SS=F	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment	K 241		12/1/26

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

Electronically Signed | 07/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315061	A. BUILDING **01** B. WING _____	**06/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 241	Continued From page 1 Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 6/17/24 and 6/18/24, in the presence of the U.S. FOIA (b) (6) and facility U.S. FOIA (b) (6) it was determined that the facility failed to provide two exits, remote from each other, for each floor or fire section of the building. This deficient practice was evidenced by the following: On 6/17/24, at approximately 9:51 AM, in the presence of the U.S. FO and U.S. FOIA (b) (6) a tour of the partial basement was conducted, the surveyor observed one acceptable means of egress from the basement. The second exit was a steep ladder with metal NJ Ex Ord hatch doors. The basement was fully sprinklered and had a fire alarm system. The door to the basement was located within a locked kitchen receiving area and was not accessible to residents. On 6/18/24, during the survey exit, the surveyor informed the U.S. FOIA (b) (6) of the ongoing Life Safety Code deficiency. The U.S. FOIA (b) (6) told the surveyor there was a Time Limited Waiver in place for the basement egress and facility produced no further documentation for review.	K 241	1. The facility failed to provide two exits, remote from each other, for each floor or fire section of the building. The exit door from the basement with the NJ Ex Ord doors near the kitchen receiving area- there is a time limited waiver in place for that basement egress. The plan will be to complete the exit by 12.1.26. 2. All residents/staff have the potential to be affected should there be an employee trapped in that area without a second possibility of safe egress. In addition, creating a lack of access by the fire department, should there be a fire in the basement. 3. The US FOIA (b)(6) and staff were in-serviced as to the danger of only having one means of egress from the basement. The facility engaged a licensed architect, who is in the process of drawing up plans, and acquiring permits to proceed with this project. Once the plans are approved, the project will be given out for bid to numerous contractors so that facility can begin the project. The facility will inform the state health department as to the progress of this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315061	A. BUILDING **01** B. WING _____	**06/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	**99 MANHEIM AVENUE** **BRIDGETON, NJ 08302**

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K 241	Continued From page 2 NJAC 8:39 - 31.1(c)	K 241	project. 4. Maintenance Department/ Administrator will monitor the progress of this project and inform the state health department as to the ongoing progress on a quarterly basis. All findings will be reviewed by the air quality assurance committee quarterly.	
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		7/19/24

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	315061	A. BUILDING **01** B. WING _____	**06/19/2024**

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K 324	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 6/18/24, in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to provide the required instructional signage, near the Class K portable fire extinguisher, to ensure all portable fire extinguishers were ready for use in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and NFPA 10, 2010 Edition. The deficient practice could affect 15 of 85 residents residing in the facility and was evidenced by the following: At approximately 11:28 AM, during the kitchen tour, the surveyor observed one K-type fire extinguisher that did not have the required instructional placard indicating: "Warning in case of appliance fire, use this extinguisher only after fixed suppression system has been activated." The U.S. FO was interviewed at the time of the observation and stated that he were unaware of this requirement. The US FOIA (b)(6) was informed of the finding at the Life Safety Code exit conference on 6/18/24. NJAC 8:39-31.2(e) NFPA 10 2010 edition 5.5.5.3(a)	K 324	1. The facility failed to provide the required instructional signage, near the Class K portable fire extinguisher. There were no residents negatively affected by this deficient practice. The proper warning signage was ordered by the facility immediately. 2. All residents have the potential to be affected. 3. The facility was checked for additional signage throughout the building. The US FOIA (b)(6) /staff will be in-serviced on the proper signage regarding the Class K portable extinguisher. The signage for the Class K portable will be added to the maintenance logs. 4. The Administrator/Designee will conduct an audit monthly for 3 months. This audit will be reviewed at the quarterly QAPI meetings for recommendations and/or feedback. The Administrator/designee will be responsible for implementing this plan of correction.	
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	K 345		7/19/24

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 345	Continued From page 4 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 documentation review and interview on 6/18/24, in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that the fire alarm system was tested and maintained in accordance with NFPA 72. This deficient practice could affect 85 residents residing in the facility and was evidenced by the following: A review of the facility's semi-annual fire alarm system inspections on date and time revealed that the licensed inspection vendor last tested and inspected the system on 9/21/23. The fire alarm system had not been tested nine months later as of 6/18/24. During an interview with the surveyor on 6/18/24 at 9:30AM, the U.S. FOIA (b) (6) stated that the system was on a semi-annual inspection schedule and the missed semi annual inspection may have been, due to a payment issue. The fire alarm system has sealed lead acid batteries and required a semi-annual inspection. The U.S. FOIA (b) (6) was informed of the finding at the Life Safety Code exit conference on 6/18/24. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 70, 72	K 345	1. The facility failed to ensure that the fire alarm system was tested and maintained in accordance with NFPA 72. The facilities semi-annual fire alarm system inspection was scheduled and tested on 6/28/24. There were no residents negatively affected by this deficient practice. 2. All residents have the potential to be affected. 3. The facilities semi-annual fire alarm system will be conducted semi-annually. The U.S. FOIA (b) (6) and staff will be in-serviced on the testing schedule. The facility maintenance director/staff will schedule the fire alarm system test in advance of the required due date. The maintenance logs will reflect the dates of completion. 4. The Maintenance Director will submit fire alarm system reports to the QAPI committee quarterly for the next year. This audit will be reviewed at the quarterly QAPI meetings for recommendations and/or feedback. The Administrator/designee will be responsible for implementing this plan of correction.	
K 347 SS=E	Smoke Detection	K 347		7/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SOUTH JERSEY EXTENDED CARE	**99 MANHEIM AVENUE** **BRIDGETON, NJ 08302**

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K 347	Continued From page 5 CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review on 6/18/24, in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure a testing and maintenance of battery-operated smoke detectors in resident rooms, in an existing structure. This deficient practice was evidenced for 40 of 62 observed battery-operated smoke detectors, observed in resident rooms and could affect 40 residents that resided in the facility and was evidenced by the following: The U.S. FO stated that resident rooms had battery operated smoke detectors, but could not provide a monthly testing log A review of the facility's preventative maintenance logs did not indicate that there was a preventative maintenance and testing document, for the testing of the detectors for the make, model, installation date, type of battery required to power the smoke detector. The U.S. FO provided a battery replacement log with dates. the log did not include any other required information. The U.S. FOIA (b) (6) was informed of the findings at the Life Safety Code exit conference on 6/18/24. NJAC 8:39-31.2(e)	K 347	1. The facility created a monthly preventative maintenance log for all battery-operated smoke detectors. All battery-operated smoke detectors were checked and logged. There were no residents negatively affected by this deficient practice. 2. All residents have the potential to be affected. 3. The facility battery-operated smoke detectors will be checked monthly. The U.S. FOIA (b) (6) and staff were in-serviced on testing battery-operated smoke detectors. The facility maintenance staff will update the preventative maintenance logs monthly. 4. The audit will be reviewed by the Administrator/designee. The monthly audits will be conducted for 6 months. This audit will be reviewed at the quarterly QAPI meetings for recommendations and/or feedback. The Administrator/designee will be responsible for implementing this plan of correction.	

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 347	Continued From page 6 NFPA 101 Life Safety Code 2012 edition 19.3.6.1, 19.3.4.5.2	K 347		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interview conducted on 6/18/24, in the presence of the U.S. FOIA (b) (6) [redacted], a). it was determined that the facility failed to ensure that their automatic sprinkler system was inspected/tested at the required fifth-year interval according to NFPA 25. b). it was determined that the facility failed to ensure the fire sprinkler system was inspected quarterly as per NFPA 13 & 25. This deficient practice was identified for 1 of 1 fire sprinkler systems observed in the facility and could affect 85 of 85 residents residing in the facility and was	K 353	1. The facility failed to ensure that the automatic sprinkler system was inspected/tested at the required fifth year interval according to NFPA 25. It was determined the facility failed to ensure the fire sprinkler system was inspected quarterly. The 4th quarter of 2023 and the 1st quarter of 2024 were missing. The Maintenance Director scheduled the 3rd and 4th quarter sprinkler inspections. The Maintenance Director scheduled the 5th year internal obstruction investigation	8/26/24

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	Continued From page 7 evidenced by the following: a). At 10:30 AM, the surveyor reviewed the facility's annual automatic sprinkler system inspection report's dated: 6/3/24 and 7/12/23, The reports indicated when the last fifth-year internal obstruction investigation of the pipe was completed: 4/27/18 and was conducted over 6-years ago. An interview was conducted with the U.S. FO during the document review and he stated he was aware of the delay. b). At 10:00 AM, during the surveyors document review of the fire sprinkler quarterly inspection reports dated: 6/3/24 2nd quarter of 2024 and 7/12/23 3rd quarter of 2023, it was determined that the facility was missing the 1st quarter of 2024 and 4th quarter of 2023. The U.S. FOIA (b) (6) indicated the missing inspections was not performed and he stated that it was most likely due to a payment issue. The U.S. FOIA (b) (6) was informed of the finding at the Life Safety Code exit conference on 6/18/24. NFPA (National Fire Protection Association) 25 requires an internal inspection of the fire sprinkler system piping every 5 years, this is to be conducted to inspect for the "presence of foreign organic material" foreign materials can cause obstructions to pipe and sprinklers. NFPA 13, 25 NJAC 8:39-31.2(e)	K 353	immediately. The Maintenance Director adjusted the preventative maintenance logs adding the 5th year internal obstruction investigation. There were no residents negatively affected by this deficient practice. 2. All residents have the potential to be affected. 3. The U.S. FOIA (b) (6) and staff were in-serviced regarding the monthly preventative logs regarding the 5th year internal obstruction investigation and the fire sprinkler system additions. The facility maintenance director/staff will update the preventative maintenance logs monthly. The Administrator/Maintenance Director schedule the quarterly fire sprinkler inspection test in advance on a quarterly basis. The Administrator/Maintenance Director scheduled the 5th year internal obstruction investigation was completed on 8.26.24 by Willetts Fire Protection with the City of Bridgeton water source. 4. All inspections will be reviewed by the Administrator/designee, monthly inspections will be conducted for 6 months. These inspections will be reviewed at the quarterly QAPI meetings for recommendations and/or feedback. The Administrator/designee will be responsible for implementing this plan of correction.	
K 511 SS=F	Utilities - Gas and Electric	K 511		7/19/24

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 511	Continued From page 8 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 on 6/18/24, in the presence of the U.S. FOIA (b) (6), 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 identified for 1 of 10 electrical outlets observed, and could affect residents in that area of the Physical Therapy room, was evidenced by the following: At 11:10 AM, the surveyor accompanied by the U.S. FOIA (b) (6)), observed in the Physical Therapy Room, that the portable hydrocollator (a device used in physical therapy) was full of water and plugged into a non- GFCI (ground-fault circuit interrupter) duplex wall outlet. The U.S. FO acknowledged that the current electrical duplex wall outlet could not be identified as a ground-fault circuit interrupter (GFCI). The U.S. FOIA (b) (6) was informed of the finding at	K 511	1. The facility failed to ensure that the electrical equipment had approved wiring and electrical outlets in accordance with NFPA 70. The Physical Therapy Room had a portable hydrocollator plugged into a non-GFCI duplex wall outlet. The Maintenance Director installed a GFCI duplex to replace the non-GFCI duplex wall outlet. The Maintenance Director/staff checked all other required areas for non-GFCI duplex wall outlets. The Maintenance Director adjusted the preventative maintenance logs to reflect GFCI duplex wall outlet inspections. There were no residents negatively affected by this deficient practice. 2. All residents have the potential to be affected. 3. The U.S. FOIA (b) (6) and staff were in-serviced regarding the monthly preventative logs regarding GFCI duplex	

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SOUTH JERSEY EXTENDED CARE	**99 MANHEIM AVENUE** **BRIDGETON, NJ 08302**

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K 511	Continued From page 9 the Life Safety Code exit conference on 6/18/24. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 511	wall outlet inspections. The Facility Maintenance Director/staff will update the preventative maintenance logs monthly based on inspections. 4. The inspection will be reviewed by the Administrator/designee. The monthly inspection regarding GFCI□s duplex wall outlets will be conducted for 3 months. These inspections will be reviewed at the quarterly QAPI meetings for recommendations and/or feedback. The Administrator/designee will be responsible for implementing this plan of correction.	
K 741 SS=F	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.	K 741		7/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315061	A. BUILDING **01** B. WING _____	**06/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	**99 MANHEIM AVENUE** **BRIDGETON, NJ 08302**

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K 741	Continued From page 10 (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 6/18/24, in the presence of the Surveyor, U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to maintain smoking areas and in accordance with the requirement of NFPA 101, 2012 Edition, Section 19.7.4. The practice of dumping cigarette butts and ash into trash cans with other combustibles, increases the risk of fire to facility occupants. This deficient practice was evidenced for 2 of 2 smoking areas observed and could affect 85 residents residing in the facility and was evidenced by the following: 1). At 12:14 PM, the surveyor and U.S. FO observed in the occupied (12 residents) main smoking courtyard that the area was observed to have four oasis style ashtrays. The smoking area was not provided with a metal container with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. The U.S. FO confirmed the finding during the observations. 2). At 12:30 PM, the surveyor, U.S. FOIA (b) and U.S. FO observed in the small smoking courtyard, that the area was observed to have two oasis style ashtrays. The smoking area was not provided with a metal container with self-closing cover devices into which ashtrays can be emptied shall	K 741	1. The facility failed to maintain smoking areas and in accordance with the requirement of NFPA 101. The facility removed the oasis style ashtrays from both areas. The facility purchased metal containers with self-closing cover devices into which ashtrays can be emptied. There were no residents negatively affected by this deficient practice. 2. All residents have the potential to be affected. 3. The U.S. FOIA (b) (6) and staff were in-serviced regarding the proper types of metal container with self-closing cover devices. The Maintenance Director/staff will monitor every month to ensure the metal containers with self-closing cover devices are in place. 4. Monitoring of the self-closing cover devices will be reviewed by the Administrator/designee monthly for 6 months. The inspections will be reviewed at the quarterly QAPI meetings for recommendations and/or feedback. The Administrator/designee will be responsible for implementing this plan of correction.	

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K 741	Continued From page 11 be readily available to all areas where smoking is permitted. The [U.S. FOIA (b) (6)] confirmed the finding during the observation. The [U.S. FOIA (b) (6)] was informed of the finding's at the Life Safety Code exit conference on 6/8/24. NJAC 8:39-31.2(e)	K 741		
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 6/18/24, in the presence of the [U.S. FOIA (b) (6)]), 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	1. 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. We had a company conduct an inspection of the fire doors. There were no residents negatively affected by this	7/19/24

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SOUTH JERSEY EXTENDED CARE	**99 MANHEIM AVENUE** **BRIDGETON, NJ 08302**

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K 761	Continued From page 12 This deficient practice was evidenced for 7 of 7 doors observed and had the potential to affect 85 residents who resided in the facility and was evidenced by the following: At 9:00 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 U.S. FO 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 U.S. FOIA (b) (6) was informed of the findings at the Life Safety Code exit conference on 6/18/24. NJAC 8:39-31.1(c), 31.2(e) NFPA 80, section 5.2.1	K 761	deficient practice. 2. All residents have the potential to be affected. 3. The facilities fire doors will be inspected and tested annually. The U.S. FOIA (b) (6) and staff will be in-serviced on the annual schedule and the preventative maintenance log. 4. The inspection and testing will be reviewed by the Administrator/designee. The inspection and testing will be conducted monthly. The fire doors inspection and testing will be reviewed at the quarterly QAPI meetings for recommendations and/or feedback. The Administrator/designee will be responsible for implementing this plan of correction.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36	K 918		7/19/24

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	315061	A. BUILDING **01** B. WING _____	**06/19/2024**

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SOUTH JERSEY EXTENDED CARE	**99 MANHEIM AVENUE** **BRIDGETON, NJ 08302**

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K 918	Continued From page 13 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 record review and interview on 6/18/24 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined the facility failed to conduct a 90 minute annual loadbank test on their Emergency Power Generator (EPG) in accordance with NFPA 110 section 8.4 (2010 edition) for 1 of 1 EPGs. This deficient practice had the potential to affect all 85 residents and was evidenced by: A record review of the emergency power generator log revealed the diesel generator was exercised monthly under load at less than 30% of the emergency power systems nameplate rating. There was no record of an annual 90 minute supplemental load exercise necessary when not meeting the monthly requirements of NFPA 110	K 918	1. The facility must ensure to conduct a 90-minute annual landbank test on the Emergency Power Generator (EPG) in accordance with NFPA 110. The Maintenance Director scheduled the 90-minute annual landbank test on 6/19/24 which was completed. The Maintenance Director added to the preventative maintenance log, the 90-minute annual landbank test. There were no residents negatively affected by this deficient practice. 2. All residents have the potential to be affected. 3. The US FOIA (b)(6) [redacted] /staff were	

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K 918	Continued From page 14 section 8.4.2 (2010 edition). In an interview at 10:24 AM the U.S. FOIA (b) (6) stated that the facility did not conduct a 90 minute load test last year and did not run the generator at or above the 30% nameplate rating during the monthly full load tests. The facility U.S. FOIA (b) (6) was was informed of the deficient practice during the Life Safety Code exit conference on 6/18/24. N.J.A.C. 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	in-serviced on the 90-minute annual landbank test. The U.S. FOIA (b) (6) and staff will be in-serviced on the annual schedule and the preventative maintenance log. The preventative maintenance logs will reflect the annual generator testing. 4. The audit will be reviewed by the Administrator/designee. The audit will be conducted for six months. The load tests will be reviewed at the quarterly QAPI meeting for any recommendations and/or feedback. The Administrator/designee will be responsible for implementing this plan of correction.	

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
315061 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	8/30/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	99 MANHEIM AVENUE BRIDGETON, NJ 08302

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 K0241	07/19/2024	LSC K0324	07/19/2024	LSC K0345	07/19/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0347	07/19/2024	LSC K0353	08/26/2024	LSC K0511	07/19/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0741	07/19/2024	LSC K0761	07/19/2024	LSC K0918	07/19/2024
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	
6/19/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO