STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 000	INITIAL COMMENTS Survey Dates: 02/13/23 - 02/16/23 Survey Census: 164 Sample Size: 32 Supplemental Residents: 6 A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH). The facility was found not to be in substantial compliance with 42 CFR 483 subpart B.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact	F 561		4/3/23

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

Electronically Signed | 03/09/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 561	Continued From page 1 with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to honor a resident's choice of a shower over bed baths for one resident (Residents (R) 67) of one resident reviewed for choices out of a total sample of 32 residents. Findings include: Review of R67's undated "Admission Record," located in the resident's electronic medical record (EMR) under the "Profile" tab, revealed [redacted] was admitted Ex Order 26. 4B1 with diagnoses that included Ex Order 26. 4B1 [redacted]. Review of R67's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of Ex Order 26. 4B1, located in the EMR under the "MDS" tab, revealed a Ex Order 26. 4B1 [redacted] score of [redacted] out of 15 which indicated R67 was Ex Order 26. 4B1. Continued review of the "MDS" revealed it was very important for R67 to be able to choose between a tub bath, shower, bed bath, or sponge bath The	F 561	I. Corrective action(s)accomplished for resident(s)affected: Resident #67 remains in the facility for Ex Order 26. 4B1 [redacted]. The shower schedule for Resident #67 was reviewed. Resident #67 requested that [redacted] shower be maintained on Tuesdays and Fridays during the 3-11 shift. Resident #67 had no negative effects from this practice. II. Residents identified having the potential to be affected and corrective action taken: Residents with showers scheduled on the 3-11 shift had the potential to be affected by this practice. The 3-11 shower schedule was reviewed with residents who are able to verbalize their choice of a shower over a bed bath. No other residents were identified as affected by this practice. III. Measures will be put into place to ensure the deficient practice will not recur: The description for the bathing task in the Ex Order 26. 4B1 module will be updated to reflect each resident□s preference for a bed bath or shower as applicable. Resident shower schedules will be reviewed quarterly and as preferences	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 561	Continued From page 2 "MDS" also revealed R67 was totally dependent in bathing and required one person physical assistance. Review of R67's "Care Plan," last revised 03/09/21 in the EMR under the "Care Plan" tab, revealed R67 Ex.Order 26.4(b)(1) with Ex Order 26. 4 and *Ex Order 26. 4B1* due to *Ex Order 26. 4B1* ness, *Ex Order 26. 4B1* difficulties, and *Ex Order 26. 4B1* R/T a hx. Of *Ex Order 26. 4B1* . Ex Orde is oriented X 3, Ex.Order 26.4(b)(1) as needed." Review of the Certified Nursing Assistant (CNA) "POC Response History Report," dated Ex Order 26. 4B1 and looking back 30 days, located in the EMR under the "Tasks" tab, revealed R67's bathing task was scheduled to occur on Tuesdays and Fridays on the "3-11 shift evenings." The report revealed that R67 had only received bathing on two of the last 30 days. It was not documented what type of bathing had occurred. During an interview on 02/13/23 at 2:18 PM, R67 stated that Ex Orc prefers showers but hasn't had a shower for two weeks. R67 stated Ex Orc should have one on Tuesdays and Fridays, but Ex Orc won't get one at all unless Ex Orc asks. During a follow up interview on 02/15/23 at 3:26	F 561	change to assure residents make choices for his or her life in the facility that are significant to the resident. The Unit Managers reviewed shower schedules with residents who were able to verbalize their choice of bed baths or showers. The bathing task in Point of Care was updated under the description to reflect the resident□s preference for a bed bath or shower. Licensed and Certified Nursing staff were in-serviced on the updates to the bathing schedule in Point of Care under the bathing description. Licensed and Certified Nursing staff were in-serviced on reporting to the nurse when residents refuse to take a shower or bed bath to allow for accurate documentation of the refusal and to determine if there has been a change in their bathing preference. The Unit Manager/Designee will interview six residents monthly for the next two quarters to ensure staff are meeting resident bathing preferences and that residents are being offered showers as scheduled. The Unit Manager/Designee will provide re-education to staff as needed. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The Director of Nursing will report the results of the monthly resident interviews on bathing 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 bathing schedules.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 561	Continued From page 3	F 561		

PM, R67 said [redacted] was showered last night and that [redacted] did have to ask for it.

Review of R67's undated, paper "Person Centered Plan of Care," provided by the Unit Manager Registered Nurse on 02/15/23 at 9:50 AM, revealed *Ex Order 26. 4B1* [redacted]

Review of the undated "3-11 Shower Book," provided by the facility, revealed that R67 should be getting showers twice a week on Tuesdays and Fridays during the 3PM - 11PM shift.

During an interview on 02/15/23 at 9:16 AM, CNA1 stated that R67 is total care and is scheduled for showers on Fridays on the 3pm-11pm shift. She stated they don't document in the EMR whether it's the resident gets a bath or shower.

During an interview on 02/16/23 at 1:02 PM, CNA2 stated that most of the time R67's okay with a bed bath if [redacted] not already dressed. She stated that [redacted] is supposed to get showers on Tuesday and Friday when [redacted] lets you do it. She stated that they try to convince [redacted] to get a shower but that [redacted] refuses a lot of things.

During an interview on 02/16/23 at 1:30 PM, the Director of Nursing (DON) stated that in theory R67 should get a shower when [redacted] wants it.

Review of the facility policy titled "Residents Rights," dated May 2019, revealed, residents have the right "To participate, in the fullest extent that you are able, in the development and implementation of your medical treatment and person-centered plan of care, including but not limited to: To participate in establishing the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 561	Continued From page 4 expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care ...To receive services and/or items included in the plan of care." NJAC 8:39--4.1(a)	F 561		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the resident assessment accurately reflected the resident's [redacted] designation for one (Resident (R) 20) of one resident sampled for [redacted] out of a total sample of 32 residents. This failure could result in the residents' needs, strengths, and areas of decline not being addressed. Findings include: Review of R20's undated "Admission Record," located in the resident's electronic medical record (EMR) under the "Profile" tab revealed the resident was admitted to the facility on [redacted]. Review of R20's "Admission Assessment Form," dated [redacted], located in the resident's EMR under the "Misc [Miscellaneous]" tab revealed R20 was admitted to the facility on [redacted]. Review of R20's admission "Minimum Data Set (MDS)," located in the resident's EMR under the	F 641	I. Corrective action(s)accomplished for resident(s)affected: Resident #20 continues to reside at this facility as a long-term resident under [redacted] services. The [redacted] for Resident #20 was corrected to reflect that [redacted] was on [redacted] services. Resident #20 had no negative outcomes from this practice. II. Residents identified having the potential to be affected and corrective action taken: Residents on [redacted] services had the potential to be affected by this practice. An audit was conducted for all residents on [redacted] services. It was determined that the [redacted] was coded correctly for all of the other residents receiving [redacted] services. No other residents were affected by this practice. III. Measures will be put into place to ensure the deficient practice will not recur: In-services were conducted for licensed nursing staff on obtaining appropriate	4/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 641	Continued From page 5 "MDS" tab with an Assessment Reference Date (ARD) of Ex Order 26. 4B1, revealed the "MDS" did not accurately reflect R20's Ex Order 26. 4B1 designation. During an interview on 02/16/23 at 9:08 AM the MDS Coordinator stated, "When a resident is on Ex Order 26. 4B1, Section [redacted] should be coded as such. It should have been done for this resident. I will correct that now." During an interview 02/16/23 at 11:32 AM, the Administrator stated, "We do not have a MDS policy. We follow the RAI [Resident Assessment Instrument] manual." NJAC 8:39-33.2(d)	F 641	orders and care plans for residents on Ex Order 26. 4B1 so that Ex Order 26. assessments are coded to accurately reflect the resident□s status. The Director of Nursing/Designee will conduct monthly audits for residents on Ex Order 26. 4B1 services to ensure physician orders are in place for Ex Order 26. 4B1 services, care plans are present related to Ex Order 26. 4B1 services, and that Ex Order 26. coding accurately reflect the resident□s status. IV. Corrective actions will be monitored to ensure the deficient practice will not recur The Director of Nursing will report the results of the monthly Ex Order 26. 4B1 audits 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 hospice residents.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart [redacted] of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the Ex Order 26. 4B1 determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and	F 644		4/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 644	Continued From page 6 all residents with newly evident or possible serious Ex Order 26. 4B1, intellectual Ex Order 26. 4B1, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure one of two residents (Residents (R) 76) reviewed out of a total sample of 32 had completed a 'Ex Order 26. 4B1 " upon receipt of a Ex.Order 26.4(b)(1) diagnoses. This failure placed resident at risk for unmet care needs and for not receiving appropriate Ex.Order 26.4(b)(1) needed. Findings include: Review of R76's Ex Order 26. 4B1 from the Ex Order 26. 4B1 "Profile" tab showed an original admission date of Ex Order 26. 4B1; readmission dates of Ex Order 26. 4B1 and Ex Order 26. 4B1; with medical diagnoses that included Ex Order 26. 4B1 The Ex Order 26. 4B1 readmission added the diagnoses of Ex Order 26. 4B1 . Review of R76's EMR "Misc [Miscellaneous]" tab showed a Level I Ex Order 26. 4B1 dated Ex Order 26. 4B1 that showed a Ex Order 26. 4B1 result Ex Order 26. 4B1 that identified R76 as having Ex Order 26. 4B1 in the 'Ex Order 26. 4B1 " section.	F 644	I. Corrective action(s)accomplished for resident(s)affected: The Ex Order 26. 4B1 was complete for Resident #76 on Ex Order 26. 4B1 reflective of both Ex Order 26. 4B1 and Ex Order 26. 4B1 diagnoses. Resident continues to reside for long-term care placement at this facility. Resident #76 has not had any untoward effects from this practice. II. Residents identified having the potential to be affected and corrective action taken: Residents with a new Ex.Order 26.4(b)(1) diagnosis had the potential to be affected. A Ex Order 26. 4B1 audit was conducted by Social Services and determined that no other residents were affected by this practice. III. Measures will be put into place to ensure the deficient practice will not recur: The Social Worker was re-educated on the requirements for completing a Ex Order 26. 4B1 for residents upon receipt of a new Ex.Order 26.4(b)(1) diagnosis. In-services were conducted for the Unit Managers and Nursing Supervisors related to the requirements for completing a Ex Order 26. 4B1 upon receipt of a new Ex.Order 26.4(b)(1) diagnosis. Education included the requirement for completion of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 644	Continued From page 7 Further review of R76's record did not reveal any further Ex Order 26. 4B1 Ex.Order 26.4(b) screenings. A request was made to the Director of Nursing (DON) on 02/15/23 at 12:40 PM for any additional Ex Order 26. 4B1 completed for R76. On 02/16/23 at 1:08 PM, the Social Services Director (SSD) provided a Ex.Order 26.4(b)(1) screening dated Ex Order 26. 4B1 and confirmed it should have been sent through again in 2021 with the Ex.Order 26.4(b)(1) diagnoses. During an interview on 02/16/23 at 1:18 PM, the DON confirmed R76's Ex Order 26. 4B1 should have been resubmitted after the Ex Order 26. 4B1 and Ex Order 26. 4B1 diagnoses were added to her record. Review of the facility policy titled "Policy and Procedure for MDS [Minimum Data Set] Ex Order 26. 4B1 Requirement Compliance," reviewed December 2022, showed: ...The Social Worker (SW) is responsible for: 1) Reviewing the Ex.Order 26.4(b)(1) for accuracy and redoing it if any errors are discovered. . . . 5) Referring clients who are newly diagnosed with Ex Order 26. 4B1 or have been previously exempted due to having Ex Order 26. 4B1 as a primary [diagnosis] but are experiencing any significant change in status, to the Medicaid District Office and eighter the Ex Order 26. 4B1 or the Ex Order 26. 4B1 in order that a Ex Order 26. 4B1 Resident Review can be completed. . . . This notification is to be made within one week of	F 644	a resident review by Social Services/Designee within one week of a new diagnosis or identification of significant change coupled with a material impact on the resident□s status. The Unit Managers and Nursing Supervisors were educated that an email must be sent to the Ex Order 26. Department and Social Services anytime a new Ex.Order 26.4(b)(1) diagnosis is added to the resident□s list for diagnoses. The Social Worker/Designee will conduct monthly audits on residents with new Ex.Order 26.4(b)(1) diagnoses to ensure that Ex Order 26. 4B1 forms are complete as required and any corrective action is done to maintain compliance. IV. Corrective actions will be monitored to ensure the deficient practice will not recur The Administrator will report the results of the monthly Ex Order 26. 4B1 audits 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 Ex Order 26. 4B1 for residents with new Ex.Order 26.4(b)(1) diagnoses	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 644	Continued From page 8 the new diagnosis or significant change. If a SW is not in the NF [nursing facility] at the time the new diagnosis or significant change has been noted, nor during the designated time frame, it is the responsibility of the Administrator or his/her designee to make the necessary notifications. . . ." NJAC 8:39-40.3(d)	F 644		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited *Ex Order 26. 4B1* does not experience reduction in *Ex Order 26. 4B1* unless the resident's clinical condition demonstrates that a reduction in [redacted] is unavoidable; and §483.25(c)(2) A resident with [redacted] receives appropriate treatment and services to increase *Ex Order 26. 4B1* and/or to prevent further decrease in *Ex Order 26. 4B1*. §483.25(c)(3) A resident with *Ex Order 26. 4B1*y receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and policy review, the facility failed to ensure that a resident received consistent [redacted] exercises for one (Residents (R) 125) of one resident reviewed for *Ex Order 26. 4B1* out of a total sample of 32 residents.	F 688	I. Corrective action(s)accomplished for resident(s)affected: Resident #125 erroneous mentioned in 2567. Resident number is #126 " The attending physician for resident #126 was notified.	4/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 9 Findings include: Review of R125's undated Ex Order 26. 4B1 located in the resident's electronic medical record (EMR) under the "Profile" tab, revealed Ex Order was admitted Ex Order 26. 4B1 with diagnoses that included Ex Order 26. 4B1 . Review of R125's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of Ex Order 26. 4B1, located in the EMR under the "MDS" tab, revealed a "Brief Interview for Metal Status (BIMS)" score of Ex Or out of 15 which indicated R125 was Ex Order 26. 4B1. The "MDS" also revealed R125 required Ex.Order 26.4(b)(1) . Review of R125's "Care Plan," last revised 06/14/22 in the EMR under the "Care Plan" tab, revealed " Ex.Order 26.4(b)(1) Ex Order 26. 4 . [R125] is Ex.Order 26.4(b)(1) with Ex Order 26. 4." Interventions included Ex.Order 26.4(b)(1) for Ex Order 26. and to use Ex Order 26. 4B1 as able to Ex.Order 26.4(b)(1) , Ex Order 26. 4B1 eval & Ex O as ordered to improve . During an interview on 02/13/23 at 2:57 PM, R125 was observed to not be able to use Ex Order 26. 4B1 or Ex Order 26. 4B1 . Ex Order 2 stated it was due to a Ex Order 26. 4B1 . Ex Order 2 stated Ex Order used to be making some progress in Ex Order 26. 4B1 on that	F 688	" Resident #126 was screened by Ex Order 26. 4B1 and is currently on program for Ex Order 26. 4B1 " Resident #126 had no negative outcomes related to not receiving consistent Ex Order 26. 4B1 exercises. II. Residents identified having the potential to be affected and corrective action taken: " Residents residing in the facility have the potential to be affected. " All new admissions and readmissions in the past thirty days have been reviewed to ensure that they received a Ex Order 26. 4B1 upon admission. III. Measures will be put into place to ensure the deficient practice will not recur: " The Director of Ex Order 26. 4B1 was re-educated by the Administrator regarding all new admissions and readmissions must receive a Ex Order 26. 4B1 upon admission. " A new measure has been put in place, the admissions department will send an admission notification for all admissions to the Ex Order 26. 4B1 department to ensure that the Ex.Order 26.4(b)(1) is completed. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: " The Assistant Director of Nursing (ADON)/Designee will conduct a weekly audit times 4 weeks, then monthly times 3 months to validate that all new admissions and readmissions have received a Ex Order 26. 4B1 upon admission. Discrepancies will be reported to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 10 side of Ex Order 26. 4B1, but that had stalled. R125 was not currently enrolled in Ex Order 26. 4B1 or other Ex Order 26. 4B1 program. During an interview on 02/15/23 at 9:16 AM, Certified Nursing Assistant (CNA) 1 stated that R125 required total care Ex Order 26. 4B1 CNA1 stated "We do AM care and Ex Order 26. 4B1 [during care]." CNA1 stated that it's not documented anywhere what type of care is given. CNA1 stated that Ex Order 26. 4B1 lets the staff know what to do for Ex Order 26. 4B1 for Ex Order. During an interview on 02/15/23 at 11:12 AM, the Ex Order 26. 4B1 stated that the facility does have a maintenance program that the CNAs can do with Ex Order. The Ex Order 26. stated lot of maintenance that the CNAs do is part of their routine care of the residents and R125 might have Ex Order 26. 4B1 in place from Ex Order previous admission. The Ex Order 26. stated R125 had reached Ex Order maximum potential at the Ex Order 26. 4B1 in the hospital. When asked for some documentation of R125's previous Ex Order 26. 4B1, she stated "we don't have anything from the last admission. Ex Order 2 had a Ex Order 26. 4B1 at some point. Ex Order 26 should be evaluated every year." During a follow up interview on 02/15/23 at 2:26 PM, R125 said the CNAs don't do any Ex Order 26. 4, Ex Order moves the Ex Order 26. 4B1. She stated that when they wash Ex Order, they just pick up the Ex Order 2 [and don't do any Ex Order 26. 4B1 exercises]. R125 stated Ex Order had had a Ex Order 26. 4 at some point, somebody had to put it on for Ex Order because the aides don't know how. During an interview on 02/16/23 at 12:48 PM, the Unit Manager Registered Nurse (RN) stated that	F 688	Director of Nursing (DON) with follow up actions as necessary. " The DON will analyze, and trend audit findings report outcomes to the Quality Assurance Committee quarterly for two quarters for recommendations as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 11	F 688		

there was no formal or Ex Order 26. 4B1 program in place for R125 and in general Ex Order 26. 4B1 would do a screen when the resident was readmitted. The Unit Manager RN stated the facility had a Ex Order 26. 4B1 program at the facility.

During an interview on 02/16/23 at 12:58 PM, CNA3 stated she does AM care for the resident that included Ex Order 26. . CNA3 stated as she changes R125 she will stretch Ex Order 26. 4B1 out back and forth and then circle it around.

During an interview on 02/16/23 at 1:30 PM, the Director of Nursing (DON) stated that R125 should have been rescreened by Ex Order 26. 4B1 when Ex Order was readmitted after the most recent Ex.Order 26.4(b)(1) "What usually happens is that they [resident] get Ex Order 26. 4B1 if Ex Order 26. 4B1 is going to pick them up, then a Ex Order 26. 4B1 program and then a maintenance program."

Review of the facility policy titled Ex Order 26. 4B1 revised Ex Order 26. 4B1, revealed, "It is the policy of Hunterdon Care Center to achieve and maintain optimal physical, mental and Ex Order 26. 4B1 for each of our residents. Procedure: Measurable objectives and interventions will be documented in the care plan and in the medical record. If a Ex Order 26. 4B1 program is in place when a care plan is being revised, it is appropriate to reassess progress, goals, and duration/frequency as part of the care planning process. The results of this reassessment will be documented in the resident's Ex Order 26. 4B1. Evidence of periodic evaluation by the licensed nurse will be present in the resident's Ex Order 26. 4B1. Ex Order 26. 4B1 staff will be trained in the techniques that promote

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 12 resident involvement in the activity. A registered nurse or a licensed practical nurse will supervise the activities in the restorative nursing program. A physician's order is not required for a Ex Order 26. 4B1 program. Although Ex Order 26. 4B1 may participate, members of the nursing staff are still responsible for overall coordination and supervision of Ex Order 26. 4B1 programs." NJAC 8:39-27.1(a)	F 688		
F 758 SS=D	Free from Unnec Ex Order 26. 4B1 /PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Ex Order 26. 4B1 . §483.45(c)(3) A Ex Order 26. 4B1 is any drug that affects brain activities associated with Ex Order 26. 4B1 . These drugs include, but are not limited to, drugs in the following categories: (i) Ex Order 26. 4B1 ; (ii) Ex Order 26. 4B1 ; (iii) Ex Order 26. 4B1 ; and (iv) Ex Order 26. 4B1 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used Ex Order 26. 4B1 are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use Ex Order 26. 4B1 receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		4/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 758	Continued From page 13 §483.45(e)(3) Residents do not receive Ex Order 26. 4B1 pursuant to a Ex Order 26. order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for Ex Order 26. 4B1 are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the Ex Order 26. order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the Ex Order 26. order. §483.45(e)(5) Ex Order 26. orders for Ex Order 26. 4B1 are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and policy review, the facility failed to ensure two of five residents (Resident (R) 119 and R152) who received Ex Order 26. 4B1, and reviewed for unnecessary medications, had monitoring for efficacy for the target symptoms (reasons for use) for the medication. This failure had the potential to keep residents from receiving the lowest possible effective Ex Order 26. 4B1 dose. Findings include: 1. Review of R119's Ex Order 26. 4B1 from the Ex Order 26. 4B1 "Profile" tab, showed an admission date of Ex Order 26. 4B1 with medical diagnoses that included Ex Order 26. 4	F 758	I. Corrective action(s)accomplished for resident(s)affected: " Residents #119 recommendation for the use of Ex Order 26. 4B1 was reviewed by the physician and the targeted symptoms to support the continued use of the Ex Order 26. 4B1 was documented. " Resident #119 had no negative outcome related to the use of Ex Order 26. 4B1 and the medication order remains current. " Resident #152 is no longer in the facility II. Residents identified having the potential to be affected and corrective	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 758	Continued From page 14 Ex Order 26. 4B1 . Review of R119's EMR "Orders" tab showed prescriptions for Ex Order 26. 4B1 daily for major Ex Order 26. 4B1 and to monitor for Ex.Order 26.4(b)(1) Review of R119's Ex Order 26. 4B1 tab showed a focus of: "[R119's name] has episodes of Ex Order 26. 4B1 with a goal of "[R119's name] will demonstrate decreased episodes of Ex Order 26. 4B1. [R119's name] will be free from s/s [signs and symptoms] Ex Order 26. 4B1." Interventions to reach that goal included: "-Administer Ex Order 26. 4B1 as ordered. Ex.Order 26.4(b)(1) etc [sic]). -Attempt to anticipate needs to decrease Ex Order 26. 4B1. . . . -Document changes in Ex.Order 26.4(b)(1) noting precipitating factors, interventions attempted, & effectiveness of interventions. Keep MD [doctor] informed of concerns. -During Ex.Order 26.4(b)(1), offer/assist to remove from common areas & others. Bring to a quiet area, preferably own room and attempt to Ex.Order 26.4(b)(1). Attempt to calm using conversation [sic] about past times. . . . -Monitor for s/s Ex Order 26. 4B1 Notify MD accordingly. . . ." Review of R119's "Progress Notes, Medication	F 758	action taken: " Residents administered Ex Order 26. 4B1 have the potential to be affected. " All resident receiving Ex Order 26. 4B1 will be audited for documentation and monitoring for efficacy for the targeted symptoms to support the continued use of the Ex Order 26. 4B1. III. Measures will be put into place to ensure the deficient practice will not recur: " Director of Nursing (DON) and the physicians met to review the facilities policy and regulations on Ex Order 26. 4B1, monitoring for efficacy for the targeted symptoms and documentation. " The DON/Designee re-educated the Physicians and nursing staff on the system to assure that Ex Order 26. 4B1 usage is evaluated weekly, and documentation for efficacy for targeted symptoms is completed. " All resident receiving Ex Order 26. 4B1 will be documented in the Ex Order 26. 4B1 Log. In addition, any newly ordered Ex Order 26. 4B1 will be added to the Ex Order 26. 4B1 Log. " DON or designee will monitor Ex Order 26. 4B1 Ordered in the past seven Days on the electronic health record dashboard weekly and review any newly initiated Ex Order 26. 4B1 to ensure documentation for necessity. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: " The DON/Designee will conduct a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 758	Continued From page 15 Administration Record [MAR], Treatment Administration Record [TAR]," and "Assessment" tab did not show any monitoring being completed for the signs/symptoms noted in the Ex Order 26. 4B1. 2. Review of R152's '*Ex Order 26. 4B1* " from the EMR "Profile" tab showed a facility admission date of Ex Order 26. 4B1 with medical diagnoses that included *Ex Order 26. 4B1* . Review of R152's EMR "Orders" tab showed a prescription for *Ex Order 26. 4B1* twice daily related to *Ex Order 26. 4B1*, may cause Ex.Order 26.4(b)(1) *Ex Order 26. 4B1* once daily related to *Ex Order 26. 4B1*; *Ex Order 26. 4B1* daily related to *Ex Order 26. 4B1*, may Ex.Order 26.4(b)(1) . Review of R152's EMR "Care Plan" tab showed a focus of "Potential for adverse effects r/t *Ex Order 26. 4B1* use r/t dx *Ex Order 26. 4B1* " with interventions that included: '*Ex Order 26. 4B1* as ordered. Monitor for Ex.Order 26.4(b)(1) . Periodic review of *Ex Order 26. 4B1* for potential dose reduction. Monitor Ex.Order 26.4(b)(1) -Attempt to anticipate needs to reduce Ex Order 26. 4B1. Attempt to keep daily routine. Attempt to identify triggers to Ex Order 26. 4B1, educate staff to avoid these areas. -Encourage diversional activities to decrease	F 758	weekly audit times 4 weeks, then monthly times 3 months then quarterly from audits of the *Ex Order 26. 4B1* Ordered and *Ex Order 26. 4B1* Logs. Discrepancies will have followed up actions as necessary. " The DON will analyze and trend audit findings and report outcomes to the Quality Assurance Committee quarterly for two quarters for recommendations as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 758	Continued From page 16 potential for Ex Order 26. 4B1 . [sic] Offer Ex.Order 26.4(b)(1) interventions. . . . -Monitor for & document changes in Ex.Order 26.4(b)(1) r noting precipitating factors, interventions attempted, & effectiveness of interventions. Keep MD informed of concerns. -Monitor for effectiveness in treating target symptoms, documenting Ex.Order 26.4(b)(1) interventions attempted and effectiveness. Update MD as needed. -Monitor for s/s Ex Order 26. 4B1 , Ex.Order 26.4(b)(1) , etc [sic]). Intervene as indicated with least restrictive measure that is effective. Keep MD informed of concerns. -Monitor for s/s Ex Order 26. 4B1 Keep MD informed of concerns. . . ." Review of R152's "Progress Notes, Ex Order 26. 4B1 ," and "Assessment" tab did not show any monitoring being completed for the signs/symptoms noted in the care plan. During an interview on 02/16/23 at 11:43 AM with the Director of Nursing (DON) and the Regional Nurse Consultant (RNC) regarding where the monitoring of the target symptoms for medication efficacy would be, the DON responded that there was no targeted Ex.Order 26.4(b)(1) for the Ex Order 26. 4B1 . The RNC stated "We don't do target Ex.Order 26.4(b)(1) [monitoring] for Ex Order 26. 4B1 ." Review of the facility policy titled "Ex Order 26. 4B1 Monitoring," revised 10/2022 showed:	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	**1 LEISURE COURT FLEMINGTON, NJ 08822**

(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 758	Continued From page 17 *Ex Order 26. 4B1* monitoring: Purpose: The intent of this policy is to ensure that each resident's *Ex Order 26. 4B1* regimen is monitored and managed to achieve the following goals: -The medication regimen helps promote or maintain the resident's highest practicable mental, physical, and *Ex Order 26. 4B1* well-being, as identified by the resident and/or representative(s) in collaboration with the attending physician, *Ex Order 26. 4B1* and facility staff; -Each resident receives only those medications, in the lowest possible dose with the least potential for side effects and for the duration clinically indicated, to treat the resident's assessed condition(s); -Non-pharmacological interventions (such as behavioral interventions) are considered and used when indicated, instead of, or in addition to, medication; -Clinically significant adverse consequences are minimized. -The potential contribution of the mediation regimen to an unanticipated decline or newly emerging or worsening symptom is recognized and evaluated, and the regimen is modified when appropriate. Monitoring of *Ex Order 26. 4B1* medications and *Ex Order 26. 4B1* : . . . -Behavior monitoring will be recorded in the medical record by the licensed nursing staff to quantify targeted behaviors and/or any adverse side effects for the prescribed *Ex Order 26. 4B1* on a monthly basis. The key objective is to track progress towards the *Ex Order 26. 4B1* goal(s) and to detect the emergence or presence of any adverse side effects. -Designated licensed nursing team members	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 758	Continued From page 18 document a monthly [redacted] summary that captures the medication, diagnosis, targeted behavior(s), non-pharmacological interventions, adverse side effects, resident's progress/deterioration, and any attempted GDR for the month. . . ." NJAC 8:39-29.2(d)	F 758		
F 812 SS=E	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 observations, interview, record review, and policy review, the facility failed to ensure that the unit nourishment rooms refrigerators and ice machines were maintained to prevent potential foodborne illness. The facility identified a census of 163 residents at the time of the survey.	F 812	I. Corrective action(s)accomplished for resident(s)affected: The thermometer in the [redacted] Unit refrigerator was replaced and the location of the thermometer was moved to the inside of the refrigerator instead of on the	4/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 19 Findings include: On 02/14/23 at 2:15 PM an observation of the nourishment room refrigerator on Ex Order 26. 4B1 unit was done with the unit clerk. She stated that they keep milk and different types of juices for the residents. A reading of the thermometer found in the refrigerator door read 50 degrees Fahrenheit (F). She stated that if there's a problem with the refrigerator, she contacts maintenance. A tour of the facility nourishments rooms was conducted on 02/15/23 at 12:08 PM through 12:46 PM with the Ex Order 26. 4B1 . The following concerns were noted: On 02/15/23 at 12:08 PM in the nourishment room on the Ex Order 26. 4B1 unit the Ex Order 26 confirmed that there was no thermometer in the refrigerator. The Ex Order 26 took the temperature of a four-ounce orange juice which measured 42 degrees Fahrenheit (F) and a four-ounce milk which measured 43 degrees F. The Ex Order 26 stated that the food items should not be at this temperature. During an interview on 02/15/23 at 12:18 PM Certified Nursing Assistant (CNA) 1 revealed that temperatures of the pantry refrigerator on the sub-acute wing are done on the night shift. A copy of the temperature log was obtained. There were no temperatures logged for the refrigerator from 02/03/23 through 02/14/23, dashes were noted where the temperatures would have been. When asked what the dashes meant on certain days of the temperature log CNA1 stated "I guess that means it's not done." The Ex Order 26 stated he doesn't do anything with the refrigerators on the units.	F 812	door. The contents of the refrigerator were discarded. A re-check of the Ex Order 26. Unit refrigerator noted a reading within normal refrigeration range. The Ex Order 26. 4B1 Unit refrigerator was fitted with a new thermometer. All the contents in the refrigerator were discarded.A new tempertaure log was placed for temperature recording. A re-check of the Ex Order 26. 4B1 Unit refrigerator noted a reading within normal refrigeration range. The ice machine on the Ex Order 26. Unit was cleaned by housekeeping and removed from service by the Director of Maintenance. The chocolate syrup from the Ex Order 26. 4B1 Unit refrigerator that was noted as expired was discarded. All contents in the refrigerator were checked for expiration dates. No other items were found expired. The ice machine on Ex Order 26. 4B1 Unit was cleaned by housekeeping and removed from service by the Director of Maintenance. II. Residents identified having the potential to be affected and corrective action taken: Residents residing on the Ex Order 26. and Ex Order 26. 4B1 Units had the potential to be affected by this practice. There were no other refrigerators on the units identified. No residents were identified as negatively affected by this practice. III. Measures will be put into place to ensure the deficient practice will not recur: The Infection Prevention Nurse/Designee re-educated nursing staff on the Ex Order 26. 4B1 and Ex Order 26. Units about the importance of maintaining unit nourishment room	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 20 On 02/15/23 at 12:24 PM the nourishment room on Ex Order 26. 4B1 was observed. The ice machine on the unit had a whitish film noted on all over the back splash and water dispenser and a black residue was observed on the chutes of the ice dispenser. On 02/15/23 at 12:32 PM the nourishment room on Ex Order 26. 4B1 unit was observed. The ice machine had a white filmy residue covering most of the machine and the machine itself was dripping and was seen with a container set up under the ice chute to contain the dripping water. On 02/15/23 at 12:35 PM, CNA2 stated that they are using the ice machine on the unit. On 02/15/23 at 12:38 PM the nourishment room on the Ex Order 26. 4B1 unit was observed. The refrigerator contained a 24-ounce bottle of chocolate syrup with an expiration date of 03/21/22. On 02/15/23 at 12:42 PM the Unit Manager (1) stated that the fridge was supposed to be strictly for residents, but that "staff put their stuff in there sometimes." She stated that the kitchen provides their ice in a cooler because the ice machine does not work. During an interview on 02/15/23 at 12:46 PM the Unit Manager (2) on the Ex Order 26. 4B1 unit stated that the ice machine is new and had been dripping for over a year. On 02/16/23 at 8:50 AM the Administrator stated that he expects the temperature to be maintained appropriately, a proper temperature log maintained and the night shift was in-serviced on how to take the temperature properly. He stated that the 11-7 shift was responsible for taking the temperature in the refrigerator and they were also responsible for making sure there's no expired	F 812	refrigerators and ice machines to prevent the potential for foodborne illness. Nursing staff was reminded that refrigerator checks are to be done on the 11-7 shift daily. A numerical temperature must be documented, not a line or a check, when checking the temperature. If temperatures are found out of normal range, all food/beverage items are to be discarded and the refrigerator taken out of service until checked by Maintenance. If a thermometer is found to be missing, all contents of the refrigerator will be discarded and a new thermometer will be obtained from the Dietary Department. Nursing staff were also re-educated to check all contents of the refrigerator for expiration dates and to discard any item that have expired. The Infection Prevention Nurse/Designee re-educated staff that ice for the units will be obtained from the Dietary Department in ice chests and that the ice machines on the units have been removed from service. The Infection Prevention Nurse/Designee will conduct monthly environmental rounds to ensure that nourishment refrigerators are checked for appropriate temperature ranges, that contents are not expired, and that refrigerators are clean. IV. Corrective actions will be monitored to ensure the deficient practice will not recur The Infection Prevention Nurse will report the findings from the monthly environmental rounds including any corrective actions taken to maintain compliance with nourishment refrigerators	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 21 food in the refrigerator. The Administrator stated that the [redacted] is responsible for the maintenance of the ice machines. A follow up visit to the [redacted] unit on 02/16/23 at 1:11 PM showed that ice machine was still covered with a whitish film, the black residue was still observed on the ice chutes, the machine was also dripping, there was no sign indicating that the machine was out of commission. On 02/16/23 at 1:16 PM the Director of Housekeeping was interviewed. He stated that housekeeping staff basically wipe down the unit ice machines every morning. He stated the white residue seen all over the machines comes from the hard water. When asked about how the chutes are cleaned, he stated that housekeeping is basically responsible for cleaning the outside of the ice machine and maintenance oversees cleaning the chutes and the inside of the machine and maintaining it. On 02/16/23 at 1:23 PM the Director of Maintenance was interviewed. He stated that "You get the white (residue)." He indicated that he mostly deals with the water hygiene company and he follows their dictates for cleaning the water and replacing the filters,. He stated that the chutes from the [redacted] wing (that were seen with a white build up as well as a black build up) were replaced two months ago. He stated that the ice machines do drip as they are battling ambient air temperatures. He stated that the ice machines had now been taken out of commission. Review of the paper "Food Safety on Units" policy, updated 1/7/18 and reviewed 12/2022, revealed "Refrigerator temperatures will be	F 812	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 the refrigerators.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 22	F 812		

monitored to assure that freezer/refrigerator temperatures are within required levels ...Packaged items will be checked for expiration dates, and discarded as appropriate ...Prepared foods from home will be discarded 72 hours after label date or if spoiled."

Review of the undated paper "Ice Machine and Equipment" policy revealed "The ice machine and equipment (scoops) will be cleaned on a monthly basis to maintain a clean, sanitary condition. If available, follow the manufacturer's cleaning and sanitizing procedures ...Procedure: 1. Unplug the ice machine and remove the ice. 2. Wash the interior thoroughly using a detergent solution, Rinse and drain the interior with clean hot tap water. 3. Sanitize 4. Air dry 5. Turn the machine on. 6. Clean the exterior of the machine with a detergent solution. Rinse and allow to air dry. Clean the area underneath and around the machine."

Review of the undated paper "Nourishment Rooms" policy revealed "Food Storage: a. Food that is stored is protected from contamination and growth of any pathogenic organisms. b. Among the food protection measures that are performed by the food service department are: Foods are refrigerated and stored at or below 41" F ...Foods with expiration dates are used prior to the date on the package ... It is the responsibility of the nursing department to check daily and to throw out any expired food products. It is the responsibility of the nursing department to log and record refrigerator temperatures. If temperatures do not meet the requirement of 41 degrees or below, this should be reported to the Maintenance department. It is the responsibility of the housekeeping department to make sure the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 23 refrigerators, ice machines and microwaves are cleaned properly. Note: In order to ensure that the dietary needs of the patients/residents are being met and that each facility maintains sanitary conditions, all food and dining areas should be self-inspected on a regular basis." NJAC 8:39-17.2(g) NJAC 8:39-19.7(d)	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;	F 842		4/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	**1 LEISURE COURT FLEMINGTON, NJ 08822**

(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 842	Continued From page 24 (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) *Ex Order 26. 4B1* must be retained for- (i) The period of time required by State law; or (ii) *Ex Order 26. 4B1* from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 842	Continued From page 25 Based on record review, interview, and facility policy review, the facility failed to ensure that one of one resident (Resident (R) 84) record reviewed for Ex.Order 26.4(b) documentation out of a total sample of 32 residents reflected the visualized Ex Order 26. [redacted]. This failure had the potential to create incorrect assessments, care planning, or worsening of the Ex Order 26. 4B1 due to the lack of monitoring. Findings include: While completing interviews and observations on 02/13/23 at 2:15 PM, R84 self-propelled Ex Orde wheelchair out of Ex Orde room and was noted to have Ex Order 26. 4B1. Observation on 02/14/23 at 10:23 AM showed the Ex Order 26. 4B1 from Ex Order 26. 4B1 to the Ex Order 26. 4B1 of the Ex Order 26. 4B1 remained. R84 did not wish to be interviewed. Review of R84's Ex Order 26. 4B1 from the Ex Order 26. 4B1 "Profile" tab showed a facility admission date of Ex Order 26. 4B1 with medical diagnoses that included Ex Order 26. 4B1 [redacted]. Further review of R84's Ex Order 26. 4B1 ," "Assessments," and Misc [Miscellaneous]" tabs did not show any documentation regarding the Ex Order 26. 4B1. The "Progress Notes" had an 02/10/23 8:55 AM note by the social worker, the next note was written on 02/15/23 at 1:16 PM stating R84 had been Ex.Order 26.4(b)(1) the physician ordered an Ex Order 26. 4B1 applied to the Ex Order 26. 4B1; and then at 1:30 PM that the physician and R84's Representative were	F 842	I. Corrective action(s)accomplished for resident(s)affected: " The attending physician for resident #84 was notified regarding the Ex Order 26. 4B1 and treatment order was obtained. " The Ex Order 26. 4B1 documentation was entered into the medical record. " Resident #84 had no negative outcomes related to the omission of documentation of Ex Order 26. 4B1 and the Ex Order 26. 4B1 have resolved. II. Residents identified having the potential to be affected and corrective action taken: " Residents residing in the facility have the potential to be affected. " Ex.Order 26.4(b)(1) were performed on all residents to ensure Ex Order 26. 4B1 documentation reflects the visualized Ex Order 26. 4B1. III. 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)/Designee regarding Principles of Documentation. " Certified Nursing Assistants (C.N.A.) were reeducated to report any new Ex.Order 26 concerns to the nurse. " A new process is in place, during weekly Ex Order 26. 4B1 rounds the ADON/ designee will ensure Ex Order 26. 4B1 documentation in the Ex Order 26. 4B1 reflects all the visualized Ex Order 26. 4B1. IV. Corrective actions will be monitored to ensure the deficient practice will not recur:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 842	Continued From page 26 notified of the Ex Order 4B1 and the plan to use an *Ex Order 26. 4B1*. A requested for documentation regarding the *Ex Order 26. 4B1* was made to the Director of Nursing on 02/15/23 at 12:40 PM. In an interview on 02/16/23 at 11:45 AM regarding R84's Ex.Order 26.4(b) documentation, the DON stated, "Ex Order 2 Ex.Order 26.4(b)(1), the manager notified the doctor yesterday and risk management was completed on the 15th." The DON confirmed that was completed after the Ex Order 26. 4B1 were brought to their attention. The DON stated there was a nurse's note written on 02/15/23 but confirmed there was no progress notes prior to then. The DON stated it was an "expectation that when there is a *Ex Order 26. 4B1* it would be notified to the nurse and doctor, an incident report upon finding it should be completed, a treatment put into place and the care plan would be updated. They [staff] think of it as Ex Orde Ex.Order 26.4(b)(1) not, well, that is why it wasn't reported timely." Review of the facility policy titled "Nursing Documentation Policy," dated December 2022, showed: "The Uses of *Ex Order 26. 4B1* Nurses document their work and outcomes for a number of reasons: the most important is for communicating within the health care team and providing information for other professionals, primarily for individuals and groups involved with accreditation, credentialing, legal, regulatory and legislative, reimbursement, research, and quality activities. Communication within the Health Care Team Nurses and other health care providers aim to share information about patients and	F 842	" The ADON/Designee will conduct a weekly wound round audits times 4 weeks, then monthly times 3 months to validate that visual Ex Order 26. 4B1 are documented in the medical record. Discrepancies will be reported to the DON with follow up actions as necessary. " The DON will analyze, and trend audit findings report outcomes to the Quality Assurance Committee Quarterly for two quarters for recommendations as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 842	Continued From page 27 organizational functions that is accurate, timely, contemporaneous, concise, thorough, organized, and confidential. . . . Foremost of such electronic documentation is the [redacted], provides an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's [redacted] [sic, [redacted]] to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care. -Assessments -Clinical problems -Communication with other health care professionals regarding the patient . . . -Patient response and outcomes, including changes in the patient's status . . ."	F 842		
F 849 SS=D	NJAC 8:39-35.2(c) Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) [redacted] services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of [redacted] services through an agreement with one or more Medicare-certified [redacted]. (ii) Not arrange for the provision of [redacted] services at the facility through an agreement with a Medicare-certified [redacted] and assist the resident in transferring to a facility that will arrange for the provision of [redacted] services	F 849		4/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	**1 LEISURE COURT FLEMINGTON, NJ 08822**

(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 849	Continued From page 28 when a resident requests a transfer. §483.70(o)(2) If Ex Order 26. 4B1 is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a Ex Order 26. 4B1, the LTC facility must meet the following requirements: (i) Ensure that the Ex Order 26. 4B1 services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the Ex Order 26. 4B1 that is signed by an authorized representative of the Ex Order 26. 4B1 and an authorized representative of the LTC facility before Ex Order 26. 4B1 care is furnished to any resident. The written agreement must set out at least the following: (A) The services the Ex Order 26. 4B1 will provide. (B) The Ex Order 26. 4B1 responsibilities for determining the appropriate Ex Order 26. 4B1 plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the Ex Order 26. 4B1 provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the Ex Order 26. 4B1 about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the Ex Order 26. 4B1 assumes	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	**1 LEISURE COURT FLEMINGTON, NJ 08822**

(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 849	Continued From page 29 responsibility for determining the appropriate course of Ex Order 26. 4B1 care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the Ex Order 26. 4B1 representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the Ex Order 26. 4B1 responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the Ex Order 26. 4B1 and related conditions; and all other Ex Order 26. 4B1 services that are necessary for the care of the resident's Ex Order 26. 4B1 and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of Ex Order 26. 4B1, including those Ex Order 26. 4B1 determined appropriate by the Ex Order 26. 4B1 and delineated in the Ex Order 26. 4B1, the LTC facility personnel may administer the Ex Order 26. 4B1 where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, Ex Order 26. 4B1, including injuries of unknown source, and misappropriation of patient property by Ex Order 26. 4B1 personnel, to the Ex Order 26. 4B1 administrator immediately when the LTC facility becomes aware of the alleged violation.	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	**1 LEISURE COURT FLEMINGTON, NJ 08822**

(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 849	Continued From page 30 (K) A delineation of the responsibilities of the [redacted] and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of [redacted] care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with [redacted] representatives to coordinate care to the resident provided by the LTC facility staff and [redacted] staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the [redacted] care planning process for those residents receiving these services. (ii) Communicating with [redacted] representatives and other healthcare providers participating in the provision of care for the *Ex Order 26. 4B1*, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the [redacted] medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the [redacted] care with the medical care provided by other physicians. (iv) Obtaining the following information from the [redacted]: (A) The most recent [redacted] plan of care specific to each patient.	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 849	Continued From page 31 (B) Ex Order 26. 4B1 election form. (C) Physician certification and recertification of the Ex Order 26. 4B1 specific to each patient. (D) Names and contact information for Ex Order 26. 4B1 personnel involved in hospice care of each patient. (E) Instructions on how to access the Ex Order 26. 4B1 24-hour on-call system. (F) Ex Order 26. 4B1 medication information specific to each patient. (G) Ex Order 26. 4B1 physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to Ex Order 26. 4B1 staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing Ex Order 26. 4B1 care under a written agreement must ensure that each resident's written plan of care includes both the most recent Ex Order 26. 4B1 and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and Ex Order 26. 4B1 well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the facility failed to ensure the appropriate coordination of Ex Order 26. 4B1 by specifically failing to maintain Ex Order 26. 4B1 orders, Ex Order 26. 4B1, and a Ex Order 26. 4B1 election form for one (Resident (R) 20) of one resident sampled for Ex Order 26. 4B1 out of a total sample of 32 residents. This failure had the potential result in the interruption of the resident's coordination of care. Findings include:	F 849	I. Corrective action(s)accomplished for resident(s)affected: Resident #20 continues to reside at this facility as a long-term resident under Ex Order 26. 4B1. The chart for Resident #20 was updated to include an order for Ex Order 26. 4B1 Ex Order 26. 4B1, a Ex Order 26. 4B1, and a Ex Order 26. 4B1 election form. There was no interruption of the resident□s coordination of care despite not having these items on the resident□s chart.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 849	Continued From page 32 Review of R20's undated "Ex Order 26. 4B1 ," located in the resident's Ex Order 26. 4B1 under the "Profile" tab revealed the resident was admitted to the facility on Ex Order 26. 4B1 . Review of R20's "Ex Order 26. 4B1 ," dated 12/09/22, located in the resident's Ex Order 26. under the "Misc [Miscellaneous]" tab revealed the resident was admitted to the facility on Ex Order 26. 4B1 . Review of R20's complete Ex Order 26. 4B1 , including paper chart and Ex Order 26. , revealed the absence of Ex Order 26. 4B1 orders, Ex Order 26. 4B1 election form, and Ex Order 26. 4B1 . During an interview on 02/15/23 at 9:59 AM, Unit Manager (UM) 1 confirmed R20's Ex Order 26. 4B1 designation. UM1 reviewed R20's Ex Order 26. and paper chart and confirmed the absence of Ex Order 26. 4B1 orders, Ex Order 26. 4B1 election form, and Ex Order 26. 4B1 . When asked how the facility knew the Ex Order 26. 4B1 responsibilities and the facility's responsibilities, UM1 stated, "The Ex Order 26. 4B1 aide comes five days a week and follows the facility's Ex Order 26. 4B1 ." UM1 further stated that R20 "came to us on Ex Order 26. 4B1 but we should still have those orders and care plan. I will reach out to the Ex Order 26. 4B1 nurse and get that information." During an interview on 02/15/23 at 10:16 AM, the Hospice Nurse (HN) stated, "The Ex Order 26. 4B1 care should be maintained in resident's chart. I must have overlooked it. I will send it to the facility." The HN further stated R20 began on Ex Order 26. 4B1 in Ex Order 26. 4B1 prior to arriving at the facility. The HN stated, "We should have an order, because we can't start Ex Order 26. 4B1 without an order. I will get the office to fax over to the facility."	F 849	II. Residents identified having the potential to be affected and corrective action taken: Residents on Ex Order 26. 4B1 services had the potential to be affected by this practice. An audit was conducted for all residents on Ex Order 26. 4B1 services. It was determined that the other residents receiving Ex Order 26. 4B1 services had an order for Ex Order 26. 4B1 , and Ex Order 26. 4B1 election form on their chart. No other residents were affected by this practice. III. Measures will be put into place to ensure the deficient practice will not recur: In-services were conducted for the assigned Ex Order 26. 4B1 nurse and facility licensed nursing staff on obtaining appropriate Ex Order 26. 4B1 orders, election forms, and care plans for residents admitted onto Ex Order 26. 4B1 services in the facility. The Unit Manager/Designee will conduct monthly audits for residents on Ex Order 26. 4B1 services to ensure physician orders are in place for Ex Order 26. 4B1 are present related to Ex Order 26. 4B1 services, and that MDS coding accurately reflects the resident□s status. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The Director of Nursing will report the results of the monthly Ex Order 26. 4B1 audits 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 hospice residents.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 849	Continued From page 33	F 849		

When asked R20's Ex Order 26. 4B1 diagnosis, HN stated, "Ex Order 2 is on Ex Order 26. 4B1 for Ex Order 26. 4B1 ; that should be on the Ex Order 26. 4B1 election form." When told there was also no Ex Order 26. 4B1 election form on file at the facility, HN stated she would also fax the Ex Order 26. 4B1 election form to the facility. When her expectations as far as Ex Order 26. 4B1 paperwork for R20, HN stated, "I expect all items to be to be in Ex Order 26. 4B1 book maintained at the facility prior to the resident's transfer to the facility."

During an interview on 02/15/23 at 10:53 AM, the Ex Order 26. 4B1 stated, "I come to the facility five days a week." When asked how she knew what type of care to provide R20, the Ex Orde stated, "I have Ex Orde care plan on my phone. That is the system we use." The Ex Orde stated she was unaware if the facility maintained the same Ex Order 26. 4B1 for R20.

During an interview on 02/15/23 at 11:26, the Director of Nursing (DON) stated she expected there to be Ex Order 26. 4B1 orders and the Ex Order 26. 4B1 for coordination of care for R20.
Review of the Ex Order 26. 4B1 agreement titled "Agreement for Nursing Home Services," dated 08/26/13, indicated "Services to be Coordinated, Supervised and Evaluated by Ex Order 26. 4B1 : Ex Order 26. 4B1 shall provide the Home with a copy of any existing Ex Order 26. 4B1 upon the admission of a Ex Order 26. 4B1 patient to the Home". This Ex Order 26. 4B1 agreement further indicated, "The Ex Order 26. 4B1 shall coordinate services by: (c) Providing the Home with: i. The most recent Ex Order 26. 4B1 specific to each patient; ii. Ex Order 26. 4B1 election form and any advance directive specific to each Patient; iii. Physician certification and recertification of the Ex Order 26. 4B1 specific to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 849	Continued From page 34 each patient." Review of an untitled and undated Ex Order 26. 4B1 policy indicated, "The Director of Nursing/Designee is responsible for the following: d. Obtaining the following information from the Ex Order 26. 4B1: (1) The most recent Ex Order 26. 4B1 specific to each resident; (2) Ex Order 26. 4B1 election form; (3) Physician certification and recertification of the Ex Order 26. 4B1 specific to each resident."	F 849		
F 880 SS=F	NJAC 8:39-5.1(a) NJAC 8:39-27.1(a) 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 Ex Order 26. 4B1 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	F 880		4/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 35 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 *Ex Order 26. 4B1* [redacted] or *Ex Order 26. 4B1* [redacted] 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 *Ex Order 26. 4* [redacted] and the corrective actions taken by the facility. §483.80(e) Linens.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 36 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 [redacted] and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure proper hand hygiene procedures were followed to potentially prevent the development and transmission of *Ex Order 26. 4B1* [redacted] for four of four dining observations involving residents (Resident (R) 18, R137, R99, and R107) on the locked *Ex Order 26. 4B1* [redacted] unit. This had the potential to affect all 31 residents who reside on the locked *Ex Order 26. 4B1* unit. Findings include: 1. During a continuous dining observation on 02/13/23 at 11:40 AM through 11:51 AM, the following was observed: Dayroom Hostess (DH) was observed seated with R18 and R137, feeding both residents at this time. DH was noted to touch the hand and shoulder of R137 prompting [redacted] to eat and putting R137's fork in [redacted] hand, while simultaneously feeding R18. When R137 would not follow DH's prompts to eat, DH would begin to feed R137, while feeding and wiping the mouth of R18. This process went back and forth throughout the duration of the observation. DH did not use appropriate hand hygiene between the residents.	F 880	I. Corrective action(s)accomplished for resident(s)affected: " Resident #18 physician was notified, and the resident was maintained on [redacted] and monitored for any documented Ex.Order 26.4(b)(1) [redacted] for a 72-hour period. Resident # 18 had no negative outcomes related to infection control practices during serving trays, set up of trays and feeding. " Resident #137 physician was notified, and the resident was maintained on [redacted] and monitored for any documented Ex.Order 26.4(b)(1) [redacted] for a 72-hour period. Resident #137 had no negative outcomes related to infection control practices during serving trays, set up of trays and feeding. " Resident #107 physician was notified, and the resident was maintained on [redacted] every shift and monitored for any documented Ex.Order 26.4(b)(1) [redacted] for a 72-hour period. Resident #107 had no negative outcomes related to infection control practices during serving trays, set up of trays and feeding. " Resident #99 physician was notified, and the resident was maintained on [redacted] every shift and monitored for any documented Ex.Order 26.4(b)(1) of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 37 Review of R18's undated "Ex Order 26. 4B1 ," located in the resident's electronic medical record (EMR) under the "Profile" tab revealed the resident was admitted to the facility on Ex Order 26. 4B1. Review of R18's quarterly "Ex Order 26. 4B1 ," located in the resident's under the " tab with an Assessment Reference Date (ARD) of , revealed a "Ex Order 26. 4B1 " score of out of 15, indicating R18 was Ex Order 26. 4B1 . Per this , R18 required Ex.Order 26.4(b)(1) during eating. Review of R137's undated "Ex Order 26. 4B1 ," located in the resident's under the "Profile" tab revealed the resident was admitted to the facility on . Review of R137's quarterly "," located in the resident's under the tab with an of 01/28/23, revealed a score of out of 15, indicating R137 was Ex Order 26. 4B1 . Per this , R137 required Ex.Order 26.4(b)(1) during eating. 2. During the second continuous dining observation on 02/14/23 at 11:23 AM through 11:50 AM, the following was observed: Certified Nursing Assistant (CNA) 5, DH, and Licensed Practical Nurse (LPN) 1 were observed serving meal trays to residents. These staff were observed to do the following: a. Remove meal trays from the meal transport cart. b. Remove the bottom hot plate from beneath the resident's plate. c. Put the hot plate onto another cart that also had pitchers of tea, water, and coffee. d. Put the resident's tray onto that same cart and pour the resident's drink. e. Remove the top lid from the resident's plate.	F 880	Ex.Order 26.4(b)(1) for a 72-hour period. Resident #99 had no negative outcomes related to infection control practices during serving trays, set up of trays and feeding. " The identified Certified Nursing Assistants (C.N.A.) 3 and C.N.A. 5, Dayroom Hostess (DH), Licensed Practical Nurse (LPN) 1 and Unit Manager (UM) 1were immediately re-educated regarding following proper hand hygiene procedures during serving meal trays, set up of meal trays and when feeding residents. II. Residents identified having the potential to be affected and corrective action taken: " Residents currently residing in the facility have the potential to be affected. " All C.N.A□s, Licensed Nurses and Dayroom Hostess were re-educated regarding following proper hand hygiene procedures during serving meal trays, set up of meal trays and when feeding residents. III. Measures will be put into place to ensure the deficient practice will not recur: " The weekly infection control round tool was updated to include dining observations to ensure staff is following proper hand hygiene procedures during serving meal trays, set up of meal trays and when feeding residents. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: " The Infection Control Preventionist/Designee will conduct a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 38 f. Put that top lid on the bottom rack of the same cart. g. Take the meal tray to the resident. h. Set up resident's meal, which included opening creamers, straws, setting up utensils, stirring in creamers. i. Return to the meal transport cart to get another resident's tray and repeat the above steps. CNA5, DH, and LPN1 did not use appropriate hand hygiene during the above process. DH was observed seated with R18 and R99, feeding both residents at this time. DH was noted to touch the hand and shoulder of R99 prompting [redacted] to eat and putting R99's fork in [redacted], while simultaneously feeding R18. When R99 would not follow DH's prompts to eat, DH would begin to feed R99, while feeding and wiping the mouth of R18. This process went back and forth throughout the duration of the observation. DH did not use appropriate hand hygiene between the residents. Review of R99's undated "[redacted]," located in the resident's EMR under the "Profile" tab revealed the resident was admitted to the facility on [redacted]. Review of R99's quarterly [redacted] located in the resident's EMR under the [redacted] tab with an [redacted] of 01/13/23, revealed a [redacted] score of [redacted] out of 15, indicating R99 was [redacted]. Per this [redacted], R99 required [redacted] during eating. 3. During the third continuous dining observation on 02/15/23 at 11:09 AM through 11:25 AM, the following was observed:	F 880	weekly infection control rounds to include dining observations to ensure staff are following proper hand hygiene procedures during serving meal trays, set up of meal trays and when feeding residents. " The Infection Control Preventionist/Designee will make recommendations regarding infection control activities based on weekly surveillance rounds with follow up action as necessary. " The Director of Nursing will analyze and trend audit findings and report outcomes to the Quality Assurance Committee quarterly for the next two quarters for recommendations as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 39 CNA5, CNA3, LPN1, DH, and Unit Manager (UM)1 were observed serving meal trays to residents. These staff were observed to do the following: a. Remove meal trays from the meal transport cart. b. Remove the bottom hot plate from beneath the resident's plate. c. Put the hot plate onto another cart that also had pitchers of tea, water, and coffee. d. Put the resident's tray onto that same cart and pour the resident's drink. e. Remove the top lid from the resident's plate. f. Put that top lid on the bottom rack of the same cart. g. Take the meal tray to the resident. h. Set up resident's meal, which included opening creamers, straws, setting up utensils, stirring in creamers. i. Return to the meal transport cart to get another resident's tray and repeat the above steps. CNA5, CNA3, LPN1, DH, and UM1 did not use appropriate hand hygiene during the above process. After serving the last tray in the dining room, DH was observed to begin feeding R107. DH opened R107's straw, touching the end of the straw to that goes into R107's mouth, with bare hands. DH did not perform hand hygiene after passing meal trays or prior to feeding R107. Review of R107's undated "Ex Order 26. 4B1," located in the resident's EMR under the "Profile" tab revealed the resident was admitted to the facility on Ex Order 26. 4B1.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 40 Review of R107's quarterly [Ex Order 26. 4B1] located in the resident's EMR under the [Ex Order 26. 4B1] tab with an [Ex Order 26.] of [Ex.Order 26.4(b)(1)], revealed R107's [Ex Order 26. 4B1] score could not be assessed. Per this [Ex Order 26.], R107 required [Ex.Order 26.4(b)(1)] during eating. During an interview on 02/16/23 at 11:09 AM, the [Ex Order 26. 4B1] stated, "I expect staff to sanitize their hands between each resident when passing trays and wash hands before feeding a resident. These are infection control issues." 4. During the fourth a continuous dining observation on 02/16/23 at 11:11 AM through 11:20 AM, the following was observed: UM1, CNA5, CNA3, and DH were observed passing and setting up meal trays to residents in the dining room and in the residents' room. The staff were observed to not use hand sanitizer between the passing of the trays or the setting up of the meal trays for the residents. DH was observed to complete passing meal trays and sat and began to feed R107. DH was observed to not sanitize or wash her hands. During an interview on 02/16/23 at 11:21 AM, CNA3 stated she was trained to "use sanitizer before passing each tray, but I know I didn't do it every time." During an interview on 02/16/23 at 11:24 AM, DH stated she was trained to wash her hands for 20 seconds before feeding a resident. DH stated she was not trained about sanitizing hands between passing resident meal trays. DH confirmed she had not washed her hands or sanitized hands before feeding residents or passing meal trays.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 41 DH further confirmed she fed R18 and R137 and R18 and R99, simultaneously. DH confirmed she did not wash or sanitize her hands before sitting to feed R107. During an interview on 02/16/23 at 11:26 AM, CNA5 stated she was trained to sanitize her hands before passing trays and before feeding residents. During an interview 02/16/23 on 11:29 AM, UM1 stated she expected staff to "sanitize hands between trays and hands should be washed before feeding." UM1 further stated, "No one should be feeding two residents a time. All these are infection control concerns." During an interview on 02/16/23 at 12:44 PM, the Director of Nursing (DON) stated she expected staff to "sanitize hands between the passing of each tray and wash hands if visibly soiled." Review of facility policy titled, "Handwashing/Hand Hygiene," revised December 2022, indicated "Hand washing situations (including but not limited to): Before and after assisting a resident with meals." NJAC 8:39-19.4(a)(n)	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
	061007	A. BUILDING: _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on 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 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	S 560	I. Corrective action(s)accomplished for resident(s)affected: " No residents were identified. 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 6 Nursing Agency contracts. " The daily bonus range has been reviewed and increased. Daily bonuses	4/3/23

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

Electronically Signed | 03/09/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061007	A. BUILDING: _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 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. (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	S 560	are offered as needed for staffing challenges. " Referral and sign on bonuses are offered. " The call out Policy has been reviewed and the staff has been re-educated " 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 " Daily transportation via bus is offered for staff members living in Essex and Union counties. IV. 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 DON/Designee will report audit findings to the Administrator. The Administrator/Designee will analyze and trend findings and report outcomes quarterly to the Quality Assurance (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
	061007	A. BUILDING: _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 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 1/29/23 and 2/05/23, revealed the following; The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -01/29/23 had 14 CNAs for 167 residents on the day shift, required 21 CNAs. -01/30/23 had 12 CNAs for 167 residents on the day shift, required 21 CNAs. -01/31/23 had 15 CNAs for 167 residents on the day shift, required 21 CNAs. -02/01/23 had 16 CNAs for 167 residents on the day shift, required 21 CNAs. -02/02/23 had 16 CNAs for 167 residents on the day shift, required 21 CNAs. -02/03/23 had 17 CNAs for 167 residents on the day shift, required 21 CNAs. -02/04/23 had 18 CNAs for 173 residents on the day shift, required 22 CNAs. -02/05/23 had 12 CNAs for 172 residents on the day shift, required 21 CNAs. -02/06/23 had 11 CNAs for 172 residents on the day shift, required 21 CNAs. -02/07/23 had 17 CNAs for 172 residents on the day shift, required 21 CNAs. -02/08/23 had 19 CNAs for 172 residents on the day shift, required 21 CNAs. -02/09/23 had 16 CNAs for 172 residents	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061007	A. BUILDING: _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 on the day shift, required 21 CNAs. -02/10/23 had 16 CNAs for 168 residents on the day shift, required 21 CNAs. -02/11/23 had 16 CNAs for 168 residents on the day shift, required 21 CNAs.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315226 Y1	A. Building B. Wing Y2	4/3/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

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 F0561	Correction	ID Prefix F0641	Correction	ID Prefix F0644	Correction
Reg. # 483.10(f)(1)-(3)(8)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.20(e)(1)(2)	Completed
LSC	04/03/2023	LSC	04/03/2023	LSC	04/03/2023
ID Prefix F0688	Correction	ID Prefix F0758	Correction	ID Prefix F0812	Correction
Reg. # 483.25(c)(1)-(3)	Completed	Reg. # 483.45(c)(3)(e)(1)-(5)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	04/03/2023	LSC	04/03/2023	LSC	04/03/2023
ID Prefix F0842	Correction	ID Prefix F0849	Correction	ID Prefix F0880	Correction
Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed	Reg. # 483.70(o)(1)-(4)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	04/03/2023	LSC	04/03/2023	LSC	04/03/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
2/16/2023	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061007 Y1	A. Building B. Wing Y2	4/3/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

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 04/03/2023	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	
2/16/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING **01** B. WING _____	**02/16/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	**1 LEISURE COURT** **FLEMINGTON, NJ 08822**

(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 An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 02/13/23. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 02/13/23 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Hunterdon Care Center is one building that was built in 1986. It is composed of Type II protected construction. The facility is divided into eight smoke zones. The generator does approximately 40 % of the building as per the Maintenance Director. The current occupied beds are 164 out of 185.	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1	K 211		4/3/23

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

Electronically Signed | 03/09/2023

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
	315226	A. BUILDING **01** B. WING _____	**02/16/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	**1 LEISURE COURT** **FLEMINGTON, NJ 08822**

(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 211	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to ensure no furnishings, decorations, or other objects obstructed exits or their access thereto, egress therefrom, or visibility thereof in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.1.10.2.1. This deficient practice had the potential to affect 31 residents. Findings include: An observation on 02/13/23 at 12:52 PM revealed the smoke barrier doors, located in the Ex Order 26. 4B1 Unit and adjacent to Room Ex Order 26., had an adhesive wallpaper with an image of a bookcase pasted on the doors, which covered the entire width and length of the doors. The doors had an exit sign located above them. During an interview at the time of the observation, the Regional Maintenance Director informed the bookcase was put on the doors to deter the residents from trying to get through the doors. During an interview with the Administrator on 02/13/23 at 4:45 PM, the Administrator also informed the bookcase was to deter the residents and stated it had been that way for years. NJAC 8:39-31.1(c), 31.2(e)	K 211	I. Corrective action(s)accomplished for resident(s)affected: The adhesive wallpaper with the image of a bookcase pasted on the doors located in the Ex Order 26. 4B1 Unit was removed to ensure visibility of the exit in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.1.10.2.1. II. Residents identified having the potential to be affected and corrective action taken: Residents residing on the Ex Order 26. 4B1 Unit had the potential to be affected. No residents or staff were negatively impacted by this practice. III. Measures will be put into place to ensure the deficient practice will not recur: The Director of Maintenance removed the adhesive wallpaper from the exit door on the Ex Order 26. 4B1 Unit to ensure the view of the exit was unobstructed. The Director of Maintenance was educated by the Administrator on the importance of ensuring there are no furnishings, decorations, or other objects obstructing exits or their access thereto, egress therefrom, or visibility thereof in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.1.10.2.1. The Director of Maintenance completed an audit of facility exit doors to ensure a means of egress was continuously maintained free of all obstructions to full use in case of an emergency. The Maintenance Department will conduct monthly audits of exit doors to ensure a means of egress is maintained free of all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING 01 B. WING	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

(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 211	Continued From page 2	K 211	obstruction to full use in case of an emergency. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The Director of Maintenance will report the results of the monthly exit door audits to assure a means of egress to the Quality Assessment and Assurance (QAA) Committee for the next two quarters. The QAA Committee will determine the need for any additional monitoring for means of egress.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 edition) Sections 8.5.6.1 and 8.5.6.2. This deficient	K 372	I. Corrective action(s)accomplished for resident(s)affected: The penetrations observed in the smoke barrier walls identified in [redacted] Wing and adjacent to Room [redacted]; [redacted] Wing [redacted] Unit and adjacent to Room [redacted]; [redacted] Wing and adjacent to	4/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. BUILDING **01** B. WING _____	**02/16/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	**1 LEISURE COURT** **FLEMINGTON, NJ 08822**

(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 372	Continued From page 3 practice had the potential to affect 164 residents. Findings include: An observation on 02/13/23 at 12:44 PM revealed the smoke barrier wall, located in [redacted] Wing and adjacent to Room [redacted], had a two-inch flexible conduit and three blue wires which penetrated the smoke barrier wall and were sealed with expanding foam. An observation on 02/13/23 at 12:52 PM revealed the smoke barrier wall, located in [redacted] Wing/Ex Order 26. 4B1 Unit and adjacent to Room [redacted], had three, two and one-half inch domestic water supply pipes which penetrated the smoke barrier wall and were sealed with expanding foam. An observation on 02/13/23 at 1:00 PM revealed the smoke barrier wall, located in [redacted] Wing and adjacent to Room [redacted], had a two and one-half inch domestic water supply pipe which penetrated the smoke barrier wall and was sealed with expanding foam. An observation on 02/13/23 at 1:06 PM revealed the smoke barrier wall, located in [redacted] Wing and adjacent to Room [redacted], had a two inch by three inch unsealed opening located next to an air duct. An observation on 02/13/23 at 1:06 PM revealed the smoke barrier wall, located in [redacted] Wing and adjacent to Room [redacted], had five pipes ranging from one inch to two inches which penetrated the smoke barrier wall and were sealed with expanding foam. During an interview at the time of the	K 372	Room [redacted]; [redacted] Wing and adjacent to Room [redacted]; and [redacted] Wing and adjacent to Room [redacted] were sealed with fire barrier sealent by the Director of Maintenance. II. Residents identified having the potential to be affected and corrective action taken: Residents residing near these areas had the potential to be affected. Resident safety checks were conducted by the Director of Maintenance. No residents or staff were affected by this practice. III. Measures will be put into place to ensure the deficient practice will not recur: All smoke barrier doors were checked by the Director of Maintenance to ensure there was no penetration through the barrier. No additional penetrations were found. The Director of Maintenance was educated by the Administrator on the importance of maintaining the integrity of smoke barrier walls to prevent smoke, fumes, and fire from passing through to the other smoke compartments in the event of a fire. The Director of Maintenance/Designee will conduct monthly inspections of smoke barrier partitions throughout the facility to ensure the integrity of the smoke barrier partition is maintained. Any untoward findings will be corrected immediately by 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 results of the monthly audits on the smoke barrier walls 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
	315226	A. BUILDING **01** B. WING _____	**02/16/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	**1 LEISURE COURT** **FLEMINGTON, NJ 08822**

(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 372	Continued From page 4 observations, the Maintenance Director confirmed the unsealed openings and that the penetrations were sealed with expanding foam. He stated the foam was used a long time ago and did not have documentation that the foam would restrict the passage of smoke. During an interview on 02/13/23 at 1:15 PM, the surveyor asked the Regional Maintenance Director if they had a system in place to check the smoke barriers for unsealed openings and penetrations after subcontractors had completed work above the ceiling and at the smoke barrier walls. He stated subcontractors are responsible for any openings and penetrations they may have created, but sometimes things are missed. NJAC 8:39-31.1(c), 31.2(e)	K 372	Committee for the next two quarters. The QAA Committee will determine the need for any additional monitoring of the smoke barrier walls.	

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)
315226	A. Building 01 - MAIN BUILDING 01 B. Wing	4/3/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	1 LEISURE COURT FLEMINGTON, NJ 08822

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 K0211	Correction Completed 04/03/2023	ID Prefix Reg. # NFPA 101 LSC K0372	Correction Completed 04/03/2023	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

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	
2/16/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO