STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	018254	A. BUILDING: _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative Code, 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 deficiecncy and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisisons of the New Jersey Admiistrative Code, Title 8, Chapter 43E, enforcement of Licensure.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to a) maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This was evident for 14 of 14-day shifts, deficient in total staff for residents on 2 of 14 evening shifts, deficient in CNAs to total staff on 7 of 14 evening shifts, and deficient in total staff for residents on 5 of 14 overnight shifts and b) Maintain a record of influenza vaccinations for all facility employees, per diem and contract employees as required for compliance with N.J.S.A 26:2H-18.79- Influenza vaccination in health care facilities. Findings include:	S 560	I. Corrective action(s)accomplished for resident(s)affected: " Resident #18 was assessed by a Registered Nurse for any physical, mental or psychological adverse effects related to lying in urine and feces. A skin assessment was performed, and the resident□s skin remains intact. There were no adverse effects noted. " Resident #41 was assessed by a Registered Nurse for any physical, mental or psychological adverse effects related to not being able to get assistance to get out of bed. A skin assessment was performed, and the resident□s skin remains intact and there is no decrease in level of function. There were no adverse effects	4/18/23

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

Electronically Signed | 03/22/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	018254	A. BUILDING: _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 1) Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The deficient practice was evidenced as follows: The facility was deficient in CNA staffing for residents on 14 of 14-day shifts, deficient in total staff for residents on 2 of 14 evening shifts, deficient in CNAs to total staff on 7 of 14 evening shifts, and deficient in total staff for residents on 5 of 14 overnight shifts as follows: -02/12/23 had 7 CNAs for 161 residents on the day shift, required 20 CNAs. -02/12/23 had 13 total staff for 161 residents on the evening shift, required 16 total staff. -02/12/23 had 5 CNAs to 13 total staff on the evening shift, required 7 CNAs.	S 560	noted. " Resident #43 was assessed by a Registered Nurse for any physical, mental, or psychological adverse effects related to staffing between 2/28/23-3/8/2023. There were no adverse effects noted. " #2. No other residents were affected by this practice. II. Residents identified having the potential to be affected and corrective action taken: " The deficient practice has the potential to affect all residents residing in the facility. " #2. Residents who have contact with staff who are not up to date with their Influenza Vaccine had the potential to be affected. " #2. The Influenza Vaccination policy was reviewed by the Infection Preventionist (IP), Director of Nursing, and the Administrator. No updates were required for the current policy. " #2. The Infection Preventionist Nurse (IP) was provided reeducation on the mandatory requirement for influenza vaccination and the process for submitting a medical exemption. " #2. Education was provided to facility staff (including contracted staff) by the IP nurse on the current Influenza Vaccination policy. Staff were educated that a medical exemption form must be submitted using the form designated by the Department of Health, stating that the influenza vaccination for that employee is medically contraindicated, as enumerated by the Advisory Committee on Immunization Practices of the federal Centers for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	018254	A. BUILDING: _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 -02/12/23 had 10 total staff for 161 residents on the overnight shift, required 11 total staff. -02/13/23 had 13 CNAs for 161 residents on the day shift, required 20 CNAs. -02/13/23 had 8 CNAs to 18 total staff on the evening shift, required 9 CNAs. -02/14/23 had 15 CNAs for 161 residents on the day shift, required 20 CNAs. -02/14/23 had 10 total staff for 161 residents on the overnight shift, required 11 total staff. -02/15/23 had 14 CNAs for 161 residents on the day shift, required 20 CNAs. -02/16/23 had 12 CNAs for 161 residents on the day shift, required 20 CNAs. -02/16/23 had 8 CNAs to 18 total staff on the evening shift, required 9 CNAs. -02/17/23 had 16 CNAs for 161 residents on the day shift, required 20 CNAs. -02/18/23 had 12 CNAs for 161 residents on the day shift, required 20 CNAs. -02/18/23 had 9 total staff for 161 residents on the overnight shift, required 11 total staff. -02/19/23 had 7 CNAs for 161 residents on the day shift, required 20 CNAs. -02/19/23 had 8 CNAs to 19 total staff for 161 residents on the evening shift, required 9 CNAs. -02/20/23 had 14 CNAs for 161 residents on the day shift, required 20 CNAs. -02/20/23 had 8 total staff for 161 residents on the overnight shift, required 11 total staff. -02/21/23 had 14 CNAs for 167 residents on the day shift, required 21 CNAs. -02/21/23 had 16 total staff for 167 residents on the evening shift, required 17 total staff.	S 560	Disease Control and Prevention if they wish to submit a medical exemption for the next influenza season. An attestation of a medical exemption will be subject to approval by this facility following review to confirm the medical exemption is consistent with standards enumerated by the Advisory Committee on Immunization Practices. " #2. The IP Nurse will continue to provide education and follow up to staff on the requirement for annual influenza vaccination. Staff have been educated that annual vaccination will be received at the facility except when an employee presents acceptable proof, including attestation, of a current influenza vaccination received from another vaccination source. This will be required no later than December 31 of the current season as determined by the federal Centers for Disease Control and Prevention. III. Measures will be put into place to ensure the deficient practice will not recur: " The facility currently has 4 Nursing Agency contracts. " Daily bonuses for the agency and in-house staff are offered for double shifts, extra shifts, weekend shifts and staff recognition. " Referral and sign-on bonuses are offered. " The call out Policy has been reviewed and the staff has been re-educated by the Assistant Director of Nursing/Designee. " Advertisement lawn signs are placed by the front of the building. " The facility is recruiting on multiple	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	018254	A. BUILDING: _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3 -02/21/23 had 7 CNAs to 16 total staff on the evening shift, required 8 CNAs. -02/21/23 had 11 total staff for 167 residents on the overnight shift, required 12 total staff. -02/22/23 had 16 CNAs for 164 residents on the day shift, required 20 CNAs. -02/22/23 had 7 CNAs to 17 total staff on the evening shift, required 8 CNAs. -02/23/23 had 18 CNAs for 165 residents on the day shift, required 21 CNAs. -02/24/23 had 15 CNAs for 164 residents on the day shift, required 20 CNAs. -02/25/23 had 9 CNAs for 161 residents on the day shift, required 20 CNAs. -02/25/23 had 8 CNAs to 19 total staff on the evening shift, required 9 CNAs. During an interview with Surveyor #1 On 3/7/2023 at 10:29 AM, the Staffing Director (SD) stated that she is aware that they are not meeting staffing mandates. She added that she is knowledgeable of the federal and state mandates. The residents are suffering, they should come first. During an interview with Surveyor #1 on 3/7/2023 at 2:14 PM, the Director of Nursing (DON) acknowledged that the facility is short staffed. She she said she meets with the Staffing Director every day and there are days our efforts to fully staff are met. The DON went on to say then there are call outs, no shows from agencies. When the DON was asked if the facility was still accepting new admissions, the DON replied yes. When asked why they continue to accept admissions in light of their staffing issues, the DON asked to defer to the facility Administrator. During an interview with the survey team on	S 560	employment search engines and multiple social media platforms. " Depending on the needs of the day Nursing management to include Unit Managers, Supervisors and ADON will be evaluated to assist with resident care. The Director of Nursing will audit Certified Nurse Aide staffing ratios weekly based on working staff schedules for 4 weeks then monthly for 5 months to determine additional staffing/recruitment needs. Results of these audits will be discussed with the facility Administrator to determine any additional interventions needed for staffing to maintain the required minimum direct care staff to resident ratios. " #2 The IP Nurse will maintain records of influenza vaccination for current and new facility staff, including contracted staff, and those who have declined vaccination with medical exemptions. Education records will be maintained by the IP nurse to include education on influenza vaccination, non-vaccine influenza control measures; and the symptoms, transmission, and potential impact of influenza. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: " The DON/Designee will report audit findings of minimum direct care staff to resident ratios to the Administrator and any corrective actions implemented weekly for 4 weeks then monthly for 5 months. The Administrator/Designee will analyze, trend these findings and report outcomes quarterly for 2 quarters to the Quality Assessment and Assurance (QAA)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	018254	A. BUILDING: _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 4 3/8/2023 at 11:45 AM, the facility Licensed Nursing Home Administrator (LNHA) confirmed that the facility is still taking admissions. The LNHA stated that we do recognize the issue and the DON will tell me we need to curb admissions and we do, but we can't close up shop. A review of a facility staffing policy with a revised date of 12/06/2022 titled "Staffing Policy and Procedures" indicated; "Certified nursing assistants will be available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care Plan and with the following ratios: -One certified nurse aide to every eight residents for the day shift -One direct care staff member to every ten residents for the evening shift, and each direct care staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties. -One direct care staff member to every fourteen residents for the night shift provide that each direct care staff member shall be signed in to work as a certified nurse aide and perform certified nurse aide duties. 2) Findings include: Reference: On January 13, 2020, Governor Murphy signed P.L. 2019 c. 330 (codified at N.J.S.A. 26:2H-18.79 and referred to hereafter as "the Statute"). The Statute requires certain healthcare facilities to establish and implement an annual influenza vaccination program. The New Jersey Department of Health (Department) is required by the Statute to promulgate rules and designate a medical exemption form to be	S 560	Committee, with follow-up recommendations, as necessary. " #2. The IP Nurse will present staff influenza vaccination rates from current staff records to the (QAA) Committee each quarter for the next 4 quarters to assure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	018254	A. BUILDING: _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 5	S 560		

distributed to the covered healthcare facilities. This memo and the attached form are intended to assist general or special hospitals, nursing homes (long-term care facilities licensed pursuant to N.J.A.C. 8:39), and home health care agencies, collectively referred to as "facility" or "facilities," in understanding and meeting their obligations under the Statute, until the rules and the medical exemption form can be adopted through rulemaking.

Covered Employees
All facility employees are required to be vaccinated, including employees who are not responsible for direct patient care. Per diem and contract employees are to be considered facility employees and are required to be vaccinated.

Record Keeping
Facilities must maintain a record or attestation, as applicable, of influenza vaccinations and medical exemptions for each employee. The Department will address through rulemaking proper procedures for submitting data to the Department.

During entrance conference on 2/28/23, the surveyor requested a list of all staff flu vaccine status for the 2022-2023 influenza season.

On 3/2/23 at 11:03 AM, a review of the facility staff and contracted staff flu vaccination documentation revealed that all facility staff and contracted staff have not received the flu vaccine.

During an interview with the surveyor on the same date and time as above, the Director of Nursing (DON) and Licensed Nursing Home Administrator confirmed that all their staff and contractors have not received the flu vaccine for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	018254	A. BUILDING: _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 6 the current flu season. The DON replied, the Infection Preventionist (IP) is responsible to make sure all staff and contracted staff receive their flu vaccination, when asked who is responsible to ensure all staff are vaccinated. The DON further stated, we have the medical exemption form and the IP has educated all departments on the flu vaccine, posted by the time clock and some of the staff won't take it. The DON continued by stating that the exemption form was given to the staff for their provider to fill out and no one has returned the completed forms. A review of the facility policy titled, "Influenza Vaccine" last reviewed on 2/2022 included, "8. The Infection Control Preventionist will maintain surveillance data on influenza vaccine coverage and reported rates of influenza among residents and staff. "	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is not in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or	E 039		4/18/23

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

Electronically Signed | 03/22/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 039	Continued From page 1	E 039		

functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For Hospices at 418.113(d):]
(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:
(i) Participate in a full-scale exercise that is community based every 2 years; or
(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 039	Continued From page 2	E 039		

is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 039	Continued From page 3 messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 039	Continued From page 4 questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 039	Continued From page 5 designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 039	Continued From page 6	E 039		

exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.

*[For ICF/IIDs at §483.475(d)]:
(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.
(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.

*[For HHAs at §484.102]
(d)(2) Testing. The HHA must conduct exercises

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 039	Continued From page 7	E 039		

to test the emergency plan at least annually. The HHA must do the following:
(i) Participate in a full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.

(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.

*[For OPOs at §486.360]
(d)(2) Testing. The OPO must conduct exercises

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 039	Continued From page 8 to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on record review and interview on 03/07/23, in the presence of the Maintenance Director, it was determined that the facility failed	E 039	I. Corrective action(s)accomplished for resident(s)affected: No residents were identified as being	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 039	Continued From page 9 to participate in the required tabletop and community based emergency drill, and failed to conduct 2 of 2 emergency disaster drills annually in accordance with the Emergency Preparedness guidelines as required by 42 CFR part 483. This deficient practice was evidenced by the following: A review of the facility's disaster drill documentation for the previous 12 months revealed there was no documented emergency disaster drill. There was also no documentation that the facility attempted to participate in a community based drill, an annual individual facility-based functional exercise, actual natural or man-made emergency, a mock disaster drill and a tabletop exercise. In an interview at 10:30 AM, the facility's Director of Maintenance confirmed the facility did not participate in or conduct any disaster drills in 2022. The Administrator was informed of the finding's at the Life Safety Code exit conference on 03/08/23. NJAC 8:39-31.2(e) Federal (42 CFR 483.73) Emergency Preparedness guidelines	E 039	negatively affected by this practice during survey. An annual individual facility-based functional exercise was conducted on 3/21/2023 at the facility to test the facility's emergency plan. II. Residents identified having the potential to be affected and corrective action taken: This deficient practice had the potential to affect all residents residing in this facility. No residents were negatively impacted by this practice. III. Measures will be put into place to ensure the deficient practice will not recur: The Maintenance Director was re-educated by the Administrator that the facility must participate in/or conduct 2 emergency disaster drills annually in accordance with the Emergency Preparedness guidelines as required by 42 CFR part 483. Drills can include a community-based drill, an annual individual facility-based functional exercise, actual natural or man-made emergency, a mock disaster drill and/or a tabletop exercise. A tabletop exercise will be conducted in November 2023 for the 2nd annual drill at the facility. The Director of Maintenance will report the scheduled date, type of exercise, and results of each emergency disaster drill scheduled to the Administrator. The Administrator will audit the emergency drill schedule and results of testing the emergency plan to assure compliance. Any corrective actions	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 039	Continued From page 10	E 039	required as a result of these audits will be addressed by the Administrator with the Director of Maintenance. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The Director of Maintenance will report the dates, type of exercise, and results of the emergency disaster drills to the Quality Assessment and Assurance (QAA) Committee quarterly over the next 4 quarters to assure compliance. The QAA Committee will determine the need for any additional monitoring of emergency disaster drills and schedules.	
F 000	INITIAL COMMENTS Standard Survey Census: 155 Sample Size: 34 + 3 closed records The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that	F 550		4/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 550	Continued From page 11 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 record review, it was determined that the facility failed to ensure that a.) the residents' were transported from one area of the unit to another area in a dignified manner for 1 of 34 sampled residents (Resident # 13) and 2 unsampled residents, who were observed to be [redacted] in the [redacted] i [redacted] and b.) failed to ensure that the residents'	F 550	I. Corrective action(s)accomplished for resident(s)affected: " Resident #13 was assessed by the Assistant Director of Nursing (ADON) on [redacted] and there were no negative psychosocial effects noted related to having the [redacted] when transporting the resident from one	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 550	Continued From page 12 dining experience was provided in a manner to promote the dignity and respect of the residents, who were not served their meal at the same time while seated at the same table during dining observations . This deficient practice was evidenced by the following: 1. On 2/28/2023 at 12:10 PM, Surveyor #1 observed an unsampled resident to be [redacted] in a [redacted] by Unit Manager Licensed Practical Nurse (UM/LPN #1) through the dining room out to the hallway. On 2/28/2023 at 12:15 PM, Surveyor #1 observed a second unsampled resident to be [redacted] out of the dining room to the hallway in [redacted] by a unit LPN. On 3/1/2023 at 9:15 AM, UM/LPN #1 was observed by Surveyor #1 to pull resident #13 [redacted] in his/her [redacted] down the hallway to activities room. During an interview with Surveyor #1 on 3/3/2023 at 10:49 AM, UM/LPN #1 said she remembered resident sitting in front of nursing station and confirmed she took resident to activity room. When asked how she took resident to the room she replied in his/her [redacted]. When asked again how did you take the resident and UM/LPN #1 said she pulled the resident [redacted] in the [redacted]. When asked by Surveyor #1 if that was an appropriate way to transport a resident, UM/LPN #1 replied no it is not appropriate. Residents should be taken forward in the chair. Surveyor #1 also reviewed the other two instances on [redacted] at 12:13 PM and 12:15 PM, that both UM/LPN #1 and unit LPN were observed to [redacted] unsampled residents	F 550	area of the facility to another area. " Resident #82 was assessed by the Assistant Director of Nursing (ADON) on [redacted] there were no negative psychosocial effects noted related to not having their meal served at the same time as other residents seated at the same table. " The Unit Manager Licensed Practical Nurse (UM/LPN #1) and the identified unit LPN were reeducated on 3/7/2023 by the ADON on the Resident Rights Policy with emphasis on the proper way to transport a resident in a [redacted] from one area of the unit to another in a dignified manner. " The UM/LPN #1 was reeducated by the ADON on 3/7/2023 on the Resident Rights Policy with an emphasis placed on serving residents their meals at the same time while seated at a common table. UM/LPN #1 was also reeducated on the communication process, (email) that the facility utilizes between departments. II. Residents identified having the potential to be affected and corrective action taken: " All residents who use a [redacted] and are transported from one area of the facility to another area had the potential to be affected. " All residents served their meals in the [redacted] dining room from [redacted] had the potential to be affected. III. Measures will be put into place to ensure the deficient practice will not recur: " All staff were re-educated by the ADON/designee regarding the proper way	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 550	Continued From page 13 [redacted] in their [redacted] out of the dining room. On 3/7/2023 at 2:10 PM, Surveyor #1 asked the facility Director of Nursing (DON) what her expectations were regarding transporting residents in a [redacted]. The DON replied they (the residents) should be pushed to wherever they are going and not [redacted]. Surveyor #1 reviewed the observation made on [redacted] and [redacted] on the [redacted] floor. 2. On 2/28/2023 at 11:42 AM, during the lunch meal observation by Surveyor #1 in [redacted] floor dining room [redacted] residents were seated in the dining room. At that time, [redacted] residents were served their meal. On 2/28/2023 at 12:04 PM, the [redacted] meal truck arrived to the unit and [redacted] more residents in the dining room received their meal. On 2/28/2023 at 12:21 PM, the [redacted] meal truck arrived to the unit and the remaining residents in dining room received their meal. On 3/1/2023 at 11:35 AM, Surveyor #1 observed the lunch meal in the [redacted] dining room. The [redacted] meal truck arrived to the unit and [redacted] residents were in the dining room. Staff were passing trays and three (3) residents were sitting together at a table. 1 resident received his/her meal and was actively eating. Another resident (sampled Resident # 82) at the table spoke to staff and staff was heard to say we have to wait for your (meal) truck to come. At that time, [redacted] of the residents in the dining room received their trays at that time.	F 550	to transport residents in [redacted] from one area of the facility to another in a dignified manner. " A new seating chart for the [redacted] dining room was completed on 3/16/2023 and an email was sent to the Director of Dietary on 3/16/2023 for notification of the residents who dine in the [redacted] dining room for their lunch and dinner meals. " All Licensed Nurses and Certified Nurses Aides were reeducated on resident rights with an emphasis placed on serving residents their meals at the same time while seated at a common table. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: " Dietician/ Designee will conduct weekly audits times 4 weeks and monthly thereafter for five months to validate that residents are served their meals at the same time while seated at a common table. " Unit Managers/ Designee will conduct weekly audits times 4 weeks and monthly thereafter for five months to validate that residents utilizing [redacted] are transported in a dignified manner. " Unit Managers will report their audit findings to the DON with follow-up recommendations as necessary. " The Dietician/designee will report their findings to the Quality Assessment and Assurance (QAA) Committee quarterly for two quarters. " The DON will trend the audits findings and report outcomes to the QAA Committee quarterly for two quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 550	Continued From page 14 On 3/1/2023 at 11:42 AM, Resident #82 was told again you have to wait until your lunch tray comes. Staff did offer him/her pudding to which he/she said no. On 3/1/2023 at 11:49 AM, staff provided Resident #82 with graham crackers. Graham crackers were also given to the 3rd resident seated at the table who was not served their meal. On 3/1/2023 at 11:57 AM, the 2nd meal truck arrived to the unit and six (6) more residents received their meal. The 3rd resident received his/her meal however Resident #82 did not. Staff told resident it will come up on next truck. At another table there were three residents were observed. Sampled Resident # 133 received his/her meal and was actively eating. The other 2 unsampled residents did not receive their meal at that time. At a 3rd table two (2) residents were seated. One resident received their meal and the other did not. The resident who was not eating was watching the other resident eat. On 3/1/2023 at 12:20 PM, a 3rd meal truck arrived to unit and the remaining residents received their meals. During an interview with Surveyor #2 on 3/1/2023 at 11:54 AM, UM/LPN #1 when asked when was the last time the [redacted] served residents from the steam table in the dining room. UM/LPN #1 responded, "We haven't served from the steam table since before [redacted] It's been about three years." On 3/1/2023 at 12:00 PM Surveyor #2 observed that all residents were not served their meal at	F 550	" The QAA committee will determine the need for any additional monitoring of this area after the 2nd quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 550	Continued From page 15	F 550		

the same time while seated at a common table.

On 3/3/2023 at 12:09 PM, Surveyor #2 observed the lunch meal served on the [redacted] dining room. Not all residents seated at the same dining table were served at the same time. One table had 3 resident's waiting for there meal while the fourth resident ate their lunch.

During an interview with the Surveyor #1 and Surveyor #2 on 3/7/2023 at 9:13 AM, UM/LPN #1 said we use the dining room for lunch and dinner. UM/LPN # 1 said whoever is out of bed and wants to come to dining room can. It can vary meal to meal and day to day. UM/LPN #1 confirmed the facility is not using steam tables for meal service and that everything come from kitchen on trays. When asked how long had the facility been using the dining room for meals, UM/LPN #1 said they had had [redacted] on unit in [redacted] er and once cleared residents came back to dining room. We have 4 carts and we are still using the [redacted] model of tray delivery where everybody ate in their rooms. There is no seating chart, we all know where everyone sits when they come in here. When asked by Surveyor #2 about communication between the unit and kitchen, UM/LPN #1 said there is no communication between [redacted] floor and kitchen as to who is eating in dining room and who eats in their rooms. I am aware that everybody should be served at the table at the same time. UM/LPN #1 said yes I am aware that everyone at the same table should be served at the same time. She went on to say this is not currently happening due to way system is set up with carts. On same date at 9:25 AM, UM/LPN #1 said, correct there is no conversation with kitchen to come up with system for residents who eat in the dining room and their trays and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 550	Continued From page 16 carts. On 3/7/2023 at 1:07 PM, Surveyor #2 observed 9 of 17 residents observed in [redacted] floor dining room served on trays. 8 of the 17 had not received their meal tray yet. During an interview with the survey team on 3/7/2023 at 2:09 PM, the director of Nursing (DON) said "When we were serving from the steam table prior to [redacted] and everybody would be served at the table at the same time. Our facility administrator has talked with me about getting the new facility Food Service Director to re-start the meal service on the floors and serving from the steam table again."	F 550		
F 584 SS=D	NJAC 8:39-4.1(a)(12) Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (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.	F 584		4/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 17 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to create a homelike environment during dining by not removing food from serving trays. The deficient practice was observed on the third-floor dining room and evidenced by the following: On 2/28/2023 at 11:42 AM, Surveyor #1 began a lunch meal observation in the [redacted] dining room with the arrival of the first meal truck. Residents were served their meals on trays. Food was not removed from the trays and placed directly on the table during meal service.	F 584	I. Corrective action(s)accomplished for resident(s)affected: Residents who dined in the [redacted] Floor Dining Room between [redacted] were assessed by the Assistant Director of Nursing on 3/7/2023 and found to have no adverse effects from this practice. The Unit Manager/Licensed Practical Nurse #1 (UM/LPN#1) was re-educated on 3/7/2023 by the Assistant Director of Nursing on the practice of removing food items from serving trays and placing them directly on the table to provide a homelike	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 18 On 2/28/2023 at 12:04 PM, the second meal truck arrived to the unit dining room and the residents were served their meals on trays. Food was not removed from the tray and placed directly on the table during meal service. On 2/28/2023 at 12:21 PM, the third meal truck arrived to unit dining room and the residents were served their meals on tray. Food was not removed from the tray and placed directly on the table. On 3/1/2023 at 11:35 AM, lunch meal observation began with the arrival of the first meal truck to the unit dining room. Residents were served their meals on trays. Food was not removed from the trays and placed directly on the table. On 3/1/2023 at 11:57 AM, the second truck arrived to unit dining room. Residents were served their meal on trays. Food was not removed from the tray and placed directly on the table. On 3/1/2023 at 12:20 PM, the third meal truck arrived to the unit dining room. Residents were served their meals on trays. Food was not removed from the trays and placed directly on the table. On 2/28/2023 at 12:14 PM, Surveyor #2 observed the [redacted] Dining Room. All residents were served lunch meal on trays. Food was not removed and placed directly on the table. During an interview with Surveyor #2 on 3/1/2023 at 11:54 AM, UM/LPN #1 when asked when was the last time the [redacted] floor unit served residents	F 584	environment during dining. II. Residents identified having the potential to be affected and corrective action taken: All residents who dined in the [redacted] Floor Dining Room from [redacted] had the potential to be affected. Seventeen residents who had dined in the dining room were assessed by the Assistant Director of Nursing and determined that no residents were negatively impacted by this practice. III. Measures will be put into place to ensure the deficient practice will not recur: Licensed and Certified Nursing Staff were re-educated on the process of removing food from serving trays and placing them directly on the table during meals served in the dining room to maintain a home-like environment. The Registered Dietitian/designee will conduct monthly audits for the next six months on the [redacted] Floor Dining Room to assure staff are serving residents in a way that maintains a home-like environment. Any discrepancies noted will be corrected by the Dietitian at the point of service. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The Registered Dietitian will report the results of the monthly [redacted] Floor Dining Room audits and any corrective actions taken to the to the Quality Assessment and Assurance (QAA) Committee for the next two quarters. The QAA Committee will determine the need for any additional monitoring of this area after the 2nd	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 19 from the steam table in the dining room. UM/LPN #1 responded, "We haven't served from the steam table since before [redacted] It's been about three years." On 3/3/2023 at 12:09 PM, Surveyor #2 observed the lunch meal served in the [redacted] dining room. All residents who were observed eating ([redacted] residents) had their meals provided to them on trays. Food was not removed from the trays and placed directly on the table. During an interview with Surveyor #1 and Surveyor #2 on 3/7/2023 at 9:13 AM, Unit Manager/Licensed Practical Nurse (UM/LPN #1) said we use the dining room for lunch and dinner. On the same dated at 9:22 AM, UM/LPN #1 said when we serve the trays we set everything up, open everything and let them (residents) know what is there. There is no reason why we are not removing the food from the trays. When asked if the staff should be removing the meal from trays she responded Yes staff should be removing plates and from tray and putting them on the table. I feel I am aware we should be doing that but this is the way we have been doing it. 03/07/23 01:07 PM [redacted] residents observed in [redacted] floor dining room served on trays. [redacted] had not received their meal tray yet. NJAC 8:39-4.1(a)(12)	F 584	quarterly meeting.	
F 695 SS=D	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	F 695		4/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 695	Continued From page 20 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 other facility documentation, it was determined the facility failed to provide necessary care of [redacted] equipment consistent with professional standards by a.) not replacing and properly storing a [redacted] in accordance with facility policy and b.) not properly storing a [redacted]) according to facility policy. The deficient practice was identified for 2 of 3 residents (Resident #145 and #36) reviewed for [redacted] The deficient practice was evidenced by the following: A.) On 2/28/2023 at 9:55 AM, during the initial tour of the facility, Surveyor #1 observed Resident #145 in bed in his/her room. Surveyor #1 observed an [redacted] (machine that produces [redacted] adjacent to the bed with a [redacted] connected to it. The [redacted] was draped over the [redacted]. Surveyor #1 observed a piece of tape attached to the [redacted] revealing the date, "[redacted]." On 3/1/2023 at 8:42 AM, Surveyor #1 observed Resident #145 in bed in his/her room. Surveyor #1 observed the [redacted] draped over the [redacted]. Surveyor #1 observed the piece of	F 695	I. Corrective action(s)accomplished for resident(s)affected: The [redacted] found draped over the [redacted] for Resident #145 was discarded and replaced. A new order for Resident #145 was received on 3/2/2023 to discontinue the use of [redacted] as it was no longer needed by the resident. The [redacted] found lying on the table for Resident #36 was discarded and replaced on 3/8/2023. II. Residents identified having the potential to be affected and corrective action taken: Residents who receive [redacted] and/or [redacted] had the potential to be affected by this practice. III. Measures will be put into place to ensure the deficient practice will not recur: Licensed and Certified Nursing Staff were re-educated by the Assistant Director of Nursing/designee on the facility policy titled [redacted] and [redacted] Products for labeling and proper storage of [redacted] equipment. The Infection Prevention Nurse (IP)/designee will conduct monthly audits for the next six months on labeling and proper storage of [redacted] equipment. Any discrepancies noted will be corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 695	Continued From page 21 tape attached to the [redacted] revealing the date, [redacted]" A review of Resident #145's most current Minimum Data Set (an assessment tool) dated [redacted] revealed Resident #145 received [redacted] while a resident in the facility. A review of Resident #145's electronic medical record (EMR) revealed a physician's order for [redacted]) to keep [redacted] every shift for [redacted] in the [redacted] A review of Resident #145's Care Plan revealed a care plan for the potential for impaired [redacted] related to a diagnosis of [redacted], The Care Plan further revealed an intervention to provide [redacted] as ordered with an initiated date of [redacted] A review of Resident #145's "[redacted] Stats Summary" located in the EMR revealed documentation that Resident #145's [redacted] (amount of [redacted]) was measured while he/she received [redacted] on the following dates and times: 3/2/2023 at 06:54 (6:19 AM) 3/1/2023 at 18:34 (6:34 PM) 3/1/2023 at 06:19 (6:19 AM) 2/28/2023 at 19:09 (7:09 PM) 2/28/2023 at 17:10 (5:09 PM) On 3/7/2023 at 1:50 PM during an interview with Surveyor #1, the Director of Nursing (DON) replied, "In a bag" when asked how a [redacted] connected to a [redacted] should be	F 695	by the IP Nurse/designee at the point of service. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The IP Nurse will report the results of the monthly respiratory equipment audits and any corrective actions taken to the to the Quality Assessment and Assurance (QAA) Committee for the next two quarters. The QAA Committee will determine the need for any additional monitoring of this area after the 2nd quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 695	Continued From page 22	F 695		

stored. The DON further replied that a [redacted] should be replaced weekly or as needed. Lastly, the DON said she would expect it [redacted] to be stored according to policy when Surveyor #1 asked if the resident has not used the [redacted] recently, should it still be stored as the facility policy described.

A review of the facility policy titled, [redacted] and [redacted] Products Policy" revealed, "Ensure if [redacted] is not in use that it is in an [redacted] labeled with the resident's name and room # as well as the date it was changed, both the [redacted] and the [redacted] shall have a date when it is changed every 7 days." The policy further revealed, "11-7 is responsible for weekly changes to all [redacted] However it is the responsibility of both Nurse and CNA to ensure that the [redacted] and the [redacted] are clean, dated and the [redacted] is stored properly when not in use at all times."

B.) On 3/1/2023 at 9:14 AM, Surveyor #2 observed Resident #36 lying in bed with [redacted] in place [redacted] ([redacted] help). A [redacted]) and [redacted] and [redacted] were observed on the bedside table. The [redacted] was lying in contact with the table surface. The [redacted] was not covered and was exposed to contamination. Surveyor #2 asked the Resident #36 if they had had a treatment this morning. Resident #36 responded, "No." The surveyor then asked if the last [redacted] treatment was received the previous day. Resident #36 stated, "Yes."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 695	Continued From page 23	F 695		

According to the Admission record Resident #36 was admitted to the facility with diagnoses including but not limited to: [redacted] characterized by [redacted].

A review of the MDS, an assessment tool, dated [redacted] revealed that Resident #36 had a Brief Interview of Mental Status score of [redacted] indicating [redacted] According to [redacted] Resident #36 had active diagnoses of [redacted] indicated that Resident #36 had [redacted], when [redacted]. [redacted] of the MDS revealed that Resident #36 received [redacted] therapy.

According to the Order Summary Sheet with active orders as of: [redacted] Resident #36 had the following physician's orders: [redacted]

every [redacted] hours related to [redacted]

[redacted] ml

every [redacted] hours as needed for [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 695	Continued From page 24 A review of the [redacted] Medication Administration Record Resident #36 received [redacted] every [redacted] hours on the following dates: 0900 on 3/3, 3/4, 3/5, 3/6, 3/7, and 3/8/2023. Resident #36 also received [redacted] at 2100 (9 PM) on the following dates: 3/3, 3/4, 3/5, 3/6, and 3/7/203. According to Resident #36's current comprehensive care plan, Resident #36 had a care plan with a Focus of: Potential for [redacted] r/t (related to) recent Dx (diagnosis) of [redacted] with Hx (history) of [redacted] & Hx of [redacted] Revision on: [redacted]. Interventions/Tasks with revision date of [redacted] included: Administer medications as ordered. Monitor for effectiveness & for adverse reactions. On 3/7/2023 at 1:11 PM, Resident #36 was observed lying in bed with [redacted] in place [redacted]. The [redacted] was observed on the bed side table. Resident #36 stated that he/she had received a [redacted] r treatment this morning when asked by Surveyor #2. The [redacted] was lying on top of the bedside table and wedged between the lamp base and [redacted]. The [redacted] was not covered and was exposed. During an interview with Surveyor #2 on 3/7/2023 at 1:18 PM, Unit Manager/Licensed Practical	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 695	Continued From page 25	F 695		

Nurse (UM/LPN #1) was asked what the facility practice was for [redacted] was when not in use. UM/LPN #1 replied, "When the [redacted] is not in use it needs to be covered with a [redacted]

During an interview with Surveyor #2 on 3/7/2023 at 1:53 PM, the DON and Assistant Director of Nursing (ADON) were asked what the facility practice was for [redacted] when not in use. The DON and ADON responded, "The [redacted] should be stored in a [redacted] when not in use."

A review of the facility policy titled [redacted] and [redacted] Products, undated revealed the following under the heading Policy:

"It is the policy of [facility name] to ensure all [redacted] is Single use for a single resident, clean, properly stored, and dated to prevent the transmission of infection."

The following was revealed under the heading Procedure:

"Ensure if [redacted] is not in use that it is in an [redacted] labeled with the resident's name and room # as well as the date it was changed, both the [redacted] and the [redacted] shall have a date when it is changed every 7 days." The policy further revealed, "11-7 is responsible for weekly changes to all [redacted], However it is the responsibility of both Nurse and CNA to ensure that the [redacted] and the [redacted] are clean, dated and the [redacted] is stored properly when not in use at all times."

"All [redacted] and equipment shall be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 695	Continued From page 26 dated and stored in an [redacted] when not in use and replaced every 7 days as mentioned above." N.J.A.C. 8:39- 27.1 (a)	F 695		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 725	I. Corrective action(s)accomplished for	4/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 725	Continued From page 27 and document review, it was determined that the facility failed to provide sufficient nursing staff to ensure resident's highest practical wellbeing by failing to: a.) provide [redacted] care, b.) provide showers as scheduled, c.) assist resident with activities of daily living, d.) maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey. 1) During an interview with Surveyor #1 on 3/2/2023 at 9:51 AM, Certified Nursing Assistant (CNA #1) stated that staffing is not great now. CNA #1 stated that on average she has 15 residents in her care. CNA #1 added that if there on only 4 aides on the unit, residents will probably not get a shower. During an interview with Surveyor #1 on 3/2/2023 at 11:50 AM, CNA #2 stated that she can have between 10-15 residents in her care during the day and weekends are about the same. During an interview with Surveyor #1 on 3/2/2023 at 11:57 AM, the surveyor Resident # 18 stated that the day before he/she had to lay in his/her [redacted]. He/she added that a couple times he/she had to lay in his/her [redacted] During an interview with Surveyor #2 on 3/6/2023 at 11:03 AM, Resident #41 stated he/she wanted to get out of bed. The resident stated that no one had offered to get him/her out of bed. During a Resident Council Meeting on 3/2/2023 at 10:00 AM, 5 of 5 residents attending the meeting stated that the facility is short staffed. One of the 5 residents stated that a little while ago (unable to give specific timeframe), the staff explained to	F 725	resident(s)affected: " Resident #18 was assessed by a Registered Nurse for any physical, mental or psychological adverse effects related to lying in [redacted]. A [redacted] was performed, and the resident's [redacted] remains intact. " Resident #41 was assessed by a Registered Nurse for any physical, mental or psychological adverse effects related to not being able to get assistance to get out of bed. A [redacted] assessment was performed, and the resident's [redacted] remains intact and there is not a decrease in level of function. " Resident #43 was assessed by a Registered Nurse for any physical, mental, or psychological adverse effects related to staffing between 2/28/23-3/8/2023. II. Residents identified having the potential to be affected and corrective action taken: " The deficient practice has the potential to affect all residents residing in the facility. III. Measures will be put into place to ensure the deficient practice will not recur: " The facility currently has 4 Nursing Agency contracts. " Daily bonuses for the agency and in-house staff are offered for double shifts, extra shifts, weekend shifts and staff recognition. " Referral and sign-on bonuses are offered. " The call out Policy has been reviewed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 725	Continued From page 28 his/her roommate that they couldn't get him/her out of bed because it would take too long to get them back in bed and asked if he/she still wanted to get up. The roommate didn't mind if he/she had to wait to get back to bed since staff explained to him/her. During an interview with Surveyor #2 on 2/28/2023 at 10:09 AM, Resident #43 stated that staffing is a problem during the 3rd shift (11pm-7am). Resident #43 claimed that he/she had to call the cops to get service because nobody was around. During an interview with Surveyor #3 on 2/28/2023 at 10:03 AM, CNA #5 that stated that she usually has 20 residents on her assignment over the weekends. During an interview with Surveyor #3 on 3/2/2023 at 11:37 AM, CNA #5 was asked if the residents get showers on the days when it is short (staffed), she replied no. During an interview with Surveyor #3 on 3/3/2023 at 12:34 PM, CNA #5 stated that she had 12 residents on her assignment today. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021:	F 725	and the staff has been re-educated by the Assistant Director of Nursing (ADON)/designee on the call out policy. " Advertisement lawn signs are placed by the front of the building. " The facility is recruiting on multiple employment search engines and multiple social media platforms. " Depending on the needs of the day Nursing management to include Unit Managers, Supervisors and ADON will be evaluated to assist with resident care. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: " The Director of Nursing (DON)/Designee will conduct daily Certified Nursing Assistant (C.N.A.) staffing schedule audits for the next 6 months. " The DON/Designee will report audit findings to the Administrator. The Administrator/Designee will analyze, trend findings and report outcomes quarterly for 2 quarters to the Quality Assessment and Assurance (QAA) Committee, with follow-up recommendations, as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 725	Continued From page 29	F 725		

One Certified Nurse Aide (CNA) to every eight residents for the day shift.
One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and
One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.

The deficient practice was evidenced as follows:

The facility was deficient in CNA staffing for residents on 14 of 14-day shifts, deficient in total staff for residents on 2 of 14 evening shifts, deficient in CNAs to total staff on 7 of 14 evening shifts, and deficient in total staff for residents on 5 of 14 overnight shifts as follows:

-02/12/23 had 7 CNAs for 161 residents on the day shift, required 20 CNAs.
-02/12/23 had 13 total staff for 161 residents on the evening shift, required 16 total staff.
-02/12/23 had 5 CNAs to 13 total staff on the evening shift, required 7 CNAs.
-02/12/23 had 10 total staff for 161 residents on the overnight shift, required 11 total staff.
-02/13/23 had 13 CNAs for 161 residents on the day shift, required 20 CNAs.
-02/13/23 had 8 CNAs to 18 total staff on the evening shift, required 9 CNAs.
-02/14/23 had 15 CNAs for 161 residents on the day shift, required 20 CNAs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 725	Continued From page 30	F 725		

-02/14/23 had 10 total staff for 161 residents on the overnight shift, required 11 total staff.
-02/15/23 had 14 CNAs for 161 residents on the day shift, required 20 CNAs.
-02/16/23 had 12 CNAs for 161 residents on the day shift, required 20 CNAs.
-02/16/23 had 8 CNAs to 18 total staff on the evening shift, required 9 CNAs.
-02/17/23 had 16 CNAs for 161 residents on the day shift, required 20 CNAs.
-02/18/23 had 12 CNAs for 161 residents on the day shift, required 20 CNAs.
-02/18/23 had 9 total staff for 161 residents on the overnight shift, required 11 total staff.
-02/19/23 had 7 CNAs for 161 residents on the day shift, required 20 CNAs.
-02/19/23 had 8 CNAs to 19 total staff for 161 residents on the evening shift, required 9 CNAs.
-02/20/23 had 14 CNAs for 161 residents on the day shift, required 20 CNAs.
-02/20/23 had 8 total staff for 161 residents on the overnight shift, required 11 total staff.
-02/21/23 had 14 CNAs for 167 residents on the day shift, required 21 CNAs.
-02/21/23 had 16 total staff for 167 residents on the evening shift, required 17 total staff.
-02/21/23 had 7 CNAs to 16 total staff on the evening shift, required 8 CNAs.
-02/21/23 had 11 total staff for 167 residents on the overnight shift, required 12 total staff.
-02/22/23 had 16 CNAs for 164 residents on the day shift, required 20 CNAs.
-02/22/23 had 7 CNAs to 17 total staff on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 725	Continued From page 31	F 725		

the evening shift, required 8 CNAs.
-02/23/23 had 18 CNAs for 165 residents on the day shift, required 21 CNAs.
-02/24/23 had 15 CNAs for 164 residents on the day shift, required 20 CNAs.
-02/25/23 had 9 CNAs for 161 residents on the day shift, required 20 CNAs.
-02/25/23 had 8 CNAs to 19 total staff on the evening shift, required 9 CNAs.

During an interview with Surveyor #4 on 3/2/2023 at 11:09 AM, CNA #3 stated that she had 10 residents in her care on today. CNA #3 stated that she normally has between 15 to 20 residents a day. She added that, we just figure it out. When asked if the residents are affected by the lack staff, CNA #3 replied, absolutely!

During an interview with Surveyor #4 on 3/2/2023 at 9:44 AM, Unit Manager/Licensed Practice Nurse (UM/LPN #2) in the presence of the Assistant Unit Manager, stated to day they had 4 CNA's for 43 residents. UM/LPN#2 acknowledged that she was aware that they were not meeting the staffing requirements or their staffing policy. UM/LPN#2 added that during the day shift they rely on nurses, managers, guest services and therapy to assist with toileting, answering call bells, passing meal trays and activities of daily living.

During an interview with Surveyor #4 on 3/3/2023 at 11:44 AM, an unsampled resident stated that he/she doesn't get care in a timely manner, especially at night. The resident stated that he/she needs assistance to get up and out of bed. He/she added that on many occasions he/she has not made it in time to the bathroom and has soiled their pants. The resident stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 725	Continued From page 32	F 725		

that he/she requested incontinent briefs to avoid soiling his/her clothes; if I can get to the bathroom on time, I would be more continent. The resident also stated that he/she has not been offered a shower since his/her admission over 2 weeks ago, however, has been offered a bed bath 2 times that he/she refused. A review of the shower schedule revealed the resident was scheduled for showers during the 3p-11p shift on Wednesdays and Saturdays.

During an interview with Surveyor #4 on 3/6/2023 at 9:48 AM, UM/LPN#2 stated that each resident is scheduled for 2 showers a week. The surveyor asked UM/LPN #2 if they are able to do all the scheduled showers. The UM/LPN #2 replied that during the day, there is staff from other areas such as therapy that help with ADL's and showers. UM/LPN #2 stated that "the 3-11 shift scheduled showers are often hard to do because of staffing. During the evening shift, we do not have additional staff such as therapy to help us with showers. We will offer bed baths but many refuse. I try to offer those residents a shower the following day shift."

During an interview with Surveyor #4 on 3/7/2023 at 10:29 AM, the Staffing Director (SD) stated that she is aware that they are not meeting staffing mandates. She added that she is knowledgeable of the federal and state mandates. The residents are suffering, they should come first.

During an interview with Surveyor #4 on 3/7/2023 at 2:14 PM, the Director of Nursing (DON) acknowledged that the facility is short staffed. She she said she meets with the Staffing Director every day and there are days our efforts to fully staff are met. The DON went on to say then there

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 725	Continued From page 33	F 725		

are call outs, no shows from agencies. When the DON was asked if the facility was still accepting new admissions, the DON replied yes. When asked why they continue to accept admissions in light of their staffing issues, the DON asked to defer to the facility Administrator.

During an interview with the survey team on 3/8/2023 at 11:45 AM, the facility Licensed Nursing Home Administrator (LNHA) confirmed that the facility is still taking admissions. The LNHA stated that we do recognize the issue and the DON will tell me we need to curb admissions and we do, but we can't close up shop.

A review of a facility staffing policy with a revised date of 12/06/2022 titled "Staffing Policy and Procedures" indicated; "Certified nursing assistants will be available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care Plan and with the following ratios:

-One certified nurse aide to every eight residents for the day shift
-One direct care staff member to every ten residents for the evening shift, and each direct care staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties.
-One direct care staff member to every fourteen residents for the night shift provide that each direct care staff member shall be signed in to work as a certified nurse aide and perform certified nurse aide duties.

A review of the Facility Assessment dated October 2022, the Staffing Plan for Direct Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 725	Continued From page 34 Staff (Certified Nurse Aides), under "Plan," revealed the following; 7-8 Aides 1st and 3rd Long Term Care Days; 5-6 Aides Evenings; 3-4 Aides Nights, 5-6 Aides 2nd SMART Days and Evenings; 3 Aides Nights.	F 725		
F 812 SS=E	NJAC 8:39-5.1(a) 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 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following:	F 812	Corrective action(s)accomplished for resident(s)affected: The bag of opened pasta, dented can, frittata, and vegetables identified in the kitchen were immediately discarded. The Food Service Director (FSD) was immediately re-educated by the Infection	4/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 35 On 2/28/2023 from 9:26 AM to 9:46 AM, the surveyor, accompanied by the Food Service Director, observed the following in the kitchen: 1. On a middle rack in the dry storage room an opened bag of pasta was wrapped in plastic wrap. The plastic wrap and the original bag had no open or use by date. The FSD threw the bag of opened pasta in the trash. 2. On a multi-tiered, wheeled can storage rack in the dry storage room, a can of sauerkraut on a lower rack had a significant dent on the upper seam. When shown to the FSD they agreed that the dent was on the seam of the can. The FSD removed the dented can to the designated dented can area. 3. On an upper shelf of the meat walk-in refrigerator a half pan under the refrigeration unit contained diced carrots, onions, and peppers. The pan had no cover, and the diced vegetables were exposed to contamination. FSD removed to the trash in the presence of the surveyor. 4. On an upper shelf in the rear of the meat walk-in freezer, a half pan contained what was labeled as '[redacted] had a "use by date" of 2/24/2023. The FSD removed to the frittata to the trash in the presence of the surveyor. On 3/3/2023 at 8:33 AM, the surveyor, accompanied by the Unit Manager/Licensed Practical Nurse/ (UM/LPN #1), observed the following in the [redacted] floor nourishment room: 1. In an upper storage cabinet a plastic plate/tray	F 812	Preventionist (IP) regarding wearing a beard guard at all times while in the kitchen. The items identified in the 3rd floor nourishment room were immediately discarded. The freezer identified in the 3rd floor nourishment room was cleaned and sanitized by housekeeping on 3/8/2023. Residents identified having the potential to be affected and corrective action taken: Residents residing in the facility had the potential to be affected by the deficient practice. The Regional Food Service Director re-educated the Food Service Director regarding labeling, dating, food storage and the dented can policy. The Regional Food Service Director will re-educate the FSD again next quarter. The Director of Nursing (DON) re-educated the UM/LPN #1 regarding labeling, dating and food storage in the nourishment room. The DON re-educated the UM/LPN #1 regarding maintaining cleanliness of the nourishment room freezer. Measures will be put into place to ensure the deficient practice will not recur: The Food Service Director (FSD) re-educated Dietary staff regarding labeling, dating, food storage and the dented can policy. The management opening and closing check list was updated to reflect identified areas to ensure compliance. The IP/ Designee re-educated all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 36 had an opened bag of plantain chips. The bag was opened and exposed to the air. In the same cabinet a can of [redacted] chicken broth had a date of "AUG 21 2021." On the same shelf, a plastic bottle of [redacted] honey had a "best before date" of 05/31/2016. The honey was crystallized and hardened. 2. The nourishment room freezer was observed to have brown and pink unidentified residue/stains on the freezer bottom surface. In addition, a black, lengthy hair was also observed on the bottom surface of the freezer. Unidentified debris was observed on the bottom surface of the shelf on the freezer door. The surveyor observed "Refrigerator and Freezer Cleaning Schedule" for 2023 on the side of the refrigerator and it revealed that the refrigerator and freezer were scheduled to be cleaned on March 6, 13, 20 and 27th. 3. On a lower shelf of the nourishment room refrigerator, a container of [redacted] yogurt was labeled with a room number and first name of a resident. The container was dated "Nov 25 2022." UM/LPN#1, who was present at the time, stated, "I'm going to throw those away." The surveyor asked UM/LPN #1 who was responsible for cleaning the refrigerator and freezer in the nourishment room. UM/LPN #1 responded, "The 11-7 shift is responsible for maintaining and cleaning the refrigerator and freezer." UM/LPN #1 provided the surveyor with a copy of the February 2023 Refrigerator and Freezer Cleaning Schedule for the [redacted] Floor nourishment room. The schedule revealed that the refrigerator/ freezer was last cleaned on February 27th. UM/LPN #1 agreed that the freezer was not clean at present.	F 812	nursing staff regarding labeling, dating and food storage in the nourishment room. The infection control rounds sheet and kitchen check sheet was updated to include monitoring of staff wearing beard guards for appropraite use. Corrective actions will be monitored to ensure the deficient practice will not recur: FSD/Designee will report the findings from the opening and closing check lists logs to the administrator monthly for six months. FSD/designee will report trends to the QAA committee for the next two quarters to assure compliance. The IP will report findings from the audits of weekly infection control rounds to the Director of Nursing (DON). The DON will trend the audit findings and report outcomes to the Quality Assessment and Assurance (QAA) Committee quarterly for two quarters with follow-up recommendations as necessary. The QAA committee will determine the need for any additional monitoring of this area after the second quarter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 37 On 3/8/2023 at approximately 11:08 AM, the surveyor entered the kitchen to observe the cook take food temperatures prior to the lunch meal service. The surveyor observed that the FSD had a lengthy beard. The FSD had donned a surgical style mask but no beard guard. The areas of the FSD's beard not directly covered by the surgical mask were exposed. The surveyor reviewed the facility policy titled Storage Areas, undated. The following was revealed under the heading Procedure: 13. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food is used within 3 days or discarded. 14. Refrigerated Food Storage: f. All foods should be covered, labeled, and dated. All foods will be checked to assure that foods (including leftovers) will be consumed by their safe use dates, or frozen (where applicable) or discarded. 15. Frozen Foods: d. All foods should be covered, labeled, and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded. The surveyor reviewed the facility policy titled Care of Storeroom, undated. The following was revealed under the heading Procedure:	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 38 4. Dented cans will be removed from storage and placed in a designated area with a visible sign. These cans will be returned to vendor for reimbursement. The surveyor reviewed the facility policy titled [facility name] Cold Storage of Foods Brought by Family/Visitors, with reviewed date of 12/2022. The following were revealed under the heading Procedure: 1. All perishable foods brought into the facility by family members or visitors that require cold storage, will be labeled, and dated before placed in cold storage. 2. The Nursing Staff will label the perishable food with the name of the resident, and the date the food was brought to the facility. 6. The nursing staff will be responsible to monitor and log the pantry refrigerator temperatures as well as discard all expired food daily. N.J.A.C. 18:39-17.2(g)	F 812		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective	F 867		4/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 867	Continued From page 39	F 867		

systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 867	Continued From page 40	F 867		

implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).
Improvement projects must include at least

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 867	Continued From page 41 annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview, and review of other facility records, it was determined that the facility Quality Assessment and Performance Improvement (QAPI) committee failed to utilize the Facility Performance Improvement Plan to follow the facility process to measure and utilize data acquired for obtaining weights as ordered and develop quantitative and measurable goals, as well as document bi-weekly meeting minutes for the performance improvement project. This deficient practice was evidenced by the following: On 3/8/2023 at 8:59 AM, the surveyors conducted an interview with the Unit Manager/Licensed Practical Nurse (UM/LPN #1) assigned to the [redacted] floor of the facility. The surveyors asked UM/LPN	F 867	I. Corrective action(s)accomplished for resident(s)affected: There were no residents identified as being negatively affected by this practice. The Administrator re-educated the Director of Nursing on conducting and documenting a performance improvement project for Quality Assessment Performance Improvement (QAPI) utilizing the facility's electronic software. II. Residents identified having the potential to be affected and corrective action taken: All residents and staff had the potential to be affected by the deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 867	Continued From page 42 #1 if she was familiar with the QAPI for weight discrepancies on the unit. UM/LPN #1 told the surveyors, "Yes, I am aware that there is a QAPI for weights. It started with a few residents that had large discrepancies in weights. It was between me and the dietitian. The dietitian brought it to the Director of Nursing's (DON) attention, and we investigated a bit further to 1.) See how they were being weighed to ensure consistent practices each time and 2.) Maintenance was to recalibrate scales. The surveyors asked UM/LPN #1 if they had received any in-service training or competency evaluations related to the facility's weight policy and procedure. UM/LPN #1 stated that she couldn't remember any in-servicing, competencies, or review of the facility policy for weights. UM/LPN #1 told the surveyors, "I can't remember if any competencies were performed with the staff. The surveyors asked UM/LPN #1 if she had any documents that she was to fill out for the QAPI project related to weights. UM/LPN #1 explained, "I have no paperwork or data for the QAPI. We meet maybe bi-weekly, I'm not sure. I can't remember when we last met but it was probably in the end of January." The RD(Registered Dietician), DON, ADON (Assistant Director of Nursing), and I were present at the meeting (QAPI meeting). UM/LPN #1 further explained that she did not go to any QAPI meetings. The last time we met we decided that the QAPI plan was working because there were not as many large weight discrepancies with the residents that had previously had large weight discrepancies. We did not do it for the whole unit just the resident's that we determined to have large weight discrepancies. The QAPI was based on weight discrepancies, not failure to perform weights monthly.	F 867	III. Measures will be put into place to ensure the deficient practice will not recur: The Director of Nursing/designee re-educated staff on the basics of Quality Assurance Performance Improvement and the roles they may play in performance improvement projects (PIP) for the facility. The performance improvement project on weights was reviewed and updated to include a root cause analysis, updated appointed team members, measures and interventions, a summary of previous actions, new meeting minutes, and supporting documents. The QAPI team will conclude this performance improvement project for 3/2023. The Administrator will conduct monthly audits on current performance improvement projects to ensure that updates to PIPs are being made by the QAPI team utilizing the facility's software to guide the project. Any noted infractions will be rectified by the QAPI team assigned. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The Director of Nursing will report the outcome of the 3/2023 concluded performance improvement project on weights to the Quality Assessment and Assurance (QAA) Committee at the April 2023 quarterly meeting (First Quarter). The Administrator will report findings from the monthly PIP audits to the Quality Assessment and Assurance (QAA) Committee for the next two quarters. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 867	Continued From page 43 On 3/8/2023 the surveyor reviewed the facility provided Performance Improvement Project (PIP) titled OBTAINING WEIGHTS AS ORDERED. The PIP had no initiation date and had an identified target end date for the PIP of 31-Mar-2023. The overall stated goal of the PIP was indicated as, "The goal of the PIP is for Nursing staff on the [redacted] floor LTC (long-term care) unit to obtain weights as per the physician order in a timely and accurate manner. Documentation of the weights shall be recorded by nursing staff." The PIP also identified that the team consisted of the facility Director of Nursing (DON) as the recorder, the Assistant Director of Nursing as a participant, UM/LPN #1 as the unit manager, and the dietitian. A further review of the OBTAINING WEIGHTS AS ORDERED PIP provided by the DON revealed that there was no documentation summarizing the findings of the Root Cause Analysis (a method of problem solving used for identifying the root causes of faults or problems). In addition, there was no documentation for measures, interventions, meeting minutes, supporting documents, and conclusions. On 3/8/2023 at 10:49 AM, the surveyor conducted an interview with the facility DON, who was also assigned as the "recorder" for the OBTAIN WEIGHTS AS ORDERED PIP. The surveyor asked the DON if she had determined a root cause analysis for the PIP. The DON responded, "I did. This was a tough one. We had another unit manager on the [redacted] floor. I did not put all the information in there. I suspect that some residents were not having their weights done monthly. I did not put in the root cause analysis. I	F 867	QAA Committee will determine the need for any additional monitoring of this area after the 2nd quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 867	Continued From page 44	F 867		

do not have any of that written down, I admit I'm a bad documenter." The surveyor asked the DON if any competencies or in-services had been conducted with the [redacted] floor nursing staff concerning weights. The DON explained that we watched them (the Certified Nursing Assistants/CNA) randomly weigh residents. We also asked the maintenance department to calibrate the scales and we asked the CNA staff to ensure that they use the same scale for every weight. There was no formal in-service. I am a poor documenter; I agree but we did do what I said I did. The DON further explained we have watched them. All the in-servicing was done informally but it was done. The surveyor asked the DON if she could provide any data from the PIP that was analyzed to assess whether the PIP was effective or not. The DON stated, I cannot present you any data that would show that. I didn't write anything down. I don't have any written results."

The surveyor reviewed the facility Quality Assurance and Performance Improvement Plan, dated[redacted]. The following was revealed under the heading Statements and Guiding Principles:

"[facility name] makes QAPI decisions based on data gathered from the input and experience of our caregivers, residents, health care practitioners, families, and other stakeholders."

The QAPI also revealed the following under the heading Addressing Care and Services: "The QAPI program will aim for safety and high quality with all clinical interventions and service delivery while emphasizing autonomy, choice, and quality of daily life for residents and family ensuring our data collection tools and monitoring systems are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 867	Continued From page 45 in place and are consistent for proactive analysis, system failure analysis, and corrective action. We will utilize the best available evidence e.g. data, national benchmarks, published best practices, clinical guidelines) to define and measure our goals. In addition, the QAPI further reveals the following under Direction of QAPI Activities: 2) Coordinating and evaluating QAPI program activities 3) Developing and implementing appropriate plans of action to correct identified quality deficiencies 4) Regularly reviewing and analyzing data collected under the QAPI program and data resulting from drug regimen review and acting on available data to make improvements. 6) Analyzing the QAPI program performance to identify and follow up on areas of concern and/or opportunities for improvement. N.J.A.C. 8:39--33.1(a), 33.2(b), 33.2(d)	F 867		
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:	F 880		4/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 46 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a 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.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 47 §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 and record review and review of other facility documentation, it was determined that the facility failed to ensure that visitors and contracted agents who provided services to residents were familiar and adhered to infection practice guidelines according to the facility's policy and Center for Disease Control (CDC). This deficient practice was identified as evidenced by the following: On 2/28/2023 at 12:01 PM, the surveyor observed a visitor dressed in street clothes, enter, and exit a resident room that was on isolation for [redacted] without the required Personal Protective Equipment (PPE). The visitor stated she did not have physical contact with the resident. The surveyor pointed out signage posted on the door that read: "STOP!! Special [redacted] Precautions in addition to Standard Precautions; only essential personnel should enter this room. If you have questions, ask nursing staff. Everyone Must: Including visitors, doctors, and staff: clean hands when entering and leaving room. Wear face mask. Wear eye	F 880	I. Corrective action(s)accomplished for resident(s)affected: " The identified volunteer and contracted lab technician were educated by The Infection Preventionist (IP) regarding entering isolation rooms, following signage, and donning proper personal protective equipment. II. Residents identified having the potential to be affected and corrective action taken: " All residents on transmission-based precaution have the potential to be affected by this deficient practice. III. Measures will be put into place to ensure the deficient practice will not recur: " Infection Control Preventionist was re-educated by the Director of Nursing (DON) regarding performing routine surveillance audits on volunteers and contracted vendors. " A new Infection Prevention Observation audit tool will be utilized to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 48 protection (face shield or goggles). Gown and glove at door." The visitor then replied, "So if a curtain is pulled does that mean that I cannot go in? The surveyor advised the visitor to check with staff. On 3/3/2023 at 8:45 AM, the surveyor, while interviewing a resident who was on droplet/contact precautions for [redacted] observed a contracted Lab Technician enter the resident's room and announced that she had to draw blood. The lab tech did not have on the required PPE. The lab tech placed her bag on the resident's chair and donned blue gloves. The surveyor said that the resident is on isolation for [redacted] and that full PPE was required. The lab technician said she didn't know and then exited the room. The surveyor pointed out the isolation signage displayed on the resident's door. Unit Manager/Licensed Practical Nurse (UM/LPN #2) was outside the room at that time and the surveyor reported the incident to the UM/LPN #2. On 3/7/2023 at 11:25 AM, the surveyor interviewed the Infection Preventionist (IP) that stated that the expectation for anyone entering an isolation room is to wear the required PPE as identified by signage on the door. She added that anyone entering and exiting a resident's room is required to perform hand hygiene and to don (put on) and doff (take off) PPE as required. The IP stated that it is the responsibility of herself and all staff members to monitor for compliance. On 3/7/2023 at 2:04 PM, during a meeting with the survey team, the Director of Nursing (DON), stated that the required PPE for [redacted] isolation rooms is a N95 mask, eye shield, gown, and gloves. The DON added that the facility	F 880	perform surveillance rounds on volunteers and contracted vendors to ensure they are adhering to infection practice guidelines. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: " The Infection Control Preventionist/ Designee will conduct weekly Infection Prevention rounds on volunteers and contracted vendors to track and trend infection surveillance on going. " The Infection Control Preventionist / Designee will formulate recommendations regarding infection control activities based on weekly surveillance rounds and data analysis and report outcomes to the Director of Nursing (DON) weekly for four weeks, with follow up actions as necessary. " The DON will trend the audits findings and report outcomes to the Quality Assessment and Assurance (QAA) Committee quarterly for two quarters with follow-up recommendations as necessary. The QAA committee will determine the need for any additional monitoring of this area after the 2nd quarter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 49 policy states that everyone going into a [redacted] room is to wear the full PPE regardless of their reason for visiting. The surveyor discussed the two observations of a volunteer and contracted lab technician entering isolation rooms without donning the proper PPE. The DON stated, "That should not have happened." On review of an undated facility policy titled, "Managing Admissions and Residents who leave the Facilities, under PPE requirements; "Staff who enter the room of a resident/patient with suspected or confirmed [redacted] infection, will adhere to standard precautions and use a [redacted] or higher, gown, gloves, and eye protection (i.e. goggles or a face shield that covers the front and sides of the face). NJAC 8:39-19.4(a)	F 880		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
018254 Y1	A. Building B. Wing Y2	4/25/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

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 04/18/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	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 3/8/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			