STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315069	A. BUILDING _____ B. WING _____	C 09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	1506 GULLY ROAD WALL, NJ 07719

(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 Survey: 09/26/23 This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS STANDARD SURVEY: 09/26/23 CENSUS: 56 SAMPLE SIZE: 14 + 3 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657		11/6/23

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

Electronically Signed | 10/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315069	A. BUILDING _____ B. WING _____	C 09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	1506 GULLY ROAD WALL, NJ 07719

(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 657	Continued From page 1 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation it was determined that the facility failed to revise care plans for 2 of 14 residents reviewed (Resident #35 and Resident #8) for care plan revision and was evidenced by the following: 1.On 09/13/23 at 11:28 AM, the surveyor observed Resident #35 in the dayroom in a wheelchair during activities. On 09/13/23 at 1:30 PM, the surveyor reviewed the residents Electronic Medical Record (EMR) progress notes which indicated that Resident #35 NJ ex order 26.4b1 Review of the annual Minimum Data Set (MDS), an assessment tool dated NJ ex order 26.4b1 revealed that Resident #35 had a Brief Interview of Mental Status of NJ ex, meaning the resident was NJ ex order 26.4b1 . Medical diagnoses NJ ex order 26.4b1	F 657	I. Corrective action(s) accomplished for resident(s) affected: • The care plan for resident #35 has been reviewed; there were no additional updates required; NJ ex order 26.4b1 • The care plan for resident #8 was updated on NJ ex order 26.4b1 to NJ ex order 26.4b1 II. Residents identified having the potential to be affected and corrective action taken: • All residents have the potential to be affected. All resident care plans will be reviewed twice weekly until all resident care plans have been reviewed. Care plan reviews will begin with any new admits and/or readmits to ensure any new diagnoses are added to the care plan, and with residents utilizing adaptive equipment for which rehab has provided a list to the Minimum Data Set Coordinator (MDSC) for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315069	A. BUILDING _____ B. WING _____	C 09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	1506 GULLY ROAD WALL, NJ 07719

(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 657	Continued From page 2 On 09/19/23 01:04 PM, further surveyor review of the EMR showed that the resident NJ ex order 26.4b1 Resident #35 NJ ex order 26.4b1 and NJ ex order 26.4b1 On 09/19/23 at 01:24 PM, the surveyor reviewed the care plan which showed that NJ Exec Order 26.4 were added as a focus on NJ Exec Order 26.4 with interventions to maintain resident safety during the NJ Exec Order 2 and interventions for caring for the resident NJ Exec Order 26.4b1. The resident returned to the facility on NJ Exec Order 26.4b On 09/21/23 at 12:30 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) regarding a delay in the care plan revision. No additional information was provided. On 09/25/23 at 12:31 PM, the surveyor reviewed the annual MDS dated NJ ex order 26.4b1 section I. (active diagnoses) NJ ex order 26.4b1 meaning the NJ ex order 26.4b1 The surveyor then reviewed the NJ ex order 26.4b1 5-day MDS, NJ ex order 26.4b1 meaning NJ ex order 26.4b1 On 09/26/23 at 09:55 AM, the surveyor met with the Minimum Data Set Coordinator (MDSC) who was responsible for updating care plans following hospitalization. The MDSC asked the issue for Resident #35. The surveyor explained that the resident NJ ex order 26.4b1, NJ ex order 26.4b1 and the residents care plan NJ ex order 26.4b1.	F 657	III. Measures to be put into place to ensure the deficient practice will not recur: • The regional nurse re-educated the MDSC on 9/26/23 regarding the importance of updating care plans timely and reviewed the facility policy that the baseline care plan will be used as the foundation for the care planning with additions/revisions being incorporated into the comprehensive care plan. Revisions are to be made to the care plan to reflect the needs of the resident. • The MDS Coordinator will continue to be responsible for assuring accuracy of all care plans. In the event the MDS Coordinator is not present, the DON/designee will be responsible for assuring the timely update of care plans. All care plans will be reviewed quarterly by the IDC team. IV. Corrective actions to be monitored to ensure the deficient practice will not recur: • The DON/designee will audit at least two care plans weekly x 4 weeks and monthly thereafter for six months. Results of the audit will be reported to the Quality Assurance (QA) Committee at the Quarterly Meetings for two consecutive quarters. The QA committee will determine the need for continued monitoring at the conclusion of the two reporting quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315069	A. BUILDING _____ B. WING _____	C 09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	1506 GULLY ROAD WALL, NJ 07719

(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 657	Continued From page 3 The MDS coordinator said, "I was on vacation". 2. On 09/14/23 at 11:48 AM, the surveyor observed Resident #8 in the room. The surveyor observed NJ ex order 26.4b1 The Resident told the surveyor he/she was able to place the arm onto the NJ Ex.Order 26.4(b)(1)NJ Exec . On 09/15/23 at 12:07 PM, the surveyor reviewed the Admission Record which indicated Resident #8 NJ ex order 26.4b1 The surveyor reviewed Resident #8 most recent quarterly Minimum Data Set, an assessment tool (MDS) dated NJ ex order 26.4b1 which reflected a Brief Interview of Mental Status (BIMS) of NJ ex meaning the resident was NJ ex order 26.4b1 . Section G of the MDS, Functional status indicated the NJ ex order 26.4b1 On 09/15/23 at 12:41 PM, Resident #8 was observed in the room NJ ex order 26.4b1 On 09/18/23 12:03 PM, surveyor interviewed a unit Certified Nurse's Assistant (CNA). The CNA said she was aware of the NJ Exec Order 26.4b1 The surveyor asked how the CNA was aware of the need for the NJ Exec Order 26 to be used and the CNA said she received the information in "report". The CNA told the surveyor she was not aware of anywhere else the information would be.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315069	A. BUILDING _____ B. WING _____	C 09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	1506 GULLY ROAD WALL, NJ 07719

(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 657	Continued From page 4	F 657		

On 09/18/23 at 12:08 PM, the surveyor asked the unit Licensed Practical Nurse (LPN) where the [NJ Exec Order 26] was documented, and she told surveyor it was on the Treatment Administration Record (TAR). The LPN said the residents chair just came like that and the resident had been here for 90 days. The LPN told the surveyor the CNA should know.

On 09/18/23 at 12:14 PM, the surveyor interviewed the Director of Rehabilitation (DOR). The DOR was aware of the [NJ Exec Order 26] for Resident #8. The surveyor asked the DOR where the information for the [NJ Exec Order 26] should be, and the DOR told the surveyor "the care plan".

On 09/18/23 at 12:19 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) regarding the [NJ Exec Order 26] and asked where it would be documented. The ADON told the surveyor, "I don't know, on the Medication Administration Record".

On 09/19/23 at 10:31 AM, the ADON told the surveyor the [NJ Exec Order 26] was on the care plan however it was resolved by accident by a nurse manager that was no longer at the facility. It was resolved on [NJ ex order 26.4b1], meaning it was removed from the care plan. The ADON stated the care plan should have been revised.

On 09/21/23 at 11:28 AM, the surveyor reviewed the facility provided policy titled Admission and Baseline Care Plan (BCP) with a review date of [NJ Exec Order 26.4b] . The policy reflected that the BCP will be used as the foundation for the care planning with additions/revisions being incorporated into the comprehensive care plan. Once the comprehensive care plan has been developed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315069	A. BUILDING _____ B. WING _____	C 09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	1506 GULLY ROAD WALL, NJ 07719

(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 657	Continued From page 5 and implemented, any additional changes will be made to the comprehensive care plan based on the needs of the resident. NJAC 8:39-11.2 (e)	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation it was determined that the facility failed to notify the physician of incomplete NJ ex order 26.4b1 for Resident #39, 1 of 1 resident reviewed for NJ Exec Order 26.4b1. This was evidenced by the following: On 09/13/23 at 10:37 AM, the surveyor observed Resident #39 in the room sitting on the side of the bed. On 09/14/23 at 09:56 AM, the surveyor observed the resident laying in bed, there was a stop sign across Resident #39 door and the resident said it was to stop any other residents from entering. Review of the Admission Record revealed Resident #39 NJ ex order 26.4b1 [redacted] Review of the quarterly	F 658	I. Corrective action(s) accomplished for resident(s) affected: • Resident #39 NJ ex order 26.4b1 [redacted] The physician was notified on NJ ex order 26.4b1 of the previously missed checks. II. Residents identified having the potential to be affected and corrective action taken: • Residents with pacemakers have the potential to be affected. All residents with pacemakers were identified (residents J.A., J.E., T.G., A.N., K.P., R.R., J.S., L.S., W.V.) and charts were reviewed. All had completed pacemaker checks as ordered. III. Measures to be put into place to ensure the deficient practice will not recur: • Nursing staff were re-educated to attempt pacemaker checks x3 when the	11/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315069	A. BUILDING _____ B. WING _____	C 09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	1506 GULLY ROAD WALL, NJ 07719

(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 658	Continued From page 6 Minimum Data Set, an assessment tool dated NJ ex order 26.4b1 revealed Resident #39 had a Brief Interview of Mental Status of [redacted] meaning NJ ex order 26.4b1 [redacted]. On 09/19/23 at 09:51 AM, the surveyor reviewed the resident's physician orders. There was an order for the resident NJ ex order 26.4b1 [redacted] It was an active order dated NJ ex order 26.4b1. On 09/20/23 at 10:00 AM, the surveyor requested Resident #39 NJ ex order 26.4b1. The facility provided the surveyor with progress notes from NJ ex order 26.4b1. The NJ Exec Order 26 progress note indicated that the company was experiencing a major system outage, unable to perform new NJ Exec Order 26.4b1 [redacted]. The NJ Exec O note revealed system failure for NJ Exec Order 26.4b1, no estimated time when system will be back up at this time. The NJ Exec O note showed that the resident was refusing at that time, resident stated he/she was feeling NJ Exec Orde" and NJ Exec Order 26.4b1. For the three separate months of NJ Exec Order 26.4b1 [redacted] there was no documentation indicating the facility notified the physician, the family, or second attempts of NJ Exec Order 26.4b1 were made by the staff. On 09/20/23 at 11:15 AM, the surveyor reviewed Resident #39 care plan. The care plan had a NJ ex order 26.4b1 and was initiated NJ ex order 26.4b1. There was an intervention to NJ ex order 26.4b [redacted] The intervention was initiated on NJ ex order 26.4b1	F 658	first attempt has failed and to notify the physician when pacemaker checks are not completed as scheduled. This education began on 9/20/23 and was completed on 10/12/23. • A pacemaker logbook was created which identifies all residents with pacemakers, applicable information, and pacemaker “check” date. The Unit Manager/designee will be responsible for maintaining the logbook, thus ascertaining compliance with pacemaker checks, physician notification, and documentation. The Unit Manager/designee will review the pacemaker logbook weekly on an ongoing basis. IV. Corrective actions to be monitored to ensure the deficient practice will not recur: • The DON/Designee will audit the pacemaker logbook twice monthly for six months to assure compliance with pacemaker checks. Results of the audit will be reported to the Quality Assurance (QA) committee at the Quarterly Meetings for two quarters. The QA committee will determine the need for continued monitoring at the conclusion of the two reporting quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315069	A. BUILDING _____ B. WING _____	C 09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	1506 GULLY ROAD WALL, NJ 07719

(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 658	Continued From page 7 On 09/21/23 at 10:30 AM, the surveyor interviewed the unit Licensed Practical Nurse (LPN) regarding residents who need NJ Exec Order 26.4b1 and who was responsible. The LPN told the surveyor the desk nurse or the floor nurse will do the NJ Exec Order 26.4b1 with the residents. The surveyor asked what would happen if the NJ Exec Order 26.4b1 was unable to be completed for any reason and the LPN said, "We would immediately call the doctor and document it". The surveyor then asked what if a resident refused and the LPN said, "We would try at least three more times, then call the doctor and the family". On 09/21/23 at 11:44 AM, the surveyor reviewed the Treatment Administration Records (TAR) for NJ Exec Order 26.4b1. The NJ Exec Order 26 TAR for NJ Exec Order 26.4b1 was signed by the nurse as completed, the NJ Exec O TAR was documented as "see nurses notes", and the NJ Exec O TAR was documented as the resident refused. On 09/21/23 at 12:44 PM, the surveyor interviewed the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) regarding NJ Exec Order 26.4b1 that could not be completed as ordered. The DON said she would expect doctor to be aware or see the resident in the office for the NJ Exec Order 26.4b1. The DON and LNHA told surveyor, "It was checked yesterday", after surveyor inquiry.	F 658		
F 812 SS=F	NJAC 8:39-11.2 (b), 27.1 (a) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		11/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315069	A. BUILDING _____ B. WING _____	C 09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	1506 GULLY ROAD WALL, NJ 07719

(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 8 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe consistent manner. This deficient practice was evidenced by the following: On 09/13/23 from 09:57 AM until 11:10 AM the surveyors, who were accompanied by the Food Service Director (FSD), observed the following in the kitchen: 1. In the first refrigerator a box of individual containers of cranberry juice had a typed label of 9/24 and a handwritten label of 8/24. The FSD stated he will throw them away just to be sure. 2. In the first refrigerator, there were two white cups of liquid with no label and no date. The FSD identified the cups as being lactose free milk. The	F 812	Corrective action(s)accomplished for resident(s)affected: ¿ No residents were identified. ¿ The box of cranberry juice dated 8/24 was immediately thrown in the trash. ¿ The undated cups of lactose free milk were immediately discarded. ¿ The individual cups of cream cheese dated 6/22 were immediately discarded. ¿ The strawberries labeled 9/14 were thrown in the trash. ¿ The unlabeled, undated, seasoning blend was thrown in the trash. ¿ The mislabeled muffins were thrown in the trash. ¿ The opened, unlabeled bag of muffins was thrown in the trash. ¿ The opened, unlabeled, undated bag of fish patties was thrown in the trash.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315069	A. BUILDING _____ B. WING _____	C 09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	1506 GULLY ROAD WALL, NJ 07719

(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 9 FSD stated the cups should have been dated and that he will discard. 3. In the first refrigerator there were individual cups of cream cheese in an opened box with a received date of 6/22/23. The FSD stated they were good for three months. He stated we are close; he will dispose of them. 4. In the third refrigerator, strawberries that were labeled 9/14/23. The FSD stated they were received on 9/5/23 but he will throw them away. 5. On the spice rack, a salt free seasoning blend container had no label and no date. The FSD stated that spices should be dated when received and are good for usually 6 months. He stated he will discard. 6. In the first freezer in the storage room, an opened bag of breakfast muffins was labeled 9/24/23. The FSD stated that they are mislabeled, and he will get rid of them. 7. In the first freezer in the storage room, an opened bag of fish patties had no label and no date. The FSD stated he will discard the fish patties. 8.In the meat freezer there were chicken tenders and meatballs in separate bags with no labels and no dates. The FSD stated he will discard the items. 9. In the meat freezer there were veal patties and hamburger patties in separate bags with a hole in each bag with no labels and no dates. The FSD stated he will discard the items.	F 812	¿ The unlabeled, undated, chicken tenders & meatballs were thrown in the trash. ¿ The unlabeled and undated veal Patties and hamburger patties were thrown in the trash. ¿ The open bag of coffee filters were thrown in the trash ¿ The Food Service employees were immediately re-educated regarding wearing beard guards at all times while in the kitchen. Residents identified having the potential to be affected and corrective action taken ¿ All residents residing in the facility have the potential to be affected by the deficient practice. ¿ The Regional Food Service Director (RFSD) educated the Food Service Director on 9/13 regarding; labeling, dating, food storage and the need to keep coffee filters in a sealed bag at all times. The Regional Food Service Director will re-educate the FSD again next quarter. ¿ The Food Service employees were immediately re-educated regarding wearing beard guards at all times while in the kitchen. Measures will be put into place to ensure the deficient practice will not recur: ¿ On 9/22 the Food Service Director (FSD) re-educated Dietary staff regarding labeling, dating, food storage and proper coffee filter storage. ¿ The management opening and closing check list was updated to reflect identified areas to ensure compliance. ¿ Inspection of the kitchen, specifically	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315069	A. BUILDING _____ B. WING _____	C 09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	1506 GULLY ROAD WALL, NJ 07719

(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 10 10. On the bottom shelf of the dry storage rack, there were coffee filters in an opened bag exposed and opened to the air. The FSD stated that they should be covered and that he would get rid of them. 11. A food service worker with short facial hair was observed with no beard guard. The FSD stated he will get him a beard guard. On 09/19/23 at 11:55 AM, the surveyors observed a food service worker with facial hair extending past his chin and another food service worker with short facial hair. The food service workers were not wearing beard guards. The FSD stated they should have something covering their facial hair. The surveyor reviewed the undated Sun Cups (juices) policy provided by the FSD. The policy reflected that juices upon delivery are to be labeled with the delivery date and thawed in the refrigerator. Juices not used within 10 days will be disposed of. The surveyor reviewed an undated and untitled policy provided by the FSD. The policy revealed that foods are labeled, dated, and put away promptly upon receipt. The surveyor reviewed the undated Employee Sanitary Practices policy provided by the facility Administrator. The policy reflected that all employees shall: 1. Wear hair restraints (hairnet, hat, and/or beard restraint) to prevent hair from contacting exposed food. NJAC 8:39-17.2(g)	F 812	beard guards were added to the weekly infection control rounds. Corrective actions will be monitored to ensure the deficient practice will not recur: ¿ FSD/Designee will report the findings from the opening and closing check lists logs to the administrator monthly for six months. ¿ The Infection Preventionist will report findings from the audits of weekly infection control rounds to the Director of Nursing (DON). The DON will trend the audits findings and report outcomes to the Quality Assurance (QA) committee quarterly for two quarters with follow-up recommendations as necessary. ¿ FSD/designee will report trends to the QA committee the next two quarters to assure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061331	A. BUILDING: _____ B. WING _____	C 09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	1506 GULLY ROAD WALL, NJ 07719

(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 Complaint # NJ00158680, NJ00164884 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny 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: Complaint # NJ00164884 and NJ00158680 Based on interview and review of other facility documents, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the day shift as mandated by the State of New Jersey for: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	I. Corrective action(s)accomplished for resident(s)affected: " No residents were affected by this practice. II. Residents identified having the potential to be affected and corrective action taken: " The deficient practice has the potential to affect all residents residing in the facility. III. Measures will be put into place to ensure the deficient practice will not recur: " The facility currently has 4 Nursing Agency contracts.	11/6/23

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

Electronically Signed | 10/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061331	A. BUILDING: _____ B. WING _____	C 09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	1506 GULLY ROAD WALL, NJ 07719

(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 nursing homes. The following ratio (s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. a. For the 2 weeks of Complaint staffing from 10/02/2022 to 10/15/2022, the facility was deficient in Certified Nursing Assistants (CNA) staffing for residents on 2 of 14 days: -10/02/22 had 5 CNAs for 50 residents on the day shift, required at least 6 CNAs. -10/03/22 had 5 CNAs for 50 residents on the day shift, required at least 6 CNAs. b. For the week of Complaint staffing from 06/11/2023 to 06/17/2023, the facility was deficient in CNA staffing for residents on 4 of 7 days: -06/11/23 had 5 CNAs for 53 residents on the day shift, required at least 7 CNAs. -06/12/23 had 5 CNAs for 53 residents on the day shift, required at least 7 CNAs. -06/13/23 had 6 CNAs for 53 residents on the day shift, required at least 7 CNAs. -06/15/23 had 5 CNAs for 52 residents on the day	S 560	" Daily bonuses for the agency and in-house staff are offered for double shifts, extra shifts, weekend shifts and staff recognition. " Referral and sign-on bonuses are offered. " Advertisement lawn signs were placed by the front of the building. " The facility is recruiting on multiple employment search engines and multiple social media platforms. " Depending on the needs of the day Nursing management to include Unit Managers, Supervisors and ADON will be evaluated to assist with resident care. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: " The Director of Nursing (DON)/Designee will conduct weekly Certified Nursing Assistant (C.N.A.) staffing schedule audits for the next six months. " The DON/Designee will report staff audit findings to the Administrator. The Administrator/Designee will analyze and trend findings and report outcomes quarterly to the Quality Assessment and Assurance (QAA) 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
	061331	A. BUILDING: _____ B. WING _____	C 09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	1506 GULLY ROAD WALL, NJ 07719

(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 shift, required at least 6 CNAs. c. For the 2 weeks of staffing prior to survey from 08/27/2023 to 09/09/2023, the facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows: -08/27/23 had 5 CNAs for 52 residents on the day shift, required at least 6 CNAs. -08/28/23 had 5 CNAs for 51 residents on the day shift, required at least 6 CNAs. -09/01/23 had 5 CNAs for 51 residents on the day shift, required at least 6 CNAs. -09/02/23 had 5 CNAs for 53 residents on the day shift, required at least 7 CNAs. -09/05/23 had 5 CNAs for 51 residents on the day shift, required at least 6 CNAs. On 09/26/23 at 10:22 AM, the surveyor interviewed the Director of Nursing (DON) who was able to verbalize the regulations for staffing requirements to the surveyor, confirmed the staffing schedules were completed two weeks at a time, and felt there were challenges but felt the facility did a great job meeting the staffing requirements. On 09/26/23 at 10:45 AM, the surveyor reviewed the policy titled, "Nursing Services and Sufficient Staff", a policy dated 08/01/23. Under the section Policy Explanation and Compliance Guidelines, number one indicated the facility will supply services by sufficient numbers of each of the following personnel types on a 24 hour basis to provide nursing care to all residents in accordance with the resident care plans, except when waived, licensed nurses and other personnel, including but not limited to nurses'	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061331	A. BUILDING: _____ B. WING _____	C 09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	1506 GULLY ROAD WALL, NJ 07719

(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 aides.	S 560		
S 720	8:39-7.3(d) Mandatory Resident Activities (d) Resident activities shall be scheduled for seven days each week, and during at least two evenings per week. Religious services shall be considered resident activities for purposes of complying with this requirement. This REQUIREMENT is not met as evidenced by: Based on interviews and review of facility documentation it was determined that the facility did not offer the residents evening activities two nights per week and was evidenced by the following: During the initial tour on 9/13/23 at 10:15 AM, the surveyor was in the day room during pet therapy. The Activities staff were in the room with the residents. The surveyor asked if the facility had evening activities and the Activities Assistant (AA) stated, "not currently the facility is in the process of hiring someone right now". On 09/18/23 at 10:30 AM, the surveyor held a group meeting with six alert and oriented residents in attendance. Five of the six residents (Residents #3, #9, #16, #22, and #25) told the surveyor that there were no evening activities. Resident #9 stated that there were no evening activities. Resident #3 said there are no activities in the evening, and he/she would participate if the facility offered them. The five residents stated there are no activities because there is no activity staff - "they (the activity staff) left."	S 720	I. Corrective action(s)accomplished for resident(s)affected: " Residents #3, #9, #16, #22, and #25 were affected by this practice. " Evening activities are now being offered at least twice a week during evening hours for residents interested in evening activities. 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. " Schedules of current activity employees have been adjusted to ensure there is activity staff in the building twice a week during evenings for evening activities. " Activity calendar has been updated to reflect what days evening activities are being offered. III. Measures will be put into place to	11/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061331	A. BUILDING: _____ B. WING _____	C 09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	1506 GULLY ROAD WALL, NJ 07719

(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 720	Continued From page 4 On 09/18/23 at 11:15 AM, the surveyor reviewed the last four months of activity calendars (June, July, August, and September 2023) which revealed no activities scheduled after 3:30 PM in August 2023. The September 2023 calendar had evening activities scheduled at 5:30 pm Monday through Friday. On 09/18/23 at 11:50 AM, the surveyor interviewed the AA and the August activity calendar was reviewed together. She stated we have activities up until 4 PM now. She stated we have no one to do evening activities. When asked if there should be evening activities, AA stated she is not sure if there should be evening activities. She further stated there have been no evening activities for August or September. On 09/18/23 at 12:24 PM, the surveyor interviewed the Administrator, who stated he is aware of staffing issues with activity staff and acknowledged that there have been no evening activities in August and September. On 09/20/23 at 09:34 AM, the Administrator provided the policy for activities which states "Activities will be scheduled at various times, seven days a week". N.J.A.C. 8:39-7.3	S 720	ensure the deficient practice will not recur: " Referral and sign-on bonuses are offered. " The facility is recruiting on multiple employment search engines and multiple social media platforms. " Director of Activities has switched schedules to accommodate in person evening activities at least twice a week if evening staff are unavailable. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: " The Director of Activities/Designee will conduct weekly staffing schedule audits. " The Director of Activities will ensure that resident are made aware of what evening activities are available. " The Director of Activities/Designee will report staff audit findings to the Administrator. The Administrator/Designee will analyze and trend findings and report outcomes quarterly to the Quality Assessment and Assurance (QAA) Committee for the next meeting, with follow up to recommendations, as necessary.	

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
315069 (Y1)	A. Building B. Wing (Y2)	11/14/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	1506 GULLY ROAD WALL, NJ 07719

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 F0657 Reg. # 483.21(b)(2)(i)-(iii) LSC	Correction Completed 11/06/2023	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 11/06/2023	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 11/06/2023
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

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	
9/26/2023	☐ 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 (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061331		11/14/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	1506 GULLY ROAD WALL, NJ 07719

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 11/06/2023	ID Prefix S0720 Reg. # 8:39-7.3(d) LSC	Correction Completed 11/06/2023	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	
9/26/2023	☐ 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
061331 Y1	A. Building B. Wing Y2	11/14/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	1506 GULLY ROAD WALL, NJ 07719

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 11/06/2023	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 9/26/2023	☐ 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
	315069	A. BUILDING **01** B. WING _____	**09/26/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	**1506 GULLY ROAD** **WALL, NJ 07719**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 9/25/23, 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 Tower Lodge Care Center is a 1- building that was built in 60's, It is composed of Type II protected. The facility is divided into 4- smoke zones. The 100 KW exterior natural gas generator does 100% of the building. The facility has 60 licensed beds currently at 56.	K 000		
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interviews conducted on 9/25/2023, in the presence of facility Maintenance Director (MD) and Regional Director (RD), it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition,	K 281	I. Corrective action(s) accomplished for resident(s) affected: No residents were identified as having a negative impact from this deficient practice. II. Residents identified having the potential	11/6/23

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

Electronically Signed | 10/15/2023

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
	315069	A. BUILDING **01** B. WING _____	**09/26/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	**1506 GULLY ROAD** **WALL, NJ 07719**

(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 281	Continued From page 1 Section 19.2.8 and 7.8. The deficient practice affected 1 of 4 occupied access areas observed and was evidenced by the following: At 9:29 AM, the surveyor in the presence of the MD and RD observed in zone 1&2 exit/egress route, as identified on the life safety code floor plan, that the left-side of the conference was provided with electric wall switches. The wall switches shutoff all the light fixtures. The area was not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention. The MD and RD confirmed the finding's at the time of observations. The Administrator was informed of these findings at the Life Safety Code survey exit conference on 9/25/2023. NFPA 101-2012 edition Life Safety Code: 7.8 Illumination of Means of Egress: 7.8.1.3* (2) NJAC 8:39-31.2(e)	K 281	to be affected and corrective action taken: This deficient practice had the potential to affect all residents residing in this facility. No residents were affected by this practice. On 10/03/2023 the deficient practice was corrected by rewiring the light and ensuring that one light fixture in the conference room will remain in operation continuously and does not have the ability to be turned off as the switch has been bypassed. III. Measures will be put into place to ensure the deficient practice will not recur: The Director of Maintenance was educated by the Administrator on the importance of having continuous illumination by all means of egress in accordance with NFPA 101. Maintenance Director will conduct biannual inspections of all means of egress and ensure there is continuous illumination by all means of egress. Results of this inspection and any corrective actions will be presented at the following Quality Assessment and Assurance (QAA) Committee meeting. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The Director of Maintenance will report the results of the biannual inspections of all means of egress and any corrective actions to the Quality Assessment and Assurance (QAA) Committee twice over the next four quarters when conducted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315069	A. BUILDING **01** B. WING _____	**09/26/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	**1506 GULLY ROAD** **WALL, NJ 07719**

(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 281	Continued From page 2	K 281	The QAA Committee will determine the need for any additional monitoring of emergency illumination.	
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview conducted on 9/25/23, in the presence of the Maintenance Director (MD) and Regional Director (RD), it was determined that the facility failed to provide exit signs that included a continuous illumination indicator showing the direction of travel, in every location, where the direction of travel to reach the nearest and secondary exit was not apparent, in accordance with NFPA 101, 2012 Edition, Section 19.2.10, 19.2.10.1, 7.10.1.2, 7.10.2, 7.10.2.1. The deficient practice was identified for 4 of 12 exit signs observed and was evidenced by the following: At 11:50 AM, the surveyor, MD and RD observed 4-sets of smoke door from the center core of the building leading into the Pearl wing, Ruby wing, Emerald wing and Diamond wing. The 4-sets of smoke doors from the core of the building, when released from the electro -magnetic holding device, closed the 4-sets of smoke doors and	K 293	K293 F Exit Signage I. Corrective action(s) accomplished for resident(s) affected: No residents were identified as having a negative impact from this deficient practice. II. Residents identified having the potential to be affected and corrective action taken: This deficient practice had the potential to affect all residents residing in this facility. No residents were affected by this practice. On 10/12/2023 the deficient practice was corrected by installing illuminated exit signs at each of the areas indicated on the exit/egress evacuation plan as an exit. III. Measures will be put into place to ensure the deficient practice will not recur:	11/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315069	A. BUILDING **01** B. WING _____	**09/26/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	**1506 GULLY ROAD** **WALL, NJ 07719**

(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 293	Continued From page 3 now it was undetermined, where the secondary evacuation route was from the center core of the building, as no illuminated exit signs were observed. The closed set of door's blocked the exit sign at the end of the corridor from being viewed in the event of an emergency The exit/egress evacuation floor plans indicated each identified wing as an exit, but provided no illuminated exit signs. The interior of each wing before the smoke doors, did have an illuminated exit signs. The findings were verified and confirmed by the MD and RD at the time of the observations. The Administrator was informed of the findings at the Life Safety Code exit conference on 9/25/23. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.2.10, 19.2.10.1, 7.10.1.2, 7.10.2, 7.10.2.1.	K 293	The Director of Maintenance was educated by the Administrator on the importance of having exit and directional signs by all areas indicated on the exit/egress evacuation plan as an exit in accordance with NFPA 101. Maintenance Director will conduct an inspection of areas indicated on the exit/egress evacuation plan as an exit and ensure illuminated exit signs are placed by all areas indicated on the exit/egress evacuation floor plan. Results of this inspection and any corrective actions will be presented at the following Quality Assessment and Assurance (QAA) Committee meeting. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The Director of Maintenance will report the results of the inspection of all areas indicated on the exit/egress evacuation plan as an exit and any corrective actions to the Quality Assessment and Assurance (QAA) Committee at the January 2024 quarterly meeting. The QAA Committee will determine the need for any additional monitoring for illuminated exit signs after the Jan 2024 quarterly meeting.	
K 914 SS=E	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional	K 914		11/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315069	A. BUILDING **01** B. WING _____	**09/26/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	**1506 GULLY ROAD** **WALL, NJ 07719**

(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 914	Continued From page 4 testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, interview and documentation review on 9/25/23, in the presence of the Regional Director (RD) and Maintenance Director (MD), it was determined that the facility failed to functionally test electrical receptacles in residents' rooms that had non-hospital grade outlets annually for grounding, polarity, and blade tension in accordance with NFPA 99. This deficient practice was evidenced for 25 of 25 resident rooms observed by the following: At 9:45 AM, while reviewing documentation provided by the Maintenance Director, the annual non-hospital grade outlet inspection was provided indicating: room #, polarity, grounding and tension. The inspection form provided was not dated and identified as to who did the actual ispection.	K 914	I. Corrective action(s) accomplished for resident(s) affected: No residents were identified as having a negative impact from this deficient practice. II. Residents identified having the potential to be affected and corrective action taken: This deficient practice had the potential to affect all residents residing in this facility. No residents were affected by this practice. Electrical inspections of resident room receptacles were conducted on 10/12/2023 including grounding, polarity, and blade tension on resident room receptacles. A signed and dated copy of the 10/12/2023 resident room receptacle inspection was obtained by the Administrator and provided to the Director of Maintenance for the inspection log	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315069	A. BUILDING **01** B. WING _____	**09/26/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	**1506 GULLY ROAD** **WALL, NJ 07719**

(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 914	Continued From page 5 The MD, confirmed that the facility had non-hospital outlets installed in resident rooms, but could not provide any further documentation indicating the annual inspection date and who did the actual testing. The Administrator was informed of the findings at the Life Safety Code exit conference on 9/25/23. NJAC 8:39-31.2(e) NFPA 99	K 914	book. III. Measures will be put into place to ensure the deficient practice will not recur: The Director of Maintenance was educated by the Administrator on the importance of dating and signing the annual testing of electrical receptacles in residents rooms for grounding, polarity, and blade tension in accordance with NFPA 99. The next annual inspection for resident rooms receptacles is scheduled for October 2024 to include grounding, polarity and blade tension. Results of this inspection and any corrective actions will be presented at the following Quality Assessment and Assurance (QAA) Committee meeting. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The Director of Maintenance will report the results of the annual resident room receptacle inspection and any corrective actions to the Quality Assessment and Assurance (QAA) Committee twice over the next four quarters when conducted. The QAA Committee will determine the need for any additional monitoring of resident room receptacles.	

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)
315069	A. Building 01 - MAIN BUILDING 01 B. Wing	11/14/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	1506 GULLY ROAD WALL, NJ 07719

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 K0281	Correction Completed 11/06/2023	ID Prefix Reg. # NFPA 101 LSC K0293	Correction Completed 11/06/2023	ID Prefix Reg. # NFPA 101 LSC K0914	Correction Completed 11/06/2023
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

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	
9/26/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO