STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315266	A. BUILDING ______ B. WING ______	C 11/05/2021

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PARK CRESCENT HEALTHCARE & REHABILITATION CENTER	**480 PARKWAY DRIVE EAST ORANGE, NJ 07017**

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F 000	INITIAL COMMENTS Standard Survey: 11/5/21 Census: 169 Sample Size: 38 C/O #NJ00148968, NJ001143237 The facility is 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 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.	F 583		12/15/21

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 11/24/2021

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

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F 583	Continued From page 1 §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview it was determined that the facility failed to provide visual privacy for a resident during a EX Order 26 § 4 treatment. The deficient practice was observed for 1 resident, #61, of 30 reviewed and was evidenced by the following: The surveyor reviewed the medical record of Resident #61 which revealed the following: The 10/7/21 quarterly Minimum Data Set (MDS) assessment tool indicated the resident had long and short-term EX Order 26 § 4b1 and EX Order 26 § 4b1 for decision making. Resident #61 was noted to have EX Order 26 § 4b1 in a care plan initiated and revised . The surveyor observed the Licensed Practical Nurse (LPN) perform EX Order 26 § 4 treatments to the resident's EX Order 26 § 4b1 on at 10:35 AM. The LPN was assisted at the bedside by the Registered Nurse Unit Manager (RNUM).	F 583	F583 D 1. Corrective action(s)accomplished for resident(s)affected: The identified nurse for resident #61 was re-educated to provide full visual privacy for the resident during EX Order 26 § 4 treatment. 2. Residents identified having the potential to be affected and corrective action taken: Residents residing in the facility have the potential to be affected by this deficient practice. Licensed Nurses were re-educated by the Assistant Director of Nursing (ADON) /Designee regarding providing full visual privacy for the residents during EX Order 26 § treatment. 3. Measures will be put into place to ensure the deficient practice will not recur: The ADON/Designee will perform EX Order 26 § 4 treatment observation audits. The facility policy for EX Order 26 § 4b Treatment was updated and revised to address	

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F 583	Continued From page 2 After entering the resident's room to begin the treatment, the LPN did not close the door to the bedroom. The privacy curtain was pulled closed. The RNUM assisted the LPN with turning and positioning the resident during the treatments. As the resident was prepared for the beginning of the treatment, the LPN removed the sheet and blanket covering the resident and lifted the resident's EX Order 26 §. The resident's EX Order 26 § 4b1 was opened exposing the resident's EX Order 26 § 4b1. The resident remained exposed from the EX Order 26 § 4b [redacted] for the duration of the two treatments. The resident was [redacted] when the LPN left the bedside to perform handwashing. The surveyor spoke with the LPN after the treatments were completed at 10:55 AM. The LPN confirmed the resident should have [redacted] [redacted] for privacy. The surveyor spoke with the Administrator and the Director of Nursing (DON) regarding the privacy concerns on 10/28/21 at 1:00 PM. The DON stated staff are frequently educated on preserving the residents' privacy. A review of the facility policy for EX Order 26 § 4 treatments, updated 7/2017 and revised 10/2021, and the EX Order 26 § 4 treatment competency, updated 7/2017, failed to address preserving the resident's privacy during the treatment. A facility policy addressing resident privacy was not provided to the surveyor. NJAC 8:39-4.1(a)16.	F 583	preserving the resident□s privacy during EX Order 26 § treatment. 4. Corrective actions will be monitored to ensure the deficient practice will not recur: The ADON/designee will conduct a weekly observational audit times 4 weeks and then monthly times 3 months noting if full visual privacy was provided during EX Order 26 § 4 treatment. Discrepancies will be reported to the DON with follow up actions as necessary. The Director of Nursing (DON) will analyze and trend audit findings and report outcomes to the QA Committee quarterly for recommendations as necessary.	

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F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to follow a physician's order to monitor the blood level of a drug the resident was receiving. This was found with 1 of 33 residents reviewed, Resident # 155. Reference: New Jersey Statues, Annotated Title 45, Chapter. Nursing Board The Nurse Practice Act for the State of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well being, and executing a medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities with in the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a	F 658	F658 D 1. Corrective action(s)accomplished for resident(s)affected: The identified Licensed Nurses were re-educated on following physician orders. Resident #155 had no negative outcomes related to not monitoring the blood level of a drug. The MD was notified and a stat Keppra level was ordered. The results were within normal limits. 2. Residents identified having the potential to be affected and corrective action taken: Residents currently residing in the facility have the potential to be affected by this deficient practice. Residents with laboratory orders were reviewed by the Unit Managers to validate that the physician order is being followed. 3. Measures will be put into place to ensure the deficient practice will not recur: Licensed Nurses were re-educated by the Assistant Director of Nursing (ADON) regarding Following Physician Orders and Principles of Documentation. NEW PROCESS: Conduct monthly recapitulation review at the first of each	12/15/21

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F 658	Continued From page 4 registered nurse or licensed or otherwise legally authorized physician or dentist." The deficient practice was evidenced by the following: On 10/27/21 at 9:30 AM, the surveyor observed Resident # 155 in the resident's room in the resident's bed. The resident was EX Order [redacted]. The surveyor reviewed the electronic medical record (EMR) of Resident # 155 which revealed the following: A physician's order dated 4/19/19 on the Physician's order sheet (POS) that read: 'EX Order 26 § 4b1 [redacted] A Physician's Order on the POS that read 'EX Order 26 § 4 [redacted] A Quarterly Minimum Data Set Assessment an assessment tool dated [redacted], indicated that the resident was rarely/never understood and rarely/never understands. The assessment also indicated that the resident had a EX Order 26 § 4b1 [redacted]. On 10/27/21 at 10:00 AM, the surveyor asked the Licensed Practical Nurse (LPN) if she could find a EX Order 26 § 4b1 that was done for Resident #155. The LPN looked in the EMR and said she was unable to find one and that she would ask the Unit Manager/Registered Nurse UM/RN.	F 658	month on all drugs that need blood level monitoring and follow physician orders as prescribed. 4.Corrective actions will be monitored to ensure the deficient practice will not recur: Unit Mangers will conduct a weekly audit times 4 weeks, then monthly times 3 months to validate that physician laboratory orders were carried out and documented as ordered. Discrepancies will be reported to the Director of Nursing (DON) with follow up actions as necessary. The DON/designee will analyze and trend physician laboratory orders audit findings and report outcomes to the QA Committee quarterly, for recommendations as necessary.	

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F 658	Continued From page 5 On 10/27/21 at 12:30 PM, the surveyor asked the UM/RN for the EX Order 26 § 4b1. The UM/RN said she reached out to the Pharmacy Consultant to see how often the facility should have done a EX Order 26 § 4b and she would have an answer after she spoke to them. At that time the surveyor saw an order on the POS that read "EX Order 26 § 4b1." The start date for the stat order was [redacted] at 10:08 AM. On 10/27/21 at 12:37 PM, the UM/RN gave literature to the surveyor that she said she received from the Pharmacy Consultant. The literature said the EX Order 26 § 4b1 were not necessary. The surveyor reviewed the Physician's Order with the UM/RN for the EX Order 26 § 4b1 to be done every 90 days. The UM/RN said "EX Order 26 [redacted]." I will call the doctor. On 10/29/21 at 9:55 AM, the surveyor spoke with the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) about the concern with the Physician's Order for the EX Order 26 § 4b every 90 days not being followed. The DON and the LNHA agreed that the nurse should have followed the order until the order was discontinued. NJAC 8:39-27.1 (a)	F 658		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the	F 698		12/15/21

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F 698	Continued From page 6 comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to provide a.) resident assessment and monitoring upon return from EX Order 26 § 4b1 for Resident #58 and b.) failed to schedule medications according to EX Order 26 § 4b days for Resident #101, 2 of 3 residents reviewed for EX Order 26 § 4b1 . This deficient practice was evidenced by the following: 1. The surveyor observed Resident #58 on 10/22/21 at 8:50 AM seated on the side of the bed eating breakfast. The resident refused to be interviewed. A review of the resident's electronic medical record (EMR) revealed the following: The Admission Record included the diagnoses of EX Order 26 § 4b1 and dependence upon EX Order 26 § 4b1 . The 10/7/21 quarterly Minimum Data Set assessment tool (MDS) indicated that the resident was EX Order 26 § 4b1 . The care plan for EX Order 26 § 4b1 and dependence upon [redacted] included interventions instructing nursing staff to monitor the EX Order 26 § 4b1 for EX Order 26 § 4b1 every shift, to monitor the site for signs and symptoms of EX Order 26 § 4b1 , and if observed to contact the doctor. (EX Order 26 § 4b1	F 698	F698 D 1. Corrective action(s)accomplished for resident(s)affected: Resident #101□s attending Physician was notified and the medications were scheduled according to EX Order 26 § 4b times. Resident #58 was immediately had a physical assessment to include assessment of the EX Order 26 § 4b1 . 2. Residents identified having the potential to be affected and corrective action taken: All residents receiving EX Order 26 § 4b have the potential to be affected by this deficient practice. 3. Measures will be put into place to ensure the deficient practice will not recur: All Medication Administrator Records (MAR) and Treatment Administration Records (TAR)were audited on all residents receiving EX Order 26 § 4b to ensure the medications and treatments were ordered according to the EX Order 26 § 4b schedule. Licensed nurses were re-educated by the Assistant Director of Nursing (ADON)/designee regarding resident assessment and monitoring post EX Order 26 § 4b . Licensed nurses were re-educated by the Assistant Director of Nursing (ADON)/designee regarding medications must be scheduled according to EX Order 26 § 4b times. A new EX Order 26 § 4b form has been	

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F 698	Continued From page 7 EX Order 26 § 4b1 .) The care plan was last revised . The care plan included no interventions to include an assessment of the resident upon return from EX Order 26 § 4b . A review of the nursing Progress Notes from the period of revealed no assessment or monitoring of the resident upon return from EX Order 26 § 4b and no documentation of EX Order 2 or thrill of the EX Order on 9 of the 11 times that the resident returned from EX Order 26 § 4b . The surveyor discussed the above concerns with the Director of Nursing (DON) and the Administrator on 10/28/21 at 12:52 PM. The DON stated that she would expect to see an assessment when a resident returned from EX Order 26 § 4b . A review of the 1/2021 facility policy titled, "Care of a Resident Receiving EX Order 26 § 4b1 " revealed that after EX Order 26 § 4b1 nurses should observe for and report indicators EX Order 26 § 4b1 EX Order 26 § 4b1 2. The surveyor observed and interviewed Resident #101 on 10/25/21 at 9:26 AM. The resident was awake in bed. The resident stated he/she goes to a EX Order 26 § 4b clinic for treatments on , leaving the building at 2:00 PM and returning between 7:00 and 7:30 PM. The resident stated he/she received medication upon returning from EX Order 26 § 4b . A review of the EMR revealed the following:	F 698	implemented to include post EX Order 26 § 4b assessment and monitoring of the resident upon return from EX Order 26 § 4b and document. The Pharmacist Consultant will resume monthly inspections. 4. Corrective actions will be monitored to ensure the deficient practice will not recur: Assistant Director of Nursing (ADON), or designee, will perform MAR and TAR audits on residents receiving EX Order 26 § 4b weekly times 4 weeks then monthly times 3 months to ensure medications are scheduled according to EX Order 26 § 4b schedules. The results of the MAR and TAR audits and follow up actions taken will be presented at the Quality Assurance Committee meeting quarterly.	

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F 698	Continued From page 8 The Admission Record indicated the resident was admitted with diagnoses including but not limited to EX Order 26 § 4b1 . The admission MDS assessed the resident to have no (evidenced by a BIMS score of a EX Or on a scale of EX to . The Clinical Physician Orders (CPO) included an order for EX Order 26 § 4b every EX Order 26 § 4b1 . Three of the medications listed in the Medication Administration Record (MAR) were scheduled to be administered at a time when the resident would be out of the facility at the EX Order 26 § 4b clinic. They were as follows: EX Order 26 § 4b1 The Licensed Practical Nurse (LPN) documented in a Nurses Note that the resident returned to the facility from the EX Order 26 § 4b1 clinic at 7:20 PM. (The surveyor was unable to reach the LPN for a telephone interview.) The Unit Manager confirmed during a interview that the resident returns to the facility between EX Order 26 § 4b1 and EX Order 26 § 4b1 on EX Order 26 § 4b days. The EX Order 26 § 4b communication sheet (a form which travels with the resident to and from the EX Order 26 § 4b EX Order 26 with pertinent nursing and medical documentation) was signed by the LPN to indicate she received the resident back from the EX Order 26 § 4b1 on EX Order 26 § 4b1 .	F 698		

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F 698	Continued From page 9 The consultant pharmacist's (CP) monthly medication review (MMR) report dated 8/4/21 instructed the facility to "adjust meds for EX Order 26 § 4b . . ." The surveyor reviewed the medication administration concerns with the Administrator and Director of Nursing (DON) on 10/29/21 at 10:00 AM. The DON provided the surveyor with policies addressing the CP monthly report and residents receiving EX Order 26 § 4b. The CP monthly report policy, reviewed 1/2021, included the following directive. A detailed report "will be set to the attention of the Director of Nursing, Administrator, and Medical Director. The Director of Nursing should review the entire report and assign someone to follow up on the findings in a timely manner . . . The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any action has been taken to address it." The policy entitled Care of a Resident Receiving EX Order 26 § 4b, reviewed [redacted], directed nursing staff to ensure "all medications and treatments will be scheduled according to EX Order 26 § 4b times." NJAC 8:39-27.1(a)	F 698		
F 711 SS=B	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program	F 711		12/15/21

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F 711	Continued From page 10 of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that the residents primary physician sign and date monthly physician orders to ensure that the residents current medical regimen was appropriate. This deficient practice was observed for 21 of 36 residents (Resident #79, #7, #37, #42, #83, #54, #73, #95, #114, #101, # 157, #57, #58, #60, #130, #9, #65, #69, #124, #362 and #116) reviewed and evidenced by the following: 1. The surveyor reviewed the Physician Orders (PO) for resident #79 which revealed that the physician did not sign and date the monthly PO for the month of [redacted]. 2. The surveyor reviewed the PO for resident #7 which revealed that the physician did not sign and date the monthly PO for the months of [redacted] 3. The surveyor reviewed the PO for resident #37 which revealed that the physician did not sign and date the monthly PO for the month of March	F 711	F711B 1. Corrective action(s)accomplished for resident(s)affected: Resident # 79, #7, #37, #42, #83, #54, #73, #95, # 114, #101, #157, #57, #58, #60, #130, #9, #65, # 69, #124, #362 and #116. Physician's orders have been signed and dated. 2. Residents identified having the potential to be affected and corrective action taken: All Residents residing in the facility have the potential to be affected by this deficient practice. Attending Physicians have been re-educated regarding physician visits to include signing and dating monthly physician orders. 3. Measures will be put into place to ensure the deficient practice will not recur: A copy of the facility□s Physician Visit Policy and Procedure has been sent to all	

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F 711	Continued From page 11 202. 4. The surveyor reviewed the PO for resident #42 which revealed that the physician did not sign and date the monthly PO for the month of March 202. 5. The surveyor reviewed the PO for resident #83 which revealed that the physician did not sign and date the monthly PO for the months of . 6. The surveyor reviewed the Physician Orders (PO) for resident #54 which revealed that the physician did not sign and date the monthly PO for the months of 7. The surveyor reviewed the PO for Resident #73 which revealed that the physician did not sign and date the monthly PO for the months . 8. The surveyor reviewed the PO for Resident #95 which revealed that the physician did not sign and date the monthly PO for the months of . 9. The surveyor reviewed the PO for Resident #114 which revealed that the physician did not sign and date the monthly PO for the months of 10. The surveyor reviewed the PO for resident #157 which revealed that the physician did not sign and date the monthly PO for the months of . 11. The surveyor reviewed the PO for resident	F 711	attending Physicians. Attending Physicians have been re-educated regarding the process for signing orders in the Electronic Health Record. 4. Corrective actions will be monitored to ensure the deficient practice will not recur: Director of Nursing (DON) or designee will audit the monthly physician orders for 4 months for all residents to ensure compliance. The results of those audits will be reviewed by facility QAPI meeting held quarterly.	

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F 711	Continued From page 12 #101 which revealed that the physician did not sign and date the monthly PO for the months of [redacted] 12. The surveyor reviewed the PO for resident #57 which revealed that the physician did not sign and date the monthly PO for the months of [redacted]. 13. The surveyor reviewed the PO for resident #58 which revealed that the physician did not sign and date the monthly PO for the months of [redacted] 14. The surveyor reviewed the PO for resident #60 which revealed that the physician did not sign and date the monthly PO for the months of [redacted]. 15. The surveyor reviewed the PO for resident #130 which revealed that the physician did not sign and date the monthly PO for the months of [redacted] 16. The surveyor reviewed the PO for resident #9 which revealed that the physician did not sign and date the monthly PO for the months of [redacted], [redacted]. 17. The surveyor reviewed the PO for resident #362 which revealed that the physician did not sign and date the monthly PO for the months of [redacted].	F 711		

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F 711	Continued From page 13 18. The surveyor reviewed the PO for resident #124 which revealed that the physician did not sign and date the monthly PO for the months of [redacted]. 19. The surveyor reviewed the PO for resident #65 which revealed that the physician did not sign and date the monthly PO for the months of [redacted] 20. The surveyor reviewed the PO for resident #69 which revealed that the physician did not sign and date the monthly PO for the months of [redacted] 21. The surveyor reviewed the PO for resident # 116 which revealed that the physician did not sign and date the monthly PO for the months of [redacted] On 10/28/21 at 12:30 PM, the surveyor discussed the concerns with Administrator and Director of Nursing who stated that the facility's policy is that the Physician should sign the orders monthly. The surveyor reviewed the facility's policy titled, "Physician Orders" dated January 2021. The policy indicated that the physician must sign and date all orders." NJAC 8:39-23.2 (b)	F 711		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident	F 756		12/15/21

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F 756	Continued From page 14 must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to respond and	F 756	F756 D	

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F 756	Continued From page 15 act upon a recommendation from the consultant pharmacist for 1 resident, Resident #101, of 33 reviewed. The deficient practice was evidenced by the following: A review of Resident #101's electronic medical record revealed the following: The [redacted] Clinical Physician Orders (CPO) included an order for EX Order 26 § 4b every [redacted] with a pickup time from the facility at 2:00 PM. Three of the medications listed in the [redacted] Medication Administration Record (MAR) were scheduled to be administered at a time when the resident would be out of the facility at the EX Order 26 § 4b clinic. They were as follows: EX Order 26 § 4b1 [redacted] scheduled for 5:00 PM; EX Order 26 § 4b1 [redacted]. Nursing documented administering the medications on EX Order 26 § 4b days when the resident was out of the building at the times the medications were scheduled to be administered. The nursing documentation did not indicate that the medications were held (not administered) on those days when the resident was not present at the scheduled times. The unit Licensed Practical Nurse (LPN) documented in a 10/27/21 Nurses Note that the resident returned to the facility from the EX Order 26 § 4b clinic at 7:20 PM. (The surveyor was unable to reach the LPN for a telephone interview.) The Unit Manager confirmed during a 10/27/21 interview that the resident returned to the facility between 7:15 PM and 7:30 PM on EX Order 26 § 4b days. The EX Order 26 § 4b communication sheet (a form which	F 756	1. Corrective action(s)accomplished for resident(s)affected: Resident #101's attending Physician was notified of the recommendations and the medications were scheduled according to EX Order 26 § 4b times. 2. Residents identified having the potential to be affected and corrective action taken: Residents administered medications have the potential to be affected. Monthly Medication Regimen Reviews were reviewed by the Unit Managers to validate that there is evidence of written follow up by the Physician on recommendations made by the Consultant Pharmacist. 3. Measures will be put into place to ensure the deficient practice will not recur: The Director of Nursing (DON) re-educated the Unit Managers on the system to assure that medication usage is evaluated monthly by the Consultant Pharmacist, and that that risks, and problems identified are acted upon by the Physician. 4. Corrective actions will be monitored to ensure the deficient practice will not recur: The Consultant Pharmacist will review monthly Medication Regimen Review findings with the Administrator and DON. The DON will review Consultant Pharmacists Medication Regimen Reviews and Physician responses monthly with Unit Managers, to validate when the Medication Regimen Review recommendations require Physician	

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F 756	Continued From page 16 travels with the resident to and from the EX Order 26 § 4b EX Order 26 with pertinent nursing and medical documentation) was signed by the LPN to indicate she received the resident back from the EX Order 26 § 4b clinic on 10/27/21 at 7:20 PM. The consultant pharmacist's (CP) monthly medication review (MMR) report dated 8/4/21 instructed the facility to "adjust meds for EX Order 26 § 4b . . . " The surveyor interviewed the CP on 10/28/21 at 9:39 AM. She stated she routinely compared the CPO to the MAR looking for medications which were held because the resident was out of the building. She stated she would then make a recommendation to adjust the time of medication administration to coincide with when the resident is present in the building (not scheduled for EX Order 26 § 4b1 The CP again spoke to the surveyor on 10/28/21 at 11:52 AM. She stated that since she is not familiar with when the resident returned to the facility from EX Order 26 § 4b she did not recognize that the resident was out at EX Order 26 § 4b at the time some medications were plotted for administration. She further stated she spoke with Nursing and recommended they contact the resident's doctor to change medication administration times on EX Order 26 § 4b days. The surveyor reviewed the medication administration concerns with the Administrator and Director of Nursing (DON) on 10/29/21 at 10:00 AM. The DON provided the surveyor with policies addressing the CP monthly report and residents receiving EX Order 26 § 4b.	F 756	intervention, that the Physician accepts and acts upon the suggestion or rejects and provides a clinically valid rationale for rejecting the pharmacist's recommendation(s) documenting why the benefit of the medication(s) or dose(s) outweighed the risks of the adverse consequences The DON will report Medication Regimen Review recommendations without comprehensive Physician response to the Administrator and Medical Director, with follow up actions as necessary. The Consultant Pharmacist will trend findings from the Medication Regimen Review audits and report outcomes to the QA Committee quarterly. The DON will trend findings from monthly audits of Physician follow up to the Consultant Pharmacist Medication Regimen Review recommendation(s) and report outcomes to the QA Committee quarterly.	

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F 756	Continued From page 17 The CP monthly report policy, reviewed 1/2021, included the following directive. A detailed report "will be set to the attention of the Director of Nursing, Administrator, and Medical Director. The Director of Nursing should review the entire report and assign someone to follow up on the findings in a timely manner . . . The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any action has been taken to address it." The policy entitled Care of a Resident Receiving Dialysis, reviewed 1/2021, directed nursing staff to ensure "all medications and treatments will be scheduled according to dialysis times." NJAC 8:39-29.3	F 756		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761		12/15/21

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F 761	Continued From page 18 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to store unopened medications appropriately during and inspection of the medication cart. This deficient practice was observed in 1 of 7 medication carts inspected. The deficient practice was evidenced by the following: 1. On 10/22/21 at 10:26 AM, the surveyor inspected the even side south medication cart in the presence of the Licensed Practical Nurse (LPN). The surveyor observed an unopened bottle of [EX Order 26 § 4b] eye drops in the top drawer of the medication cart. The manufacturer specifications indicated that the eye drops should be refrigerated until opened. The LPN stated that the medication came here with a resident from the hospital, and it should have been discarded. The LPN further stated that since it was in the medication cart and it was unopened, it should have been in the refrigerator for proper storage. The surveyor reviewed the facility's policy titled, "Medication Storage" dated January 2021. The policy indicated that medications requiring refrigeration will be stored in a refrigerator that is maintained between 36 to 46 degrees F.	F 761	F761 D 1. Corrective action(s)accomplished for resident(s)affected: The unopened eye drops were immediately removed from the identified cart and discarded. 2. Residents identified having the potential to be affected and corrective action taken: All residents have the potential to be affected by this deficient practice. 3. Measures will be put into place to ensure the deficient practice will not recur: All medication carts were audited to ensure unopened medications were stored properly and none were found in any other carts. Licensed nurses were re-educated by the Director of Nursing (DON) on the importance of checking all items in the medication cart for proper storage and refrigeration if required. Nurse will check the medication carts daily to identify and remove any unopened medications that are not stored properly and/or require refrigeration. Upon orientation, and periodically	

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F 761	Continued From page 19 On 10/22/21 at 1:14 PM, the surveyor discussed the above concerns with the facility Administrator and Director of Nursing. NJAC 8:39- 29.4(b)2	F 761	thereafter, nurses will be in-serviced on the importance of proper storage of unopened medication. 5. Corrective actions will be monitored to ensure the deficient practice will not recur: Assistant Director of Nursing (ADON), or designee, will perform medication cart audits weekly times 4 weeks then monthly times 3 months. The Pharmacist Consultant will resume monthly inspections. The Pharmacist Consultant will include in the monthly report any identification of improperly stored unopened medications. Results of the audits will be reviewed by the Director of Nursing and Administrator. The results of the monthly inspections and follow up actions taken will be presented at the Quality Assurance Committee meeting quarterly.	
F 812 SS=D	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	F 812		12/15/21

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F 812	Continued From page 20 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, record review and policy review, it was determined that the facility failed to a.) store potentially hazardous foods in a manner to prevent food borne illness and b.) failed to maintain the kitchen environment and equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development a food borne illness. This deficient practice was evidenced by the following: On 10/21/21 at 10:05 AM, in the presence of the Food Service Director (FSD), the surveyor observed the following: 1. In food preparation area, the surveyor observed the following: -A black colored substance on four different areas on the floor which appeared to be approximately 1/2 inch thick, - Four of four convection oven knobs were soiled with a yellow colored crusted substance, -The sides of the connection was soiled with white colored drip marks and black colored grease-like substances, -Two of the three fire suppression poles and red caps were soiled with a black colored grease-like substance, - Nine of nine oven knobs were soiled with a black colored substance, -Four of the four stove cook top areas were soiled	F 812	F812 1. Corrective action(s)accomplished for resident(s)affected: The floor was washed and sanitized. All convection oven knobs were washed and sanitized. The sides of the connection were washed and sanitized. The four stove cook tops were washed and sanitized. All Fire suppression poles and red caps were washed and sanitized. All oven knobs were washed and sanitized. The identified spice bottles were discarded. The identified cans were immediately discarded. 2. Residents identified having the potential to be affected and corrective action taken: Residents residing in the facility have the potential to be affected. 3. Measures will be put into place to ensure the deficient practice will not recur: Staff cleaning matrix was updated to reflect identified areas. Management will identify the areas and monitor daily. Management closing check list was	

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F 812	Continued From page 21 with a colored grease-like substance, 2. In the dry storage area, the surveyor observed ten spice top bottles lids soiled with gray particles. 3. In the dry storage area, the surveyor observed a random sampling of dented cans which were in rotation for use. The surveyor observed the following: - A #10 sized can of sweet potatoes with a 1 inch dent on the upper lip of the can, - A # 10 sized can of ketchup with a 2 inch dent on body of the can, On 10/21/21 at 1:56 PM, the surveyor brought the above concerns to the attention of the Administrator and the Director of Nursing (DON). The surveyor reviewed the facility's policy titled "Ranges" dated January 2021, which indicated that spills should be cleaned as they occur. The surveyor reviewed the facility's policy titled "Cleaning and Sanitation of Food Service Areas" dated January 2021, which indicated to follow the cleaning schedule of cleaning the floors daily and after each use and cleaning the stove top (range) after each use. NJAC 8:39-17.2(g)	F 812	updated to reflect identified areas to ensure compliance. An in-service was given to all staff on the up-dated cleaning matrix. An in-service was given to all supervisors on the up-dated closing check list. An up-dated dented can policy and procedures has been put into effect. An in-service was given to all staff on the up-dated dented can policy. Management closing check list was updated to reflect identified areas to ensure compliance. 4. Corrective actions will be monitored to ensure the deficient practice will not recur: FSD/Designee will report the findings from the logs and any system changes implemented as a result of monitoring sanitation to the administrator monthly for six months. FSD/designee will report the findings from the logs and any system changes implemented as a result of monitoring dented cans to the administrator monthly for six months. FSD/designee will report trends to the quality assurance the next two quarters to assure compliance.	
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	F 880		1/20/22

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F 880	Continued From page 22 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a 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.	F 880		

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F 880	Continued From page 23 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow appropriate measures to prevent and control the spread of infection for: a.) hand hygiene for safe food handling during food preparation; b.) infection prevention during EX Order 26 § treatment observations and c.) infection prevention during medication pass observation. The deficient practices were evidenced by the following: 1. On 10/21/21 at 10:54 AM, in the presence of the Food Service Director (FSD) in the food preparation area in the kitchen, the surveyor observed a Food Service Worker (FSW) wash her hands for 20 seconds, used a paper towel to dry her hands, then took a clean paper towel to	F 880	F880 D 1. Corrective action(s)accomplished for resident(s)affected: Resident #61 had no negative outcomes related to infection control practices during EX Order 26 §4 treatment. The physician for Residents #61 was notified, and the resident was maintained on vital signs every shift and monitored for any documented signs and symptoms of infection for a 72-hour period. The medicated powder bottle was sanitized. The pen was sanitized and placed in a plastic bag in the treatment cart	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315266	A. BUILDING ______ B. WING ______	C 11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK CRESCENT HEALTHCARE & REHABILITATION CENTER	**480 PARKWAY DRIVE EAST ORANGE, NJ 07017**

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F 880	Continued From page 24 turn off the faucet. The FSW used the paper towel to wipe off the sink basin, discarded the paper towel and walked to the food preparation area. The FSD state that the FSW should not have wiped the sink basin after washing her hands. 2. The surveyor observed Resident #61 on 10/21/21 at 10:15 AM in bed with eyes open. The resident was EX Order 26 § 4b1 to the surveyor's voice. A review of the resident's electronic medical record revealed the following. The 10/7/21 quarterly Minimum Data Set an assessement tool, indicated the EX Order 26 § 4b1 The 10/2021 Electronic Treatment Administration Record included physician treatment orders for the EX Order 26 § 4b1. The surveyor observed the Licensed Practical Nurse (LPN #1) perform the EX Order 26 § 4 treatments on 10/28/21 at 10:35 AM. LPN #1 performed handwashing six times during the treatment. Each time LPN #1 turned off the water faucet with a wet paper towel. A wet paper towel is porous and does not provide a barrier between sanitized hands and the water faucet. After setting up the clean field on the sanitized over bed table and placing the clean treatment supplies on the clean field, LPN #1 took a pen out	F 880	Immediate in-service was given to the identified Nurses on the facilities policy for hand hygiene and EX Order 26 § 4 care treatments. 2. Residents identified having the potential to be affected and corrective action taken: Residents receiving EX Order 26 § 4 treatments have the potential to be affected by this practice. The identified Licensed Nurses and Food Service Worker were re-educated on hand hygiene. The identified Licensed Nurse performing EX Order 26 § care was reeducated on performing EX Order 26 § 4 treatment per facility policy to include, sanitizing of the pen used for labeling, cleansing of the EX Order 26 § 4 and maintaining a clean field. A Root Cause Analysis (RCA) was conducted, and it was determined that there were no physical or environmental factors contributing to these deficient practices. The deficient practices were due to human error. The following directed in-service training were completed by the Infection Preventionist, Topline staff and frontline staff: Module 1, 4, 11A – Infection Prevention & Control Program- Top line staff and infection preventionist. CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID-19 Out!, Sparkling surfaces, Clean Hands and Use PPE Correctly for Covid-19 -Frontline staff	

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PARK CRESCENT HEALTHCARE & REHABILITATION CENTER	**480 PARKWAY DRIVE EAST ORANGE, NJ 07017**

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F 880	Continued From page 25 of her uniform pocket and wrote the date on the topper dressing and on a bottle of normal EX Order 26 § [redacted]. The pen was placed back in her pocket. The pen was neither sanitized before or after use. One of the items removed from the treatment cart and placed on the clean field was a bottle of EX Order 26 § 4b1. The medication was brought into the resident's room for use during the treatment. LPN #1 cleansed the EX Order 26 § 4b1 with EX Order 2 soaked gauze. LPN #1 cleansed the EX Order 26 § from the center (where the EX Order 26 § 4b1) to outside the EX Order 26 § 4b1) and back into the open area of the EX Order. Wearing the soiled gloves, she handled the bottle of EX Order 26 § 4b1. This was repeated when the EX Order 26 § 4b1 was cleansed. When the treatments were completed, the EX Order 26 § [redacted] was returned to the treatment cart. The bottle was not sanitized before returning to the clean treatment cart. The surveyor interviewed LPN #1 immediately following the completion of the treatments. LPN #1 confirmed the infection control breaches. A review of the facility policy for wound treatment, updated 7/7/17 and reviewed 10/13/21, revealed nursing staff should doff [remove] gloves and perform hand hygiene after cleansing a wound (procedures 6 and 7). Procedure 13 indicated only clean supplies should be returned to the treatment cart. According to the U.S. CDC guidelines Hand Hygiene Recommendations, Guidance for Healthcare Providers for Hand Hygiene and	F 880	Module 6A, 6B, 7, 11B Nursing Home Infection Preventionist Training Course- All staff including topline staff and infection preventionist. 3. Measures will be put into place to ensure the deficient practice will not recur: Infection Control Preventionist /Designee will complete Hand Hygiene competencies on all staff. Infection Control Preventionist /Designee will complete EX Order 26 § 4 Treatment competency on all Licensed Nurses. Infection Control Preventionist /Designee will perform quarterly hand washing competencies on all staff. 4. Corrective actions will be monitored to ensure the deficient practice will not recur: Assistant Director of Nursing (ADON)/Designee will conduct a weekly audit times 4 weeks, then monthly times 3 months to validate that Licensed Nurses are performing hand hygiene and EX Order 26 § 4 treatment per the facilities policy. Discrepancies will be reported to the Director of Nursing (DON)/Designee with follow up actions as necessary. ADON/Designee will conduct a weekly audit times 4 weeks, then monthly times 3 months to validate that all Food Service Workers are performing hand hygiene per facility policy. The DON/Designee will analyze and trend hand hygiene and EX Order 26 § 4 treatment audit findings and report outcomes of each to the QA Committee quarterly for recommendations as necessary.	

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F 880	Continued From page 26 COVID-19, updated 5/17/2020 included, "Hands should be washed with soap and water for at least 20 seconds when visibly soiled, before eating, and after using the restroom." It further specified the procedure for hand hygiene which included, "When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use EX Order 26 § 4b1 towels to dry. Use a towel to turn off the faucet. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times." 4. On 10/28/21 at 8:30 AM during the medication pass observation, the surveyor observed LPN #2 wash her hands three times. The first and second hand washing observation LPN #2 washed her hands for 10 seconds. After the third hand washing, LPN #2 took a clean paper towel, turned off the facet off and then picked up an item off the floor to discard it and did not wash her hands. The surveyor then observed LPN #2 take gloves out of her pocket, put them on and began to take the resident's blood pressure. The surveyor interviewed LPN #2 who wasn't aware of what the surveyor had observed. On 10/28/21 at 12:30 PM, the surveyors spoke to the Administrator and Director of Nursing regarding the above concerns. No additional information was provided.	F 880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK CRESCENT HEALTHCARE & REHABILITATION CENTER	**480 PARKWAY DRIVE** **EAST ORANGE, NJ 07017**

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F 880	Continued From page 27 NJAC 8:39-19.1;19.4; 27.1	F 880		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060733	A. BUILDING: ______ B. WING ______	C 11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK CRESCENT HEALTHCARE & REHABILITATION	480 PARKWAY DRIVE EAST ORANGE, NJ 07017

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General	S 560	S560 1. Corrective action(s)accomplished for resident(s)affected: No residents were identified 2. 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. 3. Measures will be put into place to ensure the deficient practice will not recur:	12/15/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 11/24/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060733	A. BUILDING: ______ B. WING ______	C 11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
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S 560	Continued From page 1 Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher.	S 560	The facility currently has 6 Nursing Agency contracts. Referral and sign on bonuses are offered. The call out Policy has been reviewed and the staff has been re-educated Advertisements signs are placed by bus stops in 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 Mangers, Supervisors and Assistant Director of Nursing(ADON) will be evaluated to assist with resident care. Rates have been increased for C.N.As Facility had a recent job fare and plans to schedule upcoming job fairs. 4. Corrective actions will be monitored to ensure the deficient practice will not recur: The Director of Nursing(DON)/Designee will conduct weekly C.N.A. staffing schedule audits. The Director of Nursing(DON)/Designee will report audit findings to the Administrator. The Administrator/Designee will analyze and trend findings and report outcomes quarterly to the QA Committee for the next meeting, with follow up to recommendations, as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 2 (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks of 10/3/21 and 10/10/21 revealed the following: The facility was not in compliance with the State of New Jersey minimum staffing requirements of CNAs during the 7:00 AM - 3:00 PM shift, ranging from 165 to 170, on 10/3/21, 10/6/21, 10/8/21, 10/9/21, 10/10/21, 10/11/21 and on the 11:00 PM - 7:00 AM shift on 10/5/21. On 10/29/21 at 11:05 AM, the surveyor discussed the staffing ratio concerns with the Administrator and Director of Nursing, who stated they were aware of the staffing ratio criteria and that they are attempting to hire new CNAs and offer incentives.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315266	A. Building B. Wing	1/20/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK CRESCENT HEALTHCARE & REHABILITATION CENTER	480 PARKWAY DRIVE EAST ORANGE, NJ 07017

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0583 Reg. # 483.10(h)(1)-(3)(i)(ii) LSC	Correction Completed 12/15/2021	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 12/15/2021	ID Prefix F0698 Reg. # 483.25(l) LSC	Correction Completed 12/15/2021
ID Prefix F0711 Reg. # 483.30(b)(1)-(3) LSC	Correction Completed 12/15/2021	ID Prefix F0756 Reg. # 483.45(c)(1)(2)(4)(5) LSC	Correction Completed 12/15/2021	ID Prefix F0761 Reg. # 483.45(g)(h)(1)(2) LSC	Correction Completed 12/15/2021
ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 12/15/2021	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 01/20/2022	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
11/5/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
060733		1/20/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK CRESCENT HEALTHCARE & REHABILITATION CENTER	480 PARKWAY DRIVE EAST ORANGE, NJ 07017

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 12/15/2021	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
11/5/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315266	A. BUILDING **01** B. WING ______	C **11/05/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK CRESCENT HEALTHCARE & REHABILITATION CENTER	**480 PARKWAY DRIVE** **EAST ORANGE, NJ 07017**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 11/04, 05/2021 and Park Crescent Healthcare and Rehabilitation Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Park Crescent Healthcare and Rehabilitation Center is a five (5) story, Type I Fire Resistant building that was built in September 1968. The facility is divided into 13 smoke zones.	K 000		
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced	K 521		12/15/21

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE — 11/24/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PARK CRESCENT HEALTHCARE & REHABILITATION CENTER	480 PARKWAY DRIVE EAST ORANGE, NJ 07017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 521	Continued From page 1 by: Based on observations and interview conducted on 11/4/21 and 11/5/2021, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for 2 of 11 resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: During a tour of the building starting at 9:40 AM, in the presence of the facility's Maintenance Director (MD), an inspection inside of eleven (11) resident bathrooms was performed. This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 2 of 11 resident bathrooms in the following locations: On 11/04/2021: 1. At 11:21 AM, inside the [redacted]) floor Resident Central Shower bathroom, the surveyor observed an approximately 6" x 6" ventilation grill. When tested by placing a single ply of tissue across the grill, the tissue identified there was air blowing into the bathroom and did not hold in place. The exhaust system did not function properly. 2. At 1:14 PM, inside the [redacted] floor Resident Central Shower bathroom, the exhaust system did not function properly when tested. At that time the surveyor asked the MD does the exhaust work. The MD told the surveyor, no its not	K 521	K 521 1. The Maintenance director has fitted the 4th floor and 3rd floor shower rooms with new exhaust systems. 2. All exhaust systems have been inspected and found to be in working order. Maintenance staff have been educated to check that the exhaust systems are functioning properly. 3. Maintenance Dir or designee will do monthly rounds for 6 months to ensure all exhaust systems are functioning and in working order. Audits will be logged in a preventative maintenance log and submitted to Administrator. 4. Administrator will review preventative maintenance log at Quality Assurance meeting for the next two Quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315266	A. BUILDING **01** B. WING ______	C **11/05/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK CRESCENT HEALTHCARE & REHABILITATION CENTER	**480 PARKWAY DRIVE** **EAST ORANGE, NJ 07017**

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K 521	Continued From page 2 working and confirmed that the bathroom exhaust system did not function properly. All the bathrooms had no windows with an area that would open. The bathrooms would rely on mechanical ventilation. The Administrator was informed of the findings at the Life Safety Code exit conference at 12:33 PM on 11/05/2021. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315266 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	1/20/2022 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK CRESCENT HEALTHCARE & REHABILITATION CENTER	480 PARKWAY DRIVE EAST ORANGE, NJ 07017

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0521	Correction Completed 12/15/2021	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
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
11/5/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO