STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315235	A. BUILDING _____ B. WING _____	C 09/11/2023

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RIVERSIDE NURSING AND REHABILITATION CENTER	**325 JERSEY STREET TRENTON, NJ 08611**

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E 000	Initial Comments Survey: 09/11/23 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 Census: 129 Sample Size: 29 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483., Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		11/11/23

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

Electronically Signed | 09/27/2023

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.

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, review of medical records and other facility documentation, it was determined that the facility failed to promote dignity. This deficient practice was identified for 1 of 1 resident (Resident #287) reviewed for dignity. This deficient practice was evidenced by the following: On Ex Order 26. 4B1 at 7:18 AM, admission records revealed that Resident #287's family member had concerns about Resident #287's Ex Order 26. 4B1	F 550	Resident #287 is no longer in the facility. Residents with catheters have the potential to be affected by this practice. An audit of current residents with catheters was completed by the Director of Nursing and/or the Unit Managers by 10/15/23 to ensure catheters were in place for residents with physician order for catheters. No other residents were found to be affected. Facility Nurses were inserviced by Staff	

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F 550	Continued From page 2 Ex Order 26. 4B1 was removed without his/her permission and Resident #287 was placed in a Ex Order 26. 4B1 the first night at the facility. On 09/11/23 at 12:15 PM, the surveyor reviewed Resident #287's Quarterly Minimum Data Set (MDS), an assessment tool revealed that the resident had a Ex Order 26. 4B1 score of Ex Order 26. 4B1 out of 15 which indicated that the resident was Ex Order 26. 4B1. Further review of the admission record for Resident #287 revealed a progress note dated for Ex Order 26. 4B1 which stated, "Ex Order 26. 4B1 ." Review of the Physician Order (PO) for the month of Ex Order 26. 4B1 made no mention of the NJ Exec. Order and there was no discontinuation order found for the removal of the Ex Order 26. 4B1. Review of the Care Plan (CP) dated Ex Order 26. 4B1 did not have the Ex Order 26. 4B1 listed nor was there any revisions. On 09/11/23 at 12:54 PM, the surveyor interviewed the Social Worker (SW) who could not recall if Resident #287 had a Ex Order 26. 4B1 and the SW's notes did not speak to this but the SW did recall speaking with the family member about the resident not wanting to wear a Ex Order 26. 4B1. The SW was able to provide a grievance form dated for Ex Order 26. 4B1, reported by the resident which stated the staff were giving Resident #287 a hard time Friday night during the 11-7 AM shift and staff had to change him or her every two hours. Resident #287 stated the staff stated he/she	F 550	Educator by 11/11/23, on obtaining Physician orders to remove or replace any type of catheters, as well as documenting any resident's refusal regarding removal of catheters. Director of Nursing and/or Assistant Director of Nursing will randomly observe residents with catheters weekly X4 weeks then monthly X2 months to ensure catheter orders are being appropriately followed and are not discontinued without obtaining a physician's order. The Director of Nursing will report findings of the catheter audit to the Quality Assurance/Performance Improvement Committee monthly x 3 months or until substantial compliance is achieved. The Administrator is responsible for ensuring this action occurs	

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F 550	Continued From page 3 needed to use their arms and do things for him or herself. The result of the grievance was that Resident #287 was having a hard time adjusting and should be seen every two hours for Ex Order 26. 4B1 and to document refusals every two hours, to add it on the CP, and a Ex Order 26. 4B1 was ordered. Review of the Medication Administration Record (MAR) revealed two blank spaces on the MAR under the dates of Ex Order 26. 4B1 and the second blank space was under the date Ex Order 26. 4B1, meaning the nurse did not sign it as complete. On 09/11/23 at 1:35 PM, the surveyor interviewed the Director of Nursing (DON) and asked for a timeline of the Ex Order 26. 4B1, no timeline was provided but the DON did confirm that a PO was needed to discontinue the Ex Order 26. 4B1 and resident #287's concern to keep the Ex Order 26. 4B1 and not wanting to wear a Ex Order 26. 4B1 should have been addressed, and there should have been a Ex Order 26. 4B1 completed. No additional documentation was provided. Review of the facility policy dated for 08/01/23 titled, "Resident Rights Regarding Treatment and Advance Directive" revealed the following: It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive. 6. The facility will define and clarify medical issues and present them to the resident or legal representative as appropriate and 11. Should the resident refuse treatment of any kind, the facility will document	F 550		

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F 550	Continued From page 4 the following in the residents chart: what the resident refused, the reason for the refusal, how the resident was educated, the offering of alternative treatments, and the continuation of providing all other services.	F 550		
F 561 SS=D	NJAC 8:39 4.1(a) 12 Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the	F 561		11/11/23

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F 561	Continued From page 5 facility. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, review of medical records and other facility documentation, it was determined that the facility failed to promote and facilitate resident self-determination through support of resident choices to have personal needs allowance (PNA) and to have use of the laundry room during the evening hours and on the weekends. This deficient practice was identified for 6 of 6 residents. This deficient practice was evidenced by the following: On 08/31/23 at 10:30 AM, the resident council meeting was held and 6 out of 6 residents stated there was no PNA available in the evenings during the week and not available at all on the weekends, and the resident laundry room on the first floor was not available in the evenings during the week or on the weekends. On 08/31/23 at 02:09 PM, the surveyor interviewed the Administrator (Admin) and the Director of Nursing (DON) regarding the PNA and the Admin's response to the PNA was that PNA is available on the weekends and in the evenings. He stated that a locked box is kept at the front desk for the residents to be able to get money after hours and the same goes for the laundry room. The Admin stated residents can ask the front desk staff or a supervisor to use the laundry room, the staff have a key to open it for the residents to use it after 5 PM. The DON was present and agreed with this. On 08/31/23 at 02:12 PM, the surveyor observed	F 561	Residents were informed by the Administrator at the resident council meeting on 8/31/23 that the First floor Personal Laundry Room is available for residents 24hours daily/7 days a week and that Personal Needs Allowance is available at the front desk on weekends, and after 5pm during the weekdays. A locked Box with Money was provided on 9/1/23 by the Business Office Manager for the front Desk for after hours and on weekends to allow residents access to their personal funds 24 hours/day. Residents that currently reside in the facility can be affected by the deficient practice. The Director of Nursing and/or Director of Social Services completed 10 random interviews with alert and oriented residents by 10/1/23 to determine if these practices have had a negative impact. No residents were found to be negatively impacted by this practice but all were made aware of the Personal Laundry Room and the Personal Needs Allowance availability 24 hours/7 days per week. The sign at the front desk was updated by the Administrator on 8/31/2023 with new hours for Personal Needs Allowance availability. The Business office manager and front desk receptionists were inserviced by the Administrator by 9/20/23 regarding the new system of Personal Needs Allowance being available for residents at the front desk on weekends and after 5pm on weekdays. The	

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F 561	Continued From page 6 the PNA sign at the front desk which stated that PNA was available M-F (Monday to Friday) 9-12 PM. There was nothing additional posted that indicated PNA was available at any other times. The surveyor then interviewed the front desk receptionist and asked about the laundry room and was advised the hours for the laundry room were everyday Monday- Sunday from 9-5 PM. The receptionist confirmed they close at 5 PM and it does not get open again until 9 AM. The receptionist stated there is a key left at the front desk with the 3-11 PM staff but that was for the staff to lock the door at 5 PM. The receptionist stated the 5 PM time came from the Maintenance Director (MD). On the same date at 2:22 PM, the MD confirmed the laundry room was open from 9-5 PM everyday Monday-Sunday and the residents did not have access to the laundry room after 5 PM because "there are a lot of behavioral residents, and they may come down and get hurt." The MD confirmed there have not been any issues but the facility was just trying to be preventative. The surveyor reinterviewed the Admin and DON regarding the PNA sign as well as the laundry room not being available after 5 PM daily and referenced that two staff were just interviewed. The Admin stated there was a lock box at the front desk which the staff have access to provide money to the residents in the evenings and on the weekends and confirmed that staff were aware that the laundry room was available to the residents in the evenings. On 08/31/23 at 2:38 PM, the surveyor interviewed the Business Manager (BM) who confirmed that the sign posted at the front desk stated PNA was	F 561	Administrator posted a sign on the Personal Laundry Room door indicating the new hours of availability and also inserviced the Maintenance Director, and front desk receptionists by 11/1/23 that the Personal Laundry Room on the first floor is available for residents use 24hours/7 days per week. Social Services will randomly interview 10 alert and oriented residents weekly x 4 weeks then 15 residents monthly x 2 months to ensure residents are aware and that services are available 24 hours/7 day per week availability for Personal Needs Allowance and Personal Laundry Room The Administrator will report findings of the Personal Needs Allowance and Personal Laundry Room availability audit to the Quality Assurance/Performance Improvement Committee monthly x 3 months or until substantial compliance is achieved. The Administrator is responsible for ensuring this action occurs.	

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F 561	Continued From page 7	F 561		

only available from 9-12 PM but stated that the BM works until 5 PM and money is available until 5 PM and when the BM was not in, a nurse will provide the funds to the resident and the nurse can get reimbursed. The BM further confirmed there was a lock box at the front desk but was removed a month and a half ago because there were new staff hired for the front desk and BM did not want the funds to disappear.

On 08/31/23 at 02:42 PM, the surveyor interviewed a resident who was coming out of the laundry room and confirmed that the laundry room was only open until 5 PM daily even after asking and stated how he/she wished it was open for 24 hours because they would love to do laundry in the evenings so they can put clothes in the washer and watch television in the hallway located near the laundry room.

On 08/31/23 at 02:48 PM, the surveyor reinterviewed the Admin and DON and brought up the resident's interview regarding the laundry room. The Admin stated they would look into the laundry room being open 24 hours since there was 24 hour coverage at the front desk and the laundry room is near the front desk.

Review of the facility policy titled, "Resident Funds" revealed our facility protects the resident's funds maintained or managed by the facility. 3. The objectives of our resident fund policies are to: c. provide a means for the resident to access his or her funds or to have a guardian or other legally appropriate representative do so.

Review of the facility policy dated for 08/01/23 titled, "Resident Rights ..." revealed the following: It is the policy of this facility to support and

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F 561	Continued From page 8 facilitate a resident's right. Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care.	F 561		
F 584 SS=E	NJAC-8:39 4.1(a), 10 Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		11/11/23

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F 584	Continued From page 9 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Complaint number: NJ00158868, NJ00159302, and NJ00158245 Based on observation, interview, and review of facility documentation it was determined the facility failed to maintain a clean, safe, and sanitary environment for the residents. This deficient practice was identified on the a.third and b.fourth floor of the facility and was evidenced by the following: a. On 08/29/23 12:09 PM, the surveyor toured the third-floor unit, the high and low side. During the tour the surveyor observed the following: In rooms 303, 304, 309, and 315 the surveyor observed cracks in the glass windows. The cracks were covered with silver tape; they were semi-private rooms. Room 304 had brown substance spots on the floor which appeared dry. Room 315 there was a nightstand with a broken door handing from the hinge. Room 321 there was a four-drawer dresser and one of the drawers was missing from the dresser.	F 584	The Maintenance and/or Housekeeping Director corrected the following: Cracked windows were replaced in 303, 304, 309, and 315 on the third floor, brown substance spots on the floor in room 304 was cleaned thoroughly, the nightstand with a broken door in room 315 was repaired, the missing drawer from the dresser in room 321 was replaced. The third-floor shower room vanity was replaced. The box of gloves under the vanity was discarded. The shower chair in the third floor shower room with a black substance on the back of the fabric and a stain on the arm of the shower chair was cleaned thoroughly. The missing shower head in shower #1 was replaced, the missing knob to turn on the water in shower #2 was replaced, the rust-colored substance on all walls in shower #3 was thoroughly cleaned, and the 3 cracked tiles on the wall in the area that met the floor were repaired or replaced as needed. The missing handles on the four-drawer dresser in Room 317 were repaired. The window screen with a large	

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F 584	Continued From page 10 On 08/31/23 at 11:58 AM, the surveyor went into the third-floor shower room and observed the following: A vanity which had a missing doorknob, paint chipping, and the door on the left hanging off the hinges. Under the vanity in the shower room were 10 boxes of gloves on the floor, there were no shelves in the vanity. There was a shower chair with a red fabric cover with black substances on the back of the fabric in four areas, the left arm of the shower chair had a dried brown substance. There were three showers in room. Shower #1 was missing a shower head, shower #2 was missing a knob to turn on the water, shower #3 had rust colored substance on all the walls and three cracked tiles on the wall in the area that met the floor. On 09/06/23 at 10:53 AM, during a Ex Order 26. 4B1 observation in room NJ Exec. O the surveyor observed a four-drawer dresser and two of the drawers did not have handles. The surveyor asked the nurse who was performing Ex Order 26. 4B1 if the dresser should have handles and she said "Yes". In the same room the window screen on the left had large tear from corner to corner and was hanging down. There was a nightstand in the room that had the drawer off, was laying on top of nightstand. On 09/06/23 at 12:45 PM, the surveyor interviewed a housekeeper (HK#1) from the fourth floor regarding cleaning assignments. HK#1 said there were two housekeepers on the fourth floor every day. The surveyor asked who was responsible for cleaning the shower rooms and HK#1 said, Whatever housekeeper is up	F 584	tear in Room 317 was replaced. The nightstand with a drawer off in Room 317 was repaired. The door jams in room 415 and 416 and the overlays of the doors to rooms 422 and 430 were painted. Current residents residing in the facility can be affected by this practice. The Maintenance and/or Housekeeping Director completed rounds in the facility to determine other areas that required replacing windows/screens, cleaning equipment or floors/walls, repair to nightstands/vanities, replacement of doorknobs, repainting areas with chipped paint, shower head repair/replacement, cracked tiles and door jams/overlays in need of painting. Areas that were found in need of repair or cleaning were repaired and cleaned and documented on a log by the Maintenance/Housekeeping Director by 11/10/23. The Housekeeping director will establish a daily log for cleaning tasks for implementation by 11/11/23 to include shower room/shower room equipment cleaning to ensure shower room/shower room equipment are cleaned as scheduled. Housekeepers will be trained by the Housekeeping Director by 11/11/23 to appropriately clean the shower room/shower equipment according to the daily log and to maintain the log, documenting the date and time of each cleaning. The Maintenance Director will implement an electronic maintenance request system by 11/11/23 to streamline and track all maintenance requests. Staff	

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F 584	Continued From page 11 there is supposed to do it". The surveyor then interviewed the third-floor housekeeper (HK#2) regarding the cleaning assignments on the third floor. HK#2 told the surveyor there were two house keepers on the third floor and the one assigned to the hall with shower does the shower room. The surveyor asked how often the showers were cleaned and HK#2 said, "Should be done every day, some do it, some don't". The surveyor asked if a log was kept for the shower cleaning and HK#2 said, "No, but that's what we need". On 09/06/23 at 12:55 PM, the surveyor interviewed the unit Licensed Practical Nurse (LPN) regarding the process for any repairs needed in resident rooms or on the unit.The LPN told the surveyor "We have a maintenance log we write in; they check it a few times a day". The Unit Manager (UM) was also present during the interview who told the surveyor the facility will soon be going to electronic maintenance requests. The surveyor asked if the maintenance department responded quickly, and the UM said, "They respond quickly, especially if it's an urgent matter". On 09/06/23 at 12:59 PM, the surveyor, in the presence of another surveyor entered the third-floor shower room. One shower remained with no knob, gloves were on the floor under a vanity, the shower chair had a black substance on the back of the chair on the material and there was a reddish pink color observed on the white plastic part of the shower chair legs and on the back of the toilet seat. On 09/07/23 at 12:44 PM, the surveyor interviewed the Maintenance Director (MD) regarding the process for repairs. The MD said	F 584	members will be trained by the maintenance director by 11/11/23 on how to use this system to report and follow up on repair needs. The Administrator will develop a Maintenance Daily Room Rounds Checklist to be completed daily by the Maintenance Director starting 11/11/23. The checklist will include maintenance inspection of 2 rooms per day Monday through Friday for equipment/furniture repairs, painting repairs, windows/screen replacement, shower rooms repairs, tile replacement, and observation for pests. Areas found during daily rounds that are in need of maintenance repair/pest eradication will be corrected immediately by the Maintenance Director. The Administrator will randomly observe resident rooms and shower rooms weekly X4 weeks then monthly X2 months to ensure cleaning and repairs are completed timely per housekeeping and maintenance logs/checklists. The Administrator will report findings of the housekeeping/maintenance audits to the Quality Assurance/Performance Improvement Committee monthly x 3 months or until substantial compliance is achieved. The Administrator is responsible for ensuring this action occurs.	

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	315235	A. BUILDING _____ B. WING _____	C 09/11/2023

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F 584	Continued From page 12	F 584		

the logbooks on each unit were checked four times daily and the maintenance department rounded on each room monthly. The MD said if anything is needed quickly the staff can call the department.

On 09/07/23 at 01:46 PM, the surveyor interviewed MD regarding the cracked windows. The MD said, "The windows were cracked for about 3 months", the MD could not tell the surveyor how the windows became cracked but did say they were "on order".

On 09/11/23 at 10:15 AM, the surveyor reviewed the policy titled, "Shower Room Cleaning Policy", an undated policy. The policy indicated that all shower rooms are to be cleaned daily in the morning (start of shift) and afternoon (after lunch break). The policy procedures section included dust mop, empty trash, fill soap dispensers, sanitize sinks, sanitize commode, and clean shower chairs. The surveyor then reviewed the wheelchair cleaning schedule with indicated third floor shower chairs were cleaned on 08/09/23 for a deep cleaning.

On 09/12/23 at 10:28 AM, the surveyor reviewed the policy titled, Preventative Maintenance Program", the policy was dated 08/01/23. The policy indicated a preventative maintenance program shall be developed and implemented to ensure the provision of a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.

b. On 08/31/23 at 8:10 AM the surveyor observed the right side of the door jam of rooms 415 and 416 with peeling tan paint exposing the blue paint underneath. The surveyor observed the overlay

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F 584	Continued From page 13	F 584		

of the doors to rooms 422 and 430 peeling off exposing the wood underneath.

On 09/07/23 at 12:35 PM, the surveyor interviewed the third floor Nurse Manager regarding repairs she stated we page maintenance, and we have a book. She stated the door jams on rooms 415 and 416 had stop signs on that ripped off the paint. She doesn't know if maintenance is aware, but she will make them aware. Regarding the doors to rooms 422 and 430 the wheelchairs often rub against door exposing the wood. She will make maintenance aware.

On 09/07/23 at 01:19 PM, the surveyor interviewed the MD regarding the paint on the door jams of 415 and 416 and the door to rooms 422 and 430. He was not aware however will see if he has other covers and will replace.

Surveyor: McCrayReid, Andrea

c. On 09/11/23 at 12:02 PM, the surveyor reviewed the pest control log and there were bugs listed under the dates of 7/28/22, 08/08/22, and 09/01/22 and there were roaches listed on the log under 09/12/22 and on 09/13/22 there was a mouse listed in the second floor pantry. Further review of the pest log revealed roaches on the second floor on 09/27/22, 10/10/22, and again on 10/11/22.

Review of the facility's policy dated for 08/01/23, titled Pest Control Program, revealed it is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents.

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F 584	Continued From page 14	F 584		
F 636 SS=D	NJAC 8:39-4.1 (a), 31.4 (a,c,f) Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of	F 636		11/11/23

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F 636	Continued From page 15 the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to complete the Annual Minimum Data Set (MDS), a periodic and federally mandated, standardized assessment tool, within the required time frame. This deficient practice was identified for 1 of 3 residents (Residents #51) reviewed for timing of assessments and was evidenced by the following: The Centers For Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual indicates that at a minimum, facilities	F 636	The annual Minimum Data Set Assessment for resident #51 was completed by Ex Order 26. 4B1 by the Minimum Data Set Nurse. Current residents in the facility have the potential to be affected by this practice. The Minimum Data Set Nurse audited annual Minimum Data Set Assessments for current residents by 10/20/23 to ensure annual assessments were completed during the required timeframe. No other residents were found to be affected by this practice.	

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F 636	Continued From page 16 are required to complete a comprehensive assessment for each resident not less than once every 12 months while a resident, where 12 months refers to a period within 366 days. This deficient practice was evidenced by the following: On Ex Order 26. 4B1 a review of the electronic health record (EHR) reflects that resident #51 was admitted to the facility in Ex Order 26. 4B1. The MDS schedule revealed the most recent MDS assessments completed were: Annual MDS Ex Order 26. 4B1 Quarterly MDS Ex Order 26. 4B1 Quarterly MDS Ex Order 26. 4B1 Quarterly MDS Ex Order 26. 4B1 The annual MDS due Ex Order 26. 4B1 for Resident # 51 was not completed nor scheduled. On 8/29/23 at 11:38 am, the surveyors interviewed the Lead MDS Coordinator and the Part time MDS Coordinator. They stated that "they split the process for MDS's. An annual assessment is due at least every 365 days." They stated that Resident #51 is still a resident at this facility. When they reviewed his MDS assessments, they stated that "his annual is missing". The Part time MDS Coordinator stated that "he was on the (paper) calendar, but was missed and that they are going to do it now." NJAC 8:39-11.2 (e)	F 636	Minimum Data Set Nurses were educated by the Staff Educator by 10/1/23 on the requirement to complete Minimum Data Set Assessments within the required timeframe. The Director of Nursing and/or the Assistant Director of Nursing will monitor Annual MDS assessments weekly x 4 weeks then monthly x2 months to ensure Minimum Data Set Assessments are completed within the required timeframe. The Director of Nursing and/or Assistant Director of Nursing will report findings of the Minimum Data Set Audits to the Quality Assurance/Performance Improvement Committee monthly x 3 months or until substantial compliance is achieved The Administrator is responsible for ensuring this action occurs	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility	F 637		11/11/23

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F 637	Continued From page 17 determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on resident observation, interview and record review, it was determined that the facility failed to complete a significant change in status assessment (SCSA) for a *Ex Order 26. 4B1*. This deficient practice was identified for 1 of 1 residents (Resident #93) reviewed for [redacted] and was evidenced by the following: The Centers For Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual indicates that a SCSA is required to be performed when a terminally ill resident enrolls in a *Ex Order 26. 4B1* [redacted] or changes hospice providers and remains a resident at the nursing home. The assessment reference date (ARD) must be within [redacted] days from the effective date of the *Ex Order 26. 4B1* [redacted]. This deficient practice was evidenced by the following: On 08/29/23 at 11:25 AM, during the tour of the	F 637	Resident #93 is no longer in the facility. Residents currently residing in the facility with a significant change can be affected by this practice. The Director of Nursing, Assistant Director of Nursing and/or the Minimum Data Set Nurse completed an audit of current residents by 9/15/23 to determine if a significant change in status assessment had been completed for other residents with a significant change in condition. No other residents were found to be affected by this practice. Minimum Data Set Nurses were educated by the Staff Educator by 10/15/23 on the requirement to complete Significant Change in Status Assessments for residents with a significant change within the required timeframe. The Director of Nursing and/or the Assistant Director of Nursing will monitor for timely significant Change in Status Assessment completion for residents with	

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F 637	Continued From page 18 facility the surveyor observed Resident #93 in bed. At that time the resident was receiving care from a staff member who identified herself as "the Ex Order 26. 4B1". The family was at the bedside and told the surveyor they were pleased with the care received from the 'Ex Order 26. 4B1". Review of the Admission Record revealed Resident #93 was admitted to the facility in Ex Order 26. 4B1. Medical diagnoses included, but were not limited to Ex Order 26. 4B1. The resident had a Ex Order 26 of Ex Or, meaning the resident was not able to complete the assessment due to Ex Order 26. 4B1. On 08/30/23 at 11:17 AM, the surveyor observed the resident in bed receiving care from the Ex Order 26. 4B1. On 08/30/23 at 11:24 AM, the surveyor reviewed the facility Ex Order 26. 4B1 which showed they utilized Ex Order 26. 4B1, a Medicare certified Ex Order 26. 4B1. On 08/30/23 at 11:57 AM, the surveyor reviewed the physician orders which showed an order for Ex Order 26. 4B1 to evaluate and treat. The order was written on Ex Order 26. 4B1. The surveyor then reviewed the Ex Order 26. 4B1 which revealed Resident #93 was admitted to Ex Order 26. 4B1 on Ex Order 26. 4B1. On 08/30/23 at 12:11 PM, the surveyor reviewed Minimum Data Sets (MDS), assessment tools. Review of the Ex Order 26. 4B1 quarterly MDS section Ex O, titled special procedures and treatments was selected as" Ex Or" for Ex Order 26. 4B1, which was prior to admission to Ex Order 26. 4B1. Review of the Ex Order 26. 4B1	F 637	a significant change in condition weekly x 4 weeks then monthly x2 months to ensure Change in Status Assessments are completed within the required timeframe. The Director of Nursing and/or Assistant Director of Nursing will report findings of the Significant Change in Status Audits to the Quality Assurance/Performance Improvement Committee monthly x 3 months or until substantial compliance is achieved. The Administrator is responsible for ensuring this action occurs.	

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F 637	Continued From page 19 quarterly MDS section [redacted] revealed a "[redacted]" for [redacted]. The resident became [redacted] on [redacted], the surveyor could not locate a significant change MDS following Resident #93 admission to [redacted]. On 09/11/23 at 11:57 AM, a surveyor interviewed the MDS Coordinators. They told the surveyor that the Resident went on [redacted] in [redacted]. One MDS Coordinator was not at the facility at that time, however the other coordinator had no knowledge that a significant change needed to be completed. It was identified in [redacted] and the MDS coordinator completed a significant change on ARD [redacted].	F 637		
F 656 SS=D	NJAC 8:39-11.2 (i) Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		11/11/23

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F 656	Continued From page 20 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to implement a comprehensive care plan for Resident #23, 1 of 29 residents reviewed for care plans and was evidenced by the following: On 08/29/23 at 12:29 PM, during the initial tour of the facility Resident #23 told the surveyor that he/she fell out of bed about week ago because the bed is small, and they were used to a king-sized bed. The surveyor asked if there was a	F 656	The comprehensive care plan for resident #23 was updated by [redacted] by the Minimum Data Set Nurse to include effective interventions to reduce residents risk for falls. A star was placed on the doorframe of resident #23's room by the Director of Nursing by [redacted] to indicate to staff that the resident is on a falling star program. Residents currently residing in the facility	

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F 656	Continued From page 21 floor mat next to the bed at the time of the [redacted] and resident said, "*Ex Order 26. 4B1* [redacted]". Resident #23 denied any major injuries from falls and said he/she already had *Ex Order 26. 4B1*. On 09/06/23 at 10:00 AM, the surveyor observed Resident #23 in bed. The bed was in the low position. On 09/06/23 at 10:40 AM, the surveyor reviewed Resident #23 incidents/accidents which revealed the resident had [redacted] on *Ex Order 26. 4B1* [redacted] On 09/06/23 at 11:00 AM, the surveyor reviewed Resident #23 current care plan. The care plan had a focus of an actual [redacted] related to [redacted]. Interventions included but were not limited to the following: continue interventions on the fall at risk plan, *Ex Order 26. 4B1* mats, and re-educate on the use of the call bell. The care plan was initiated on *Ex Order 26. 4B1*, with the most recent revision on *Ex Order 26. 4B1*. On 09/06/23 at 12:30 PM, the surveyor observed the resident in the bed, prior to entering the room, the surveyor observed that there was not a star on the outside of the door indicating the resident was on a falls program. The resident did have *Ex Order 26. 4B1* mats in the room. On 09/07/23 at 12:27 PM, the surveyor went to the unit to see the resident. The resident was observed in bed. Prior to entering the room, the surveyor looked for the "fall prevention star" on the door jamb or name plate and it was not present.	F 656	can be affected by this practice. The Director of Nursing, Assistant Director of Nursing and/or the Minimum Data Set Nurse completed an audit of current residents by 10/15/23 to determine if comprehensive care plans were updated and accurate after an actual fall. No other residents were found to be affected by this practice. Minimum Data Set Nurses were educated by the Staff Educator by 10/15/23 on the requirement to develop/update the comprehensive care plan when a resident has a fall and to ensure comprehensive care plans are person centered and meet each resident's medical, nursing and mental and psychosocial needs. The Director of Nursing and/or the Assistant Director of Nursing will audit Comprehensive Care Plans for residents with a fall to ensure the care plan is updated to reflect the fall and effective interventions to reduce fall risk weekly x 4 weeks then monthly x2 months to ensure Comprehensive Care Plans are updated after each fall. The Director of Nursing and/or Assistant Director of Nursing will report findings of the Comprehensive Care Plan Audits to the Quality Assurance/Performance Improvement Committee monthly x 3 months or until substantial compliance is achieved. The Administrator is responsible for ensuring this action occurs	

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F 656	Continued From page 22 On 09/08/23 at 12:30 PM, the surveyor interviewed unit Licensed Practical Nurse (LPN) regarding the fall prevention program and at-risk residents. The surveyor asked how the staff would know if a resident was a high fall risk and the LPN responded, "I look at how they follow instructions, I'm not sure what paper scoring they use". The Unit Manager (UM) who was present during the interview said, "If they have a falling star next to the door, they are a fall risk". The LPN said, "We round on them as much as possible and when the light is on, we get there as soon as possible. Not everyone is a high fall risk, it depends on the resident and the situation". The surveyor then reviewed the policy titled, Fall Prevention Program, dated 08/01/23. The policy indicated that each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Number six of the policy, High Risk Protocols indicated the resident with high fall risk would be placed on the facility's Fall Prevention Program which included placing a fall prevention indicator, such as a star or color-coded sticker on the name plate to the resident room. Number seven of the policy indicated that when a resident who does not have a history of falling experiences a fall, the resident will be placed on the facility's Fall Prevention Program. NJAC-8:39-11.2 (f)	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		11/11/23

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F 658	Continued From page 23 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 observations, interviews, review of medical records and other facility documentation, it was determined that the facility failed to follow professional standards of nursing practice by incorrectly transcribing a physician's order for the appropriate dose of *Ex Order 26. 4B1* . This deficient practice was identified for 9 out of 10 administered *Ex Order 26. 4B1* for Unsampled Resident #1 observed during medication administration. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey state: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing a medical regimen as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey state: "The practice of nursing as a licensed practical nurse is defined as performing tasks and	F 658	The physician was notified regarding the transcription error for Resident #1 and the order was corrected on the Medication Administration Record immediately by ADON to reflect the correct *Ex Order 26. 4B1* . There was no negative outcome for resident #1. Residents receiving medications, including insulin, can potentially be affected by this practice. The Director of Nursing and/or Assistant Director of Nursing completed an audit of current residents insulin orders by 10/15/23 to ensure physician orders for insulin are reflected correctly on the Medication Administration Record. No other residents were found to be affected by this practice. Nurses were inserviced by Staff Educator by 11/11/23 on completion of chart checks on 11-7 shift to ensure accuracy of transcribing new admission orders, including insulin orders. Director of Nursing/Assistant Director of Nursing and/or Unit Managers will audit new orders and corresponding Medication Administration Records 5 days/week Monday through Friday in morning clinical meeting to ensure accuracy of transcribing new orders, including insulin orders.	

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F 658	Continued From page 24 responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 8/31/23 at 8:38 AM, the surveyor, accompanied by a second surveyor, observed Licensed Practical Nurse #1 (LPN #1) as she began to start medication administration to Unsampled Resident #1. The LPN reviewed physician orders and started with obtaining the resident's pertinent vital signs which included Ex Order 26. 4B1, which was Ex Order at the time of this check. Once completed, at 9:10 AM, she began to review and dispense and gather the medications for the resident, which included Ex Order 26. 4B1. The LPN reviewed the order and informed the surveyor that the resident is to receive Ex Order 26. 4B1 Ex Order 26. 4B1 on a Ex Order 26. 4B1 in addition to five units that are on a standing order to be given with meals. The surveyor observed the Ex Order 26. 4B1 on the medication administration record (MAR) on the nurse's computer to be: 1.) Ex Order 26. 4B1 with meals for Ex Order 26. 4B1, administer 5 units plus Ex Order 26. 4B1. 2.) Ex Order 26. 4B1	F 658	The Director of Nursing and/or the Assistant Director of Nursing will audit 10 new orders weekly X4 weeks then 20 new orders monthly X2 months to ensure transcription accuracy. The Director of Nursing and/or Assistant Director of Nursing will report findings of the Transcription Audits to the Quality Assurance/Performance Improvement Committee monthly x 3 months or until substantial compliance is achieved. The Administrator is responsible for ensuring this action occurs	

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F 658	Continued From page 25 Ex Order 26. 4B1 [redacted] ... LPN #1 obtained the Ex Order 26. 4B1 which the surveyor observed to be Ex Order 26. 4B1 [redacted]. She then dialed the pen to Ex Order 26. 4B1 [redacted] and proceeded with the continuation of the medication administration process. At 9:41 AM, LPN #1 prepped the resident's Ex Orde [redacted] with an alcohol prep pad and was about to administer the Ex Order 26. 4B1 of Ex Order 26. 4B1 [redacted] to the resident. The surveyor stopped the LPN and asked to recheck the physician's order before administering this medication. At 9:47 AM, LPN #1 went back to medication cart outside the resident's room door and confirmed the two different strengths of Ex Order 26. 4B1 [redacted] ordered and confirmed that it was incorrect to have combined the Ex Order 26. 4B1 on the Ex Order 26. 4B1 [redacted]. She looked through the medication cart for the resident's Ex Order 26. 4B1 [redacted] but was unable to find it. She proceeded to the medication storage room to check the refrigerator, and informed the surveyor there was no Ex Order 26. 4B1 [redacted] for this resident. At 9:53 AM, LPN #1 asked the LPN Unit Manager (LPN/UM) about the order, to which the LPN/UM stated to LPN #1 and the surveyor the resident's order should both be for Ex Order 26. 4B1 [redacted] not Ex Order 26. 4B1. At this time, LPN/UM provided the surveyor a copy of the resident's hospital discharge orders which he/she was admitted with and indicated a new order for Ex Order 26. 4B1 [redacted]	F 658		

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Ex Order 26. 4B1 three times a day with meals. The LPN/UM confirmed that the Ex Order 26. 4B1 in the MAR was incorrect, and she will have to complete a med error form, since this was the order being carried out since the resident arrived Ex Order 26. 4B1 earlier.

A review of the Face Sheet (an admission summary) reflected that Unsampled Resident #1 was originally admitted to the facility in Ex Order 26. 4B1 with diagnoses which included Ex Order 26. 4B .

A review of the resident's individualized resident-centered Care Plan initiated on Ex Order 26. 4B1, included a focused care area of a diagnosis of Ex Order 26. 4B1 .

Review of the resident's Physician Order Summary Report included an active order started on Ex Order 26. 4B1 for Ex Order 26. 4B1 with meals for diabetes management, administer Ex Order 26. 4B1 .

Review of the resident's Ex Order 26. 4B1 discharge documents, under "Medications" was a new order for Ex Order 26. 4B1 three times a day with meals.

Review of the resident's Ex Order 26. 4B1 , since admission to the facility, in the Weights and Vitals Summary revealed no harm had occured.

On 8/31/23 at 10:46 AM, the surveyor interviewed the LPN/UM who stated this was a transcription error, and the order was put in by the weekend

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F 658	Continued From page 27 nursing supervisor. She stated that the 11 PM - 7 AM nurse should have done a chart check since it was for a new admission, and "clearly it was not done." On 9/6/23 at 1:07 PM, the surveyor interviewed the Director of Nursing (DON) who stated that during a new resident admission, the admitting nurse goes over the medication list with the physician, gets approval for the medications and puts them into the MAR. "Usually the 3 PM- 11 PM supervisor puts in the order, and then 11 PM-7 AM nursing goes back to review meds and complete a chart check." The DON confirmed that this process did not occur by stating, "the nurses who put in the order and did not do the chart check will both be disciplined and educated." Review of the facility's "Medication Reconciliation" policy with a revised date of 8/1/23 included "the facility reconciles medication frequently throughout a resident's stay to ensure that the resident is free of any significant medication errors, and that the facility's medication error rate is less than 5 percent." The section labeled "policy explanation and compliance guidelines" includes, "1. medication reconciliation involves collaboration with the resident/representative and multiple disciplines, including admission liaisons, licensed nurses, physicians, and pharmacy staff ... 4. Admission processes: a. Verify resident identifiers on the information received. b. compare orders to hospital records, etc. obtain clarification orders as needed. c. transcribe orders in accordance with procedures for admission orders. d. have a second nurse review transcribed orders for accuracy and cosign the orders, indicating the review. e. order medications	F 658		

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F 658	Continued From page 28 from pharmacy in accordance with facility procedures for ordering medications. f. verify medications received match the medication orders. g. obtain home list of medications from resident/representative. place on chart for physician review and revision of medication regimen, if warranted." NJAC 8:39- 27.1(a)	F 658		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate	F 755		11/11/23

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F 755	Continued From page 29 reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and pertinent record review, it was determined that the facility failed to: 1.) ensure the accountability of the Narcotic Shift Count logs were completed in accordance with facility policy and 2.) accurately account for and document the administration of controlled medications. This deficient practice was identified on 3 of 3 medication carts and was evidenced by the following: 1. On 9/1/23 at 11:19 AM, the surveyor, in the presence of the Licensed Practical Nurse #1 (LPN #1) and a second surveyor, reviewed the narcotic logbook for the fourth floor's low side medication cart. The "Record of Narcotic Count" shift log revealed the following incomplete or blank sections: Ex Order 26. 4B - 7 AM incoming nurse and outgoing nurse signature and "total number of narcotics remaining - cards, bottles, gels, and patches." Ex Order 26. 4B - 3 PM outgoing nurse signature and "total number of narcotics remaining - cards, bottles, gels, and patches." Ex Order 26. 4B - 7 AM outgoing nurse signature Ex Order 26. 4B - 7 AM "total number of narcotics remaining - patches." Ex Order 26. 4B1 - 11 PM "total number of narcotics remaining - gels." Ex Order 26. 4B1 - 7 AM, 3 PM, and 11 PM "total number of narcotics remaining - gels." Ex Order 26. 4B1 - 7 AM "total number of narcotics	F 755	The Director of Nursing and the Unit Managers completed a narcotic count for each medication cart on 9/7/23 to ensure accurate narcotic counts. No other discrepancies were found. Residents on Narcotics can potentially be affected by this practice. The Director of Nursing, Assistant Director of Nursing and/or Unit Managers assessed residents that receive narcotic medication by 10/15/23 to determine if any resident had complaints or physical evidence of distress related to potential medication issues. No other residents were found to be affected by this practice. Nurses were educated by the Staff Educator by 11/11/23 on proper facility Narcotic administration policies and procedures, including proper documentation on the Narcotic Shift Count Logs and on the Medication Administration Record, to ensure an account of all controlled drugs is maintained and documentation is accurate. Director of Nursing, Assistant Director of Nursing and/or Unit managers will audit Narcotic books weekly X 4 weeks then monthly X2 months to ensure compliance	

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F 755	Continued From page 30 remaining - gels." [redacted] - 7 AM incoming nurse signature At this time, the surveyor interviewed LPN #1 who stated that both the incoming and outgoing nurses on the shift were to complete the narcotic count and the narcotic count log together at the time of the count. The LPN further confirmed that if "not documented it's not done." On 9/1/23 at 12:33 PM, the surveyor, in the presence of the Licensed Practical Nurse Unit Manager #1 (LPN/UM #1) and a second surveyor, reviewed narcotic logbook for the second floor's high side medication cart. The "Record of Narcotic Count" shift log revealed the following incomplete or blank sections: [redacted] - 7 AM outgoing nurse signature [redacted] - 7 AM outgoing nurse signature [redacted] - 7 AM "total number of narcotics remaining - patches." [redacted] - 11 PM outgoing nurse signature [redacted] - 3 PM incoming nurse signature [redacted] - 7 AM outgoing nurse signature [redacted] - 7 AM incoming nurse signature [redacted] - 3 PM outgoing nurse signature [redacted] - 11 PM outgoing nurse signature On 9/1/23 at 1:10 PM, the surveyor, in the presence of LPN #2 and a second surveyor, reviewed narcotic logbook for the second floor's high side medication cart. The "Record of Narcotic Count" shift log revealed the following: [redacted] - 3 PM pre-signed outgoing nurse section, and "total number of narcotics remaining - cards, bottles, gels, and patches" prefilled count. At this time, the LPN acknowledged that she had	F 755	with nurses counting narcotics, signing Narcotic Shift Count Logs, and signing narcotics on the Medication Administration Record after administration. The Director of Nursing and/or Assistant Director of Nursing will report findings of the Narcotic Audits to the Quality Assurance/Performance Improvement Committee monthly x 3 months or until substantial compliance is achieved. The Administrator is responsible for ensuring this action occurs.	

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prefilled and pre-signed the log, and it "should not be pre-signed."

On 9/6/23 at 12:47 PM, the surveyor, in the presence of a second surveyor, interviewed the Director of Nursing (DON). The DON stated that the narcotic shift log should be completed and signed by two nurses together, the incoming and the outgoing nurses, when the shift-to-shift narcotic count is completed. The DON also stated that it is not appropriate or acceptable for a nurse to pre-sign or have missing signatures or sections on the log. She confirmed that this process is in place to "ensure counts and narcotics are correct and accounted for."

A review of the facility's "Controlled Substance Administration & Accountability" policy revised on 8/1/23 under the section labeled "General Protocols" included "all controlled substances obtained from a non-automated medication cart or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided." Under the section labeled "Inventory Verification" the policy included " ...for areas without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift."

2. On 9/1/23 at 12:33 PM, the surveyor, in the presence of the Licensed Practical Nurse Unit Manager #1 (LPN/UM #1) and a second surveyor, reviewed the narcotic logbook for the second floor's high side medication cart. At this time the LPN/UM stated to the surveyor that she had administered narcotic medications that morning and had not yet signed them out of the individual narcotic logs (declining inventory log).

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F 755	Continued From page 32 The LPN/UM was able to show the surveyor at the time of this review the administration record recorded in each resident's electronic medical record (EMR). The surveyor identified the following missing signatures on the individual declining inventory logs: Unsampled Resident #2A received *Ex Order 26. 4B1* [redacted] on 9/1/23 at 9:01 AM Unsampled Resident #3 received *Ex Order 26. 4B1* [redacted], and *Ex Order 26. 4B1* [redacted] on [redacted] at 9 AM Unsampled Resident #4 received *Ex Order 26. 4B1* [redacted] on [redacted] at 8 AM, and *Ex Order 26. 4B1* [redacted] solution at 9 AM. Further comparison of the declining inventory logs and the resident's medication administration record (MAR) for *Ex Order 26. 4B1* revealed the following discrepancies: Unsampled Resident #2A was administered *Ex Order 26. 4B1* [redacted] on [redacted] at 10 PM, [redacted] at 9 PM, [redacted] at 1 AM, [redacted] at 7 AM, 8/17 at 2:54 PM, [redacted] at 1 AM, [redacted] at 10 AM, [redacted] at 12 AM, [redacted] with undocumented time, and [redacted] at 12 AM. These administrations were recorded on the medication declining inventory log, but were not documented as being administered in the resident's MAR. On 9/6/23 at 12:47 PM, the surveyor, in the presence of a second surveyor, interviewed the	F 755		

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F 755	Continued From page 33 Director of Nursing (DON). The DON stated nurses are expected to sign out the controlled medications at the time they are dispensed to the patient. She further stated "I know some nurses like to take the logbook and wait till later to fill it out, but that's not ok. It should be filled out at the time of dispensing to the resident." A review of the facility's "Controlled Substance Administration & Accountability" policy revised on 8/1/23 under the section labeled "General Protocols" included "the controlled drug record (or other specified form) serves the dual purpose of recording both narcotic disposition and patient administration. The controlled drug record is a permanent medical record document and in conjunction with the MAR is the source for documenting any patient-specific narcotic dispensed from the pharmacy." NJAC 8:39-29.7(c)	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure all medications were administered without an error of 5% or less. During the medication observation on 7/21/23, the survey team observed two (2) nurses	F 759	Resident #1 was assessed by the Director of Nursing on Ex Order 26: 4B and no negative effects were found. The physician was notified of the transcription error and the correct order was transcribed on the medication	11/11/23

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F 759	Continued From page 34 administer medications to three (3) residents. There were 25 opportunities, and two (2) errors were observed which calculated a medication administration error rate of 8%. This deficient practice was identified for 1 of 3 residents (Unsampled Resident #1) that were administered medications by 1 of 2 nurses on the second-floor low side nursing unit. On 8/31/23 from 8:18 AM through 9:47 AM, the surveyor, in the presence of a second surveyor, during medication pass observation of the Licensed Practical Nurse (LPN) made the following observations: At 8:18 AM, a certified nursing assistant (CNA) was collecting eaten breakfast meal trays from resident rooms and placing on the tray cart in the hallway. The CNA informed the surveyor that breakfast was served to residents at approximately 7:50 AM that day. At 8:38 AM, the LPN prepared to obtain Unsampled Resident #1's vitals including [redacted] as required for medications to be administered. There was no meal tray in the resident's room at this time, and the nurse documented the resident's [redacted] to be [redacted]. At 9:10 AM, the LPN checked the medication administration record (MAR) for physician orders, which included: 1.*Ex Order 26. 4B1* [redacted] with meals for diabetes management, administer *Ex Order 26. 4B1*	F 759	administration record by ADON immediately. Resident #1 received the correct dosage of [redacted] immediately and there was no negative outcome for this resident. Residents receiving insulin can potentially be affected by this practice. The Director of Nursing and/or Assistant Director of Nursing completed an audit of current residents insulin orders by 10/15/23 to ensure physician orders for insulin are reflected correctly on the Medication Administration Record. No other residents were found to be affected by this practice. Nurses were inserviced by Staff Educator by 11/11/23 on identification of specific insulins that require administration of insulin during appropriate timeframe in conjunction with mealtimes and on ensuring blood sugars and insulin for these identified insulins are obtained and administered within appropriate timeframe in conjunction with mealtimes. Director of Nursing/Assistant Director of Nursing and/or Unit Managers will observe 5 nurses per week x 4 weeks then 10 nurses monthly x 2 months while obtaining blood sugar and during insulin medication administration to ensure blood sugar is obtained and insulin is administered within appropriate timeframe in conjunction with mealtimes for specific insulins that require administration with meals. The Director of Nursing and/or Assistant	

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	315235	A. BUILDING _____ B. WING _____	C 09/11/2023

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F 759	Continued From page 35 Ex Order 26. 4B1. 2.) Ex Order 26. 4B1 [redacted] ... At this time, the LPN obtained the resident's Ex Order 26. 4B1 and informed the surveyor she is dialing the pen to administer Ex Order 26. 4B1 total units, Ex Order 26. 4B1 for the standing order and Ex Order 26. 4B1 as ordered since the Ex Order 26. 4B1. (Error #1) At 9:34 AM, the LPN entered the resident's room and administered the oral medications as prescribed. At 9:41 AM, the LPN prepped the resident's Ex Orde [redacted] with an alcohol prep pad, installed the Ex Order 26. 4B1 to the Ex Order 26. 4B1, and brought the Ex Order 26. 4B1 to the resident's Ex Order [redacted] to administer. At this time the surveyor stopped the LPN prior to administering this medication and asked the LPN to recheck the physician orders. The LPN returned to the medication cart and acknowledged to the surveyor that the Ex Order 26. 4B1 [redacted] is for Ex Order 26. 4B1 and the standing order was for Ex Order 26. 4B1 [redacted] and they should not have been combined on the Ex Order 26. 4B1. The nurse also confirmed the resident had eaten his meal that morning, which was approximately one hour and forty minutes earlier. (Error #2) A review of the Face Sheet (an admission summary) reflected that Unsampled Resident #1 was originally admitted to the facility in Ex Order 26. 4B1 [redacted] with diagnoses which included Ex Order 26. 4B	F 759	Director of Nursing will report findings of the Insulin Audits to the Quality Assurance/Performance Improvement Committee monthly x 3 months or until substantial compliance is achieved. The Administrator is responsible for ensuring this action occurs.	

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F 759	Continued From page 36	F 759		

Ex Order 26. 4B1.

A review of the resident's individualized resident-centered Care Plan initiated on Ex Order 26. 4B1, included a focused care area of a diagnosis of Ex Order 26. 4B1.

Review of the resident's Physician Order Summary Report included an active order started on Ex Order 26. 4B1 for Ex Order 26. 4B1 with meals for NJ Exec. Order 26:4.b.1 management, administer Ex Order 26. 4B1, and an order started on Ex Order 26. 4B1 for Ex Order 26. 4B1 above Ex Order call MD, subcutaneously with meals for NJ Exec. O management administer Ex Order 26. 4B1.

On 8/31/23 at 11:32 AM, the surveyor interviewed the LPN who stated, "when I got to the Ex Order 26. 4B1, I only looked at the name of the medication and Ex Order 26. 4B1."

On 9/6/23 at 1:07 PM, the surveyor interviewed the Director of Nursing (DON) who acknowledged "Ex Order 26. 4B1 should be given within 15-30 minutes after eating at the latest." She stated that obtaining Ex Order 26. 4B1 over an hour after eating may not be accurate and administering Ex Order 26. 4B1 at 9:41 AM "is not even within the hour time period." The DON also acknowledged that the LPN did not check the order.

Review of the facility's "Medication

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F 759	Continued From page 37 Administration" policy with a revised date of 8/1/23 included, "medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection." The section labeled "policy explanation and compliance guidelines" includes, "compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time ... administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician ... administer medication as ordered in accordance with manufacturer specifications. Provide appropriate amount of food and fluid." NJAC 8:39-11.2(b); 29.2(d)	F 759		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761		11/11/23

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F 761	Continued From page 38 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to 1.) properly store medications including controlled substances, 2.) maintain clean and sanitary medication storage areas, and 3.) properly label opened multidose medications. This deficient practice was observed in 2 of 2 medication storage rooms and 3 of 3 medication carts reviewed for medication storage and labeling and was evidenced by the following: On 9/1/23 at 10:06 AM, the surveyor, in the presence of Licensed Practical Nurse Unit Manager #1 (LPN/UM #1) and a second surveyor, observed the fourth-floor medication storage room. The following observations were made: The medication storage refrigerator had a locking mechanism on the door which was left unlocked allowing the refrigerator door to be opened. In the refrigerator was a narcotic lock box which was secured to the inside of the refrigerator with a chain, had an unlocked hasp and padlock on the lid. Without the use of a key, the surveyor was able to open the narcotic which was found to contain fifteen (15) prefilled syringes of [redacted]	F 761	The 4th floor medication storage refrigerator and Narcotic box inside the refrigerator was immediately locked by DON. The 3rd floor medication storage refrigerator and Narcotic box inside the refrigerator was immediately locked by DON. The unlabeled medications and the expired medical supplies found in the 3rd floor medication storage room were immediately destroyed/discarded by DON/ADON. The expired and unlabeled medications and the loose pills found in 4th floor med cart were immediately destroyed/discarded by DON. The 4th floor medication cart Narcotic box was immediately secured to the cart drawer by the Pharmacy technician. The unlabeled eyedrops and the 10 loose unidentified pills in the 2nd floor high side medication cart were immediately discarded/destroyed by DON. The 17 loose pills found in 2nd floor low side medication cart were immediately destroyed by DON. All residents can potentially be affected by the deficient practice. The Director of Nursing, Assistant Director of Nursing and Unit Managers audited all medication	

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F 761	Continued From page 39 [redacted], and [redacted] vials of [redacted]. At this time, the surveyor interviewed LPN/UM #1 who stated the medication fridge and narcotic box should be locked, being unlocked "could be a problem" as "someone could steal meds, or they can go missing." The LPN/UM stated all nurses have the key to the med fridge. On 9/1/23 at 10:38 AM, the surveyor, in the presence of LPN/UM #2 and a second surveyor, observed the third-floor medication storage room. The medication storage refrigerator in the room had a locking mechanism on the door which was left unlocked allowing the refrigerator door to be opened. In the refrigerator was a narcotic lock box which was secured to the inside of the refrigerator with a chain. The box had a hasp, but the padlock used to secure the box was off the hasp and placed on the fridge shelf next to the box. The surveyor opened the box and found it to be empty. At this time, the surveyor interviewed LPN/UM #2 who stated the narcotic box should remain locked even if it does not contain any medication, "because we have (resident) wanderers and if the med room door is left open accidentally, they can get it and meds can go missing." Upon further observation of the medication storage room, the surveyor observed the following items: One (1) amber colored medication bottle which had no identifying label and contained 14 unidentifiable purple and white capsules. To which LPN/UM #2 stated "should be labeled, I	F 761	carts and medication rooms in the facility by 10/15/23 to ensure no other expired medical supplies, expired, unlabeled or loose medications were found. Expired supplies/medication, unlabeled/loose medications that were found were discarded/destroyed by the Director of Nursing on 10/15/23. Nurses were inserviced by Staff Educator by 11/11/23 on notification to administration if issues with narcotic boxes or medication cart locks are identified, appropriate Narcotic Storage per facility policy, Medication Storage Policy that includes proper labeling and dating of medication and discarding of expired medications to ensure Narcotics are stored and locked properly and all medications are labeled, dated, and stored properly. The Director of Nursing, Assistant Director of Nursing and/or the Unit Managers will audit medication carts weekly X4 weeks then Monthly X2 months to ensure compliance with Medication Storage policies including appropriate narcotic storage, labeling and dating medications and discarding expired medications. The Director of Nursing and/or Assistant Director of Nursing will report findings of the Medication Room/Cart Audits to the Quality Assurance/Performance Improvement Committee monthly x 3 months or until substantial compliance is achieved. The Administrator is responsible for ensuring this action	

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F 761	Continued From page 40 don't know what that is or why it's back here." Two (2) small sample medication boxes of [redacted] each containing 7 capsules, with no pharmacy label or resident name. *Ex Order 26. 4B1* [redacted] with normal saline solution labeled with a best by date of [redacted] to which LPN/UM #2 stated the resident it was prescribed for was "not on it any longer and should have been returned to the pharmacy." One (1) expired box of *Ex Order 26. 4B1* [redacted]. *Ex Order 26. 4B1* [redacted]. *Ex Order 26. 4B1* [redacted]. *Ex Order 26. 4B1* [redacted]. During these observations, LPN/UM #2 informed the surveyor regarding these items, "they just toss them in here, not the right thing to do." The LPN/UM further stated that "it's probably my responsibility to look at needles and stuff for expiration. The pharmacy consultant come in monthly and look at medication, I don't think they look at expirations. The consultant was in this week." On 9/1/23 at 11:19 AM, the surveyor, in the presence of LPN #1 and a second surveyor, reviewed the fourth-floor low side's medication cart. The surveyor observed the following: One (1) bottle of *Ex Order 26. 4B1*, which LPN #1 confirmed as being opened and not properly labeled with resident name or date opened. Two (2) foil packages of *Ex Order 26. 4B1* [redacted]	F 761	occurs.	

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F 761	Continued From page 41 Ex Order 26. 4B1 each containing 3 out of 5 single use vials, opened and not dated. Each foil package was labeled with a manufacturer's instructions indicating one week expiration once foil is opened. One (1) opened Ex Order 26. 4B1 , not labeled or dated. Nine (9) loose pills of varying sizes and colors in the bottom of the cart drawers. The controlled substance/narcotic lockbox, which has an open bottom, was not secured to the cart drawer and was able to be lifted and removed out of the cart by the surveyor. At this time LPN #1 informed the surveyors that everything should be labeled appropriately, multidose vials should be labeled with patient name and date of opening, and there should not be loose pills in the medication cart. The LPN further states nurses clean the carts but was unsure of the frequency. On 9/1/23 at 12:33 PM, the surveyor, in the presence of LPN/UM #3 and a second surveyor, reviewed the second-floor high side's medication cart. The surveyor observed one (1) box of Ex Order 26. 4B1 dated with an opened date of Ex Order 26. 4B1 , but the bottle of Ex Order 26. 4B1 inside was not labeled with the open date or resident name, and ten (10) loose pills of varying sizes and colors in the bottom of the cart drawers. On 9/1/23 at 1:10 PM, the surveyor, in the presence of LPN #2 and a second surveyor, reviewed the second-floor low side's medication cart, which contained seventeen (17) loose pills of varying sizes and colors in the bottom of the cart drawers. At this time, LPN #2 stated the nurse assigned to the cart should be checking for	F 761		

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F 761	Continued From page 42 loose pills. On 9/6/23 at 12:47 PM, the surveyor, in the presence of a second surveyor, interviewed the Director of Nursing (DON). The DON stated medication carts, rooms, medication fridges, and narcotic boxes should be always locked. Narcotic or controlled substance boxes should also be double locked and secured to the drawer for safety reasons so that patients, staff, or anyone else could not get to them to minimize diversion of medication "because someone could just grab it and go." The DON also included that there should never be loose pills in the carts, if pills come loose during handling of the cards, they should be collected and destroyed with another nurse. Multidose vials and medications should be dated and labeled when opened for use, and "standard practice is to label the actual device especially inhalers and insulin. The DON included that the unit managers and central supply person check supplies for expiration dates usually weekly. The DON informed the surveyor that sample medications are usually brought in by the nurse practitioner to be used if there is a delay in obtaining the medication from the specialty pharmacy. She states, these medications should still be labeled with the resident's name and room number and any medication or prescription bottle containing medication should be labeled. The medication bottle with no label containing 14 capsules "should not be like that, absolutely not." A review of the facility's "Controlled Substance Administration & Accountability" policy revised on 8/1/23, under the section labeled "General Protocols," included "controlled substances are stored in a separate compartment of an automated dispensing system or other locked	F 761		

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F 761	Continued From page 43 storage unit with access limited to approved personnel." The section labeled "Storage and Security" included "areas without automated dispensing systems utilize a substantially constructed storage unit with two locks and a paper system for 24-hour recording of controlled substance use. Patient specific controlled substances (e.g., narcotic/epidural infusion, tablets, etc.) are stored under double lock until administered to the patient." A review of the facility's "Medication Storage" policy revised 8/1/23, included "It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security." Under the section labeled "General Guidelines," included "all drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls." "Narcotics and controlled substances: Schedule II drugs and back-up stock of schedule III, IV, and V medications are stored under double-lock and key. Schedule II controlled medications are to be stored within a separately locked permanently affixed compartment when other medications are stored in the same area, such as in refrigerator." "Unused medications: the pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with our destruction of unused drug policy."	F 761		

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F 761	Continued From page 44 Review of the facility's "Medication Administration" policy with revised date of 8/1/23 included "keep medication cart clean, organized, and stocked with adequate supplies."	F 761		
F 812 SS=F	N.J.A.C. 8:39-29.4 Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of documentation, it was determined that the facility failed to store, label, and date potentially hazardous food and maintain kitchen sanitation in a manner intended to limit the spread of food-borne illnesses. The deficient practice was evidenced by the	F 812	The full case of bacon, loaves of bread, boxes of tea bags, crackers, bag of chips, and containers of condiments were properly labeled by the Certified Dietary Manager immediately. The metal container of grape jelly containing peanut butter, the dirty coffee filters, the potatoes that were improperly stored next to the	11/11/23

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F 812	Continued From page 45 following: On 08/28/23 at 09:55 AM, the surveyor entered the kitchen and toured with the Certified Dietary Manager (CDM). The surveyor observed several items throughout the kitchen that were not labeled properly to include a full case of bacon, several loaves of bread, boxes of tea bags, crackers in a yellow box, a bag of chips, and a metal container of grape jelly that was unlabeled. The jelly container contained peanut butter inside the jelly. The meat slicer was stored on the counter uncovered. The CDM made the observations alongside of the surveyor and confirmed the items should have been labeled,that separate spoons should have been used for the jelly and the peanut butter, and after the meat slicer was cleaned, it should have been covered. On the same day at 09:55 AM, the surveyor observed coffee filters in a dirty uncovered box with coffee grinds and other unknown particles. The coffee filters were laying in the bottom of the box on top of the dirty particles, outside of the plastic bag, and exposed to the air. On 08/28/23 at 10:15 AM, the surveyor observed two types of potatoes (roasted and white) that were stored in two separate boxes under the food prep table next to the chemical sanitizing bucket. There were two small insects observed flying around the two boxes. The CDM confirmed that the potatoes were normally stored next to the santitizing bucket and also confirmed that there were two flying insects. On the same day at 10:42 AM, there was a personal water bottle in the food prep area on the	F 812	sanitizing bucket, the personal water bottle in the food prep area and the empty apple juice container were discarded by the Certified Dietary Manager immediately. The meat slicer was cleaned and covered by the Certified Dietary Manager immediately. Exterminator was notified and the kitchen was sprayed for pests related to the flying insects. The dumpster lids were immediately closed by the Certified Dietary Manager to prevent pest access. The Certified Dietary Manager instructed the Dietary Aides that were not wearing gloves to wash their hands and put on gloves immediately on 9/6/23. Current residents residing in the facility can be affected by this practice. The Certified Dietary Manager audited the dietary department on 9/15/23 to ensure food items were properly labeled/stored, no personal items were stored in the food prep areas, equipment clean and covered when not in use and that no pests were identified in the dietary department. Items that were found not stored or labeled properly or equipment not appropriately covered were discarded or cleaned by the Certified Dietary Manager at that time. Dietary staff, including the Dietary Manager received education by the Administrator by 11/11/23 regarding Food Storage and Labeling policy to include proper food storage and labeling, equipment storage, and personal items storage to ensure food is properly labeled, dated, and stored, and equipment is clean	

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F 812	Continued From page 46 counter and an empty apple juice container in the refrigerator. Upon surveyor inquiry, the CDM confirmed that the water bottle and the apple juice container belonged to staff and should have been discarded. The outside dumpster area contained four dumpsters and two of the four dumpster door lids were left open. On 09/06/23 at 12:56 PM, the surveyor observed the dish washing area and there were three dietary aides (DA) working in that area without gloves on. The first DA was scraping food off the plates into the garbage, the second DA started to use the dish machine to run dishes through the cycle, and the third was removing the dishes after the cycle was ran. The Regional CDM advised all three to put on gloves. A review of the facility's policy, "Food Storage and Labeling" reviewed/revised 02/2023, revealed food storage areas shall be maintained in a clean, safe, and sanitary manner. A review of the facility's policy, "Dish Machine" the Dietary Manager will train dish washing staff to wear gloves throughout the dishwashing process.	F 812	and stored properly when not in use. Dietary Staff were educated by the Dietary Manager by 11/11/23 on the Dish Machine policy and procedures related to food safety and sanitation,including wearing gloves when cleaning dishes, and maintaining the dumpster area clean and lids covered. The Administrator will audit the kitchen weekly X4 weeks then Monthly X2 months to ensure proper compliance with Labeling and dating, food storage, personal items, and hand hygiene. The Administrator will report findings of the Dietary Audits to the Quality Assurance/Performance Improvement Committee monthly x 3 months or until substantial compliance is achieved. The Administrator is responsible for ensuring this action occurs.	
F 868 SS=D	NJAC 8:39-17.2(g) QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee;	F 868		11/5/23

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F 868	Continued From page 47 (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview and document review of pertinent facility documentation, the facility failed to have the medical director present for two out of six Quality Assurance and Performance Improvement (QAPI) meetings as evidenced by the following: On 08/29/23 at 11:49 AM, the Director of Nursing (DON) provided the surveyor with six quarterly	F 868	The old Medical Director is no longer employed at the facility. The new medical Director that started in 2023 has been attending the QAPI meetings monthly. All residents can be affected by the deficient practice. New Medical Director will continue to	

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F 868	Continued From page 48 sign in sheets for the four most recent quarterly meetings which revealed: -Reporting Month of June 2022 Quality Assurance Performance Improvement (QAPI) Quarterly Meeting dated July 21, 2022, Medical Director's (MDs) signature was blank. - Reporting Month of December 2022/4th Quarter 2022 (QAPI) Sign In, the Medical Director's (MDs) signature was blank. During an interview on 09/01/23 at 12:56 PM, the DON stated the Medical Director did not attend the July 21, 2022 meeting and she did not attend the December 2022 meeting because she left the company. She furthered that the Medical Director should be attending the QAPI meetings. The Quality Assessment Performance Improvement Policy, implemented on 02/28/23 23 reflects that the committee shall a.consist at a minimum of ii. The Medical Director or his/her designee.	F 868	attend at least Quarterly QAPI meetings per facility policy and sign off on the QAPI signature form. The Administrator will Monitor QAPI meeting Monthly X12 to ensure that Medical Director attends at least the Quarterly QAPI meeting and sign off.	
F 880 SS=D	NJAC 8:39-33.1(b) 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.	F 880		11/11/23

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F 880	Continued From page 49 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 50 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of pertinent facility documents, it was determined that the facility failed to 1.) follow appropriate infection control practices and perform hand hygiene as indicated during a medication pass, and 2.) ensure [redacted] was kept in a clean and sanitary condition and stored properly to reduce the risk of infection. This deficient practice was identified for 1 of 3 residents reviewed for medication pass (Unsampled Resident #1), and for 1 of 1 resident reviewed for [redacted] (Resident #337). 1.) On 8/31/23 from 8:18 AM through 9:47 AM, the surveyor, in the presence of a second surveyor, during medication pass observation of Licensed Practical Nurse (LPN) made the following observations:	F 880	Resident #1 and #337 were assessed for negative effects by the Director of Nursing on [redacted] related to the infection control practices. The [redacted] for resident #337's was replaced and stored in a bag by ADON immediately. There was no negative outcome for resident #1 or #337. Identified LPNs were educated by Staff educator on [redacted] regarding proper infection control policies, hand hygiene during medication pass and [redacted]. Current residents residing in the facility have the potential to be affected by this practice. The Director of Nursing/IP audited 3 random nurses during medication pass for appropriate	

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F 880	Continued From page 51 At 8:18 AM a certified nursing assistant (CNA) was collecting breakfast meal trays from resident rooms and placing on the tray cart in the hallway. The CNA informed the surveyor that breakfast was served to residents at approximately 7:50 AM that day. At 8:38 AM, LPN prepared to obtain Unsampled Resident #1's vitals including [redacted] and *Ex Order 26. 4B1* as required for medications to be administered. There was no meal tray in the resident's room at this time. LPN brought into the room from her medication cart, a *Ex Order 26. 4B1* [redacted], *Ex Order 26. 4B1* [redacted] along with items needed to check *Ex Order 26. 4B1* [redacted], test strip and alcohol prep pads), box of disposable gloves, and a container of disinfectant wipes. She then, without first clearing or disinfecting the surface, placed all these items on the bedside tray table which was visibly soiled with small food like particles, used tissues, cups of water, and other belongings of the resident. Then, after washing her hands, donning (putting on) gloves, and identifying the resident, obtained the resident's bp, using the same gloves, obtained a disinfectant wipe, wiped the bp cuff, doffed (took off) the gloves, and without performing hand hygiene, donned new gloves. Wiped the glucometer with alcohol pad, doffed the gloves, without hand hygiene went into the resident's shared bathroom, gathered a short length of toilet paper from the dispenser (next to the toilet which had brown substance smeared on the seat). Without performing hand hygiene, donned new gloves, then stuck the resident's finger to get a small amount of blood for the [redacted] check. Once the blood was collected on the test strip, LPN used the toilet paper to wipe the finger stick site to stop the bleeding. Using the same gloves, grabbed the disinfectant wipes to tear off a sheet,	F 880	don/doff/hand hygiene and audited storage of 3 residents stored *Ex Order 26. 4B1* [redacted] by *Ex Order 26. 4B1*. There were no other issues found. Nurses were educated by Infection Preventionist by 11/11/23 on the facility's Infection Prevention and Control policy and procedures in reference to medication pass, don/doff of gloves, hand hygiene. Licensed nurses were educated by Infection Preventionist on 11/11/23 regarding proper infection control policies in regard to proper Nebulizer masks and tubing storage. The Director of Nursing, Assistant Director of Nursing, Infection Preventions and/or Unit Managers will audit 5 nurses weekly x 4 weeks then 10 nurses weekly x 2 months to ensure nurses are compliant with infection control techniques in reference to medication pass, donning/doffing gloves, hand hygiene and proper infection control storage of nebulizer masks and tubing storage. The Infection Control Nurse will report findings of the Infection Control Audits to the Quality Assurance/Performance Improvement Committee monthly x 3 months or until substantial compliance is achieved. The Administrator is responsible for ensuring this action occurs..	

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F 880	Continued From page 52 wiped the Ex Order 26. 4B1, grabbed the wipes container again to get another sheet and wiped the Ex Order 26. 4B1. She then doffed the gloves, no hand hygiene, gathered the Ex Order 26. 4B1, Ex Order 26. 4B1, box of gloves, and wipes container off the tray table, and without wiping each item with disinfectant wipe, brought and placed them back on her medication cart. At this time, the LPN stated she could not recall the resident's Ex Ord, brought the Ex Order 26. 4B1 and container of disinfectant wipes back to the resident's tray table donned new gloves which she brought with her from the cart and rechecked the Ex Ord. Using the same gloves, tore out a sheet of wipes, disinfected the Ex Order 26. 4B1, doffed gloves, without hand hygiene or disinfecting these supplies, brought them back to the medication cart, placed on top of the cart before placing into the drawer. At this point she looked at the medication orders, gathered the medications, and brought them along with the box of gloves and placed them onto the same tray table (still not disinfected or cleared). She then administered the oral medication, one of the Ex Order 26. 4B1 before the surveyor stopped the LPN to recheck the second Ex Order 26. 4B1. The LPN then brought the box of gloves and Ex Order 26. 4B1 back to the medication cart. On 8/31/23 at 11:32 AM, the surveyor, in the presence of a second surveyor, interviewed LPN who acknowledged the tray table "probably wasn't clean" and should have been disinfected prior to use, and bringing items back and forth from the resident's room without disinfecting could cause contamination, and stated, "the cart being locked is a hassle getting them out with dirty things." LPN also acknowledged that using toilet paper to wipe the fingerstick could infect the Ex Order 26. 4B1.	F 880		

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F 880	Continued From page 53 On 9/6/23 at 1:07 PM, the surveyor, in the presence of a second surveyor, interviewed the Director of Nursing (DON) who acknowledged that the surface used to place supplies for resident care should first be disinfected with a sanitizer wipe. She also stated that only the supplies needed should be brought into the room and not the entire containers, stating bringing them in and out of every room would be a break in infection control. The DON also acknowledged that "using toilet paper to wipe a fingerstick is not ok because of cross contamination and infection control, especially with residents that share bathrooms." 2.) On 8/28/23 at 12:00 PM, during initial tour of the facility, the surveyor observed Resident #337 resting in bed. The resident was actively receiving *Ex Order 26. 4B1* with a *Ex Order 26. 4B1* from an *Ex Order 26. 4B1*. The surveyor also observed a *Ex Order 26. 4B1* hanging by its elastic strap, not in a bag, from the handle of the nightstand top drawer next to the resident's bed. The mask had tubing which was connecting it to a *Ex Order 26. 4B1* on top of the nightstand. On 8/29/23 at 11:23 AM, the surveyor observed Resident #337 resting in their room. The nightstand top drawer was open and the *Ex Order 26. 4B1*, still connected to the *Ex Order 26. 4B1*, was laying in the drawer with no *Ex Order 26. 4B1*. On 9/5/23 at 10:38 AM, the surveyor, observed Resident #337 in their room. A personal belongings bag was hanging from the nightstand's top drawer's handle by its drawstring, with the bag resting on the floor. The resident confirmed that the bag contained the *Ex Order 26. 4B1*	F 880		

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F 880	Continued From page 54 Ex Order 26. 4, and stated, "Ex Order 26. 4B1 ."	F 880		

A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility in Ex Order 26. 4B1 with diagnosis which included Ex Order 26. 4B1

Review of the physician "Order Summary Report" revealed an active physician's order (PO) with start date Ex Order 26. 4B1 for Ex Order 26. 4B1 1 unspecified NJ Exec. Order 26:4.b.1 every 4 hours as needed for Ex Order 26.

A review of the corresponding Ex Order 26. 4B1 Medication Administration Record (MAR) reflected the above physician's order and was documented as administered.

On 9/6/23 at 10:43 AM, the surveyor interviewed the LPN Unit Manager (LPN/UM) who acknowledged that the Ex Order 26. 4B1 should not be stored this was and should be in an appropriate bag.

On 9/6/23 at 1:07 PM, the surveyor interviewed the DON who acknowledged that Ex Order 26. 4B1 should always be stored in a bag when not in use to keep clean and comply with infection control practices.

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F 880	Continued From page 55 Review of the facility's "Infection Prevention and Control Program" policy with an implemented date of 5/16/23 included, "this facility has established and maintains 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 as per accepted national standards and guidelines ... all staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing care services. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures ... environmental cleaning and disinfection shall be performed according to facility policy. All staff have responsibilities related to the cleanliness of the facility and are to report problems outside of their scope to the appropriate department." Review of the facility's "Medication Administration" policy with a revised date of 8/1/23 included, "medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection." Review of the facility's "Nebulizer Therapy" policy with a revised date of 8/1/23 under the section labeled "care of equipment" included, "1. Clean after each use. 2. Wash hands before handling equipment. 3. Disassemble parts after every treatment. 4. Rinse the nebulizer cup and mouthpiece with sterile or distilled water. 5. Shake off excess water. 6. Air dry on an absorbent towel. 7. Once completely dry, store	F 880		

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F 880	Continued From page 56 the nebulizer cup and the mouthpiece in a zip lock bag." NJAC 8:39 - 19.4(a)(n); 27.1 (a)	F 880		

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RIVERSIDE NURSING AND REHABILITATION C	325 JERSEY STREET TRENTON, NJ 08611

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint # NJ00158868, NJ00158961, NJ00158635, NJ00159302 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: a.) For the week of complaint staffing from 04/10/2022 to 04/16/2022, the facility was deficient Certified Nursing Assistants (CNA) staffing for residents on 5 of 7 day shifts and	S 560	Staffing reviewed for the referenced dates/shifts. No residents were negatively affected. All residents have potential to be affected. Daily review of staffing by DON (or designee) to ensure compliance with NJSA 30:13-18 minimum staffing requirements for nursing homes for day and evening shifts. Call-out policy reviewed. Agency engaged as needed.	11/10/23

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

Electronically Signed | 09/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061112	A. BUILDING: _____ B. WING _____	C 09/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE NURSING AND REHABILITATION C	325 JERSEY STREET TRENTON, NJ 08611

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S 560	Continued From page 1 deficient in total staff for residents on 1 of 7 overnight shifts. b.) For Complaint staffing from 07/31/2022 to 08/06/2022, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts, c.) For the 3 weeks of Complaint staffing from 10/02/2022 to 10/22/2022, the facility was deficient in CNA staffing for residents on 12 of 21 day shifts, d.) For the week of Complaint staffing from 10/30/2022 to 11/05/2022, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts, and e.) For the 2 weeks of staffing prior to survey from 08/13/2023 to 08/26/2023, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One (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	S 560	The DON (or designee) to have weekly meetings to determine upcoming schedules to anticipate staffing needs and will report findings to the Administrator x 4 weeks; monthly x 3 months with results reported to QAPI. QAPI meets monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061112	A. BUILDING: _____ B. WING _____	C 09/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE NURSING AND REHABILITATION C	325 JERSEY STREET TRENTON, NJ 08611

(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 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 week of Complaint staffing from 04/10/2022 to 04/16/2022, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts and deficient in total staff for residents on 1 of 7 overnight shifts as follows: -04/10/22 had 14 CNAs for 124 residents on the day shift, required at least 15 CNAs. -04/11/22 had 13 CNAs for 124 residents on the day shift, required at least 15 CNAs. -04/13/22 had 14 CNAs for 124 residents on the day shift, required at least 15 CNAs -04/14/22 had 7 total staff for 124 residents on the overnight shift, required at least 9 total staff. -04/15/22 had 13 CNAs for 126 residents on the day shift, required at least 16 CNAs. -04/16/22 had 11 CNAs for 126 residents on the day shift, required at least 16 CNAs. b.) For the week of Complaint staffing from 07/31/2022 to 08/06/2022, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -07/31/22 had 14 CNAs for 127 residents on the day shift, required at least 16 CNAs. -08/03/22 had 13 CNAs for 127 residents on the day shift, required at least 16 CNAs. -08/04/22 had 12 CNAs for 127 residents on the day shift, required at least 16 CNAs. -08/05/22 had 14 CNAs for 127 residents on the day shift, required at least 16 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE NURSING AND REHABILITATION C	325 JERSEY STREET TRENTON, NJ 08611

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S 560	Continued From page 3 -08/06/22 had 14 CNAs for 127 residents on the day shift, required at least 16 CNAs. c.) For the 3 weeks of Complaint staffing from 10/02/2022 to 10/22/2022, the facility was deficient in CNA staffing for residents on 12 of 21 day shifts as follows: -10/03/22 had 15 CNAs for 130 residents on the day shift, required at least 16 CNAs. -10/04/22 had 13 CNAs for 127 residents on the day shift, required at least 16 CNAs. -10/06/22 had 14 CNAs for 125 residents on the day shift, required at least 16 CNAs. -10/10/22 had 12 CNAs for 126 residents on the day shift, required at least 16 CNAs. -10/11/22 had 15 CNAs for 126 residents on the day shift, required at least 16 CNAs. -10/12/22 had 14 CNAs for 126 residents on the day shift, required at least 16 CNAs. -10/13/22 had 13 CNAs for 126 residents on the day shift, required at least 16 CNAs. -10/16/22 had 14 CNAs for 126 residents on the day shift, required at least 16 CNAs. -10/17/22 had 12 CNAs for 125 residents on the day shift, required at least 16 CNAs. -10/18/22 had 14 CNAs for 125 residents on the day shift, required at least 16 CNAs. -10/20/22 had 13 CNAs for 125 residents on the day shift, required at least 16 CNAs. -10/22/22 had 15 CNAs for 125 residents on the day shift, required at least 16 CNAs. d.) For the week of Complaint staffing from 10/30/2022 to 11/05/2022, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows:	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061112	A. BUILDING: _____ B. WING _____	C 09/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE NURSING AND REHABILITATION C	325 JERSEY STREET TRENTON, NJ 08611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 4 -10/31/22 had 14 CNAs for 128 residents on the day shift, required at least 16 CNAs. -11/01/22 had 12 CNAs for 128 residents on the day shift, required at least 16 CNAs. -11/03/22 had 14 CNAs for 128 residents on the day shift, required at least 16 CNAs. -11/04/22 had 13 CNAs for 128 residents on the day shift, required at least 16 CNAs. -11/05/22 had 13 CNAs for 126 residents on the day shift, required at least 16 CNAs e.) For the 2 weeks of staffing prior to survey from 08/13/2023 to 08/26/2023, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts as follows: -08/13/23 had 12 CNAs for 130 residents on the day shift, required at least 16 CNAs. -08/14/23 had 13 CNAs for 128 residents on the day shift, required at least 16 CNAs. -08/15/23 had 15 CNAs for 128 residents on the day shift, required at least 16 CNAs. -08/17/23 had 13 CNAs for 128 residents on the day shift, required at least 16 CNAs. -08/18/23 had 12 CNAs for 128 residents on the day shift, required at least 16 CNAs. -08/19/23 had 13 CNAs for 129 residents on the day shift, required at least 16 CNAs. -08/20/23 had 11 CNAs for 129 residents on the day shift, required at least 16 CNAs. -08/21/23 had 13 CNAs for 129 residents on the day shift, required at least 16 CNAs. -08/24/23 had 15 CNAs for 127 residents on the day shift, required at least 16 CNAs. -08/25/23 had 14 CNAs for 127 residents on the day shift, required at least 16 CNAs. -08/26/23 had 14 CNAs for 127 residents on the day shift, required at least 16 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 5 On 09/11/23 at 09:22 AM, the surveyor interviewed the Staffing Coordinator (SC) who had been employed at the facility since 11/2022. The SC was able to verbalize the regulations for staffing requirements to the surveyor. The surveyor asked how the schedules were completed and the SC said the schedules were completed "Two weeks out". The SC said, "If the numbers do not meet the regulations, I call down a list of numbers for staff and if unable to get staff to come in the supervisors have to come in and go to the floors". The surveyor asked the SC if she felt they met the regulations and the SC said, "I feel we can be definitely better, there are challenges of the pay, a big challenge here. I whole heartedly believe it could be better". On 09/11/23 at 11:39 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' aides.	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
315235 Y1	A. Building B. Wing Y2	11/19/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE NURSING AND REHABILITATION CENTER	325 JERSEY STREET TRENTON, NJ 08611

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0561	Correction	ID Prefix F0584	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(f)(1)-(3)(8)	Completed	Reg. # 483.10(i)(1)-(7)	Completed
LSC	11/11/2023	LSC	11/11/2023	LSC	11/11/2023
ID Prefix F0636	Correction	ID Prefix F0637	Correction	ID Prefix F0656	Correction
Reg. # 483.20(b)(1)(2)(i)(iii)	Completed	Reg. # 483.20(b)(2)(ii)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	11/11/2023	LSC	11/11/2023	LSC	11/11/2023
ID Prefix F0658	Correction	ID Prefix F0755	Correction	ID Prefix F0759	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(f)(1)	Completed
LSC	11/11/2023	LSC	11/11/2023	LSC	11/11/2023
ID Prefix F0761	Correction	ID Prefix F0812	Correction	ID Prefix F0868	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)	Completed
LSC	11/11/2023	LSC	11/11/2023	LSC	11/05/2023
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/11/2023	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/11/2023	☐ YES ☐ NO

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
315235 Y1	A. Building B. Wing Y2	11/19/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE NURSING AND REHABILITATION CENTER	325 JERSEY STREET TRENTON, NJ 08611

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0584 Reg. # 483.10(i)(1)-(7) LSC	Correction Completed 11/11/2023	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	
9/11/2023	☐ 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
061112 (Y1)	A. Building B. Wing (Y2)	11/19/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE NURSING AND REHABILITATION CENTER	325 JERSEY STREET TRENTON, NJ 08611

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 11/10/2023	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 9/11/2023	☐ 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 (Y2)	DATE OF REVISIT (Y3)
061112	A. Building B. Wing	11/19/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE NURSING AND REHABILITATION CENTER	325 JERSEY STREET TRENTON, NJ 08611

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 11/10/2023	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
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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 9/11/2023	☐ 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
	315235	A. BUILDING **01** B. WING _____	**09/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE NURSING AND REHABILITATION CENTER	**325 JERSEY STREET** **TRENTON, NJ 08611**

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K 000	INITIAL COMMENTS The nursing home building construction was stated to be 1980s with no current major renovations or noted additions. It was a two story building Type I (222) construction and was fully sprinklered. The facility has 2-diesel generators, one Kohler 150 KW interior and one Stamford 25 KW exterior. The 25 KW does the 4th floor only. The generators do approximately 80% of the facility.The facility has 15-smoke zones. The facility has four stories and attached to an unused section that was vacant on floors 4,3 and 2, floor 1 was attached to a Pediatric Day Health Service Program. The building utilizes an electric fire pump to support the fire sprinkler system. There was supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life The facility has 141 certified beds. At the time of the survey, the census was 132. The facility was recently sold to a different company and the name will be changed in the near future. The requirement at 42 CFR Subpart 483.90(a) was NOT MET as evidenced by:	K 000		
K 131 SS=F	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care	K 131		11/11/23

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

Electronically Signed | 09/27/2023

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
	315235	A. BUILDING **01** B. WING _____	**09/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE NURSING AND REHABILITATION CENTER	**325 JERSEY STREET** **TRENTON, NJ 08611**

(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 131	Continued From page 1 Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/31/23, in the presence of the Regional Plant Operations Director (RPOD) and Maintenance Staff Member (MSM), it was determined that the facility failed to provide two-hour fire resistance-rated elements and assemblies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.1.3.3* between the LTC license and the currently unlicensed sections of the building. The deficient practice could affect all residents. This deficient practice was evidenced for 2 of 5 door observations by the following: From 09:30 AM to 1:45 PM, the Surveyor and	K 131	The 4th floor Door separating the LTC from the Deadzone will be replaced with a 90-minute fire-rated door. The 2nd floor Door Separating the LTC from the deadzone with the paint over the Fire resistance label will be removed to show proper fire rating. All residents can be effected by the deficient practice. A Facility door audit will be performed by Maintenance Director to ensure Fire doors are rated for 90 minutes, and fire labels are not painted, if painted, paint will be	

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K 131	Continued From page 2 RPOD and MSM observed: Floor 4- LTC section to the unoccupied north-side (deadzone) of the building. The door seperating the sections of the building was observed to be labeled as a 1-hour (60 minutes) fire resistance rating and not the required 1-1/2 hour (90 minutes) rating. Floor 3- LTC section to the unoccupied north-side (deadzone) of the building. The door seperating the sections of the building was observed to be labeled with the correct 90 minute fire resistance rating. Floor 2- LTC section to the unoccupied north-side (deadzone) of the building. The door seperating the sections of the building was observed to be labeled with a fire resistance rating, but the attached label was painted and the fire resistance rating could not be determined. Floor 1- LTC section to the occupied north-side "Riverside Pediatric Day Health Program" door was properly identified with a 90-minute label. Lower Level section of the LTC section was seperated and protected by a full 2-hour fire resistance seperation rated wall. The findings were verified by the RPOD and MSM at the time of the observations. The Administrator was informed of the finding at the Life Safety Code exit conference on 8/31/23. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.1.3.4.	K 131	removed to ensure 90 minute fire rating. Maintenance department was educated by the Administrator to ensure not to paint door tag fire resistant labels, and to ensure all fire doors are rated for 90 minutes. Maintenance Director to Monitor Door Tags monthly x3 and report results to monthly QAPI to ensure compliance.	

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K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/31/23, in the presence of the Regional Plant Operations Director (RPOD) and Maintenance Staff Member (MSM), it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, labeled and were separated by	K 321	1. The double doors in the basement Laundry room will be repaired or replaced to ensure proper closing and latching into door frame. The paint on the fire tag will be removed to reveal and ensure proper 90 minute fire rating.	11/18/23

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K 321	Continued From page 4 smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was identified in 10 of 13 hazardous storage room doors observed and was evidenced by the following: 1). At 11:00 AM, the surveyor observed on the lower level, that the laundry room double doors when engaged,would not close and latch into the frame. The doors were observed to have the fire resistant rating labels, but they were painted. 2). At 11:15 AM, the surveyor observed the laundry folding room, that the door would not latch into its frame, had loose hardware and was not provided with a fire resistant label. 3). At 11:18 AM, the surveyor observed the work shop room, that the double doors were provided with fire resistant labels, but they were painted. 4). At 11:27 AM, the surveyor observed the activities room door was provided with a fire resistant label, but it was painted. 5). At 11:29 AM, the surveyor observed the medical supply room, that the double doors were provided with fire resistant labels, but they were painted. 6). At 11:29 AM, the surveyor observed the housekeeping room that the double doors were provided with fire resistant labels, but they were painted. 7). At 11:32 AM, the surveyor observed the	K 321	2. The laundry folding room door will be repaired or replaced to ensure proper latching into its frame, no loose hardware, and a proper fire resistant label. 3. In the maintenance workshop room, with the painted double doors fire resistant labels, paint will be removed to ensure proper fire rating. 4. In the Activities room, the painted door fire resistant label, will be removed to ensure proper fire rating 5. The painted Fire resistance label on the Double doors in the medical supply room, paint will be removed to ensure proper fire rating. 6. The painted Fire resistance label on the Double doors in the housekeeping room, paint will be removed to ensure proper fire rating. 7. In the maintenance shop, the painted double doors fire resistant labels, will be removed to ensure proper fire rating 8. The painted Fire resistance label on the Central elevator Room #2 door, paint will be removed to ensure proper fire rating. 9. The chemical storage/housekeeping supply room Door will be repaired or replaced to ensure Proper closure and latching to the frame, without a gap. 10. The central supply/medical records room doors (2- sets of double doors) will be replaced with proper fire rated doors All residents can be effected by the deficient practice. A Facility door audit was performed by	

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K 321	Continued From page 5 maintenance shop, that the double doors were provided with fire resistant labels, but they were painted. 8). At 11:36 AM, the surveyor observed the central elevator room #2, that the door was provided with a fire resistant label, but it was painted. 9). At 11:38 AM, the surveyor observed in the chemical storage/housekeeping supply room, that the lower area of the door did not close properly, leaving an approximately 1/2" opening. The door did not latch into its frame. 10). At 11:40 AM, the surveyor observed that the central supply/medical records room doors (2-sets of double doors) were not provded with any fire resistant labels. The RPOD and MSM both confirmed the findings during the observations. The Administrator was informed of the findings at the Life Safety exit conference on 8/31/23. NJAC 8:39-31.2 (e)	K 321	Maintenance Director to ensure door fire ratings are not painted, and if painted, paint will be removed, as well as proper closing and latching. Maintenance department were educated by Administrator on making sure not to paint door tag fire resistant labels, as well as ensure doors properly close and latch. Maintenance Director will Monitor Door Tags and positive latching monthly x3 and report results to the monthly QAPI meeting X3 to ensure compliance.	
K 345 SS=F	Life Safety Code 101-2012 edition Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily	K 345		11/11/23

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K 345	Continued From page 6 available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review on 8/30/23, in the presence of the Regional Plant Operations Director (RPOD) and Maintenance Staff Member (MSM), it was determined that the facility failed to ensure smoke detection sensitivity testing were completed of the facility smoke detectors in accordance with NFPA 72 (2010 edition) section 14.4.5.3.2. The deficient practice was identified for 4 of 4 semi annual inspection reports provided and was evidenced by the following: At 10:00 AM, the surveyor reviewed all related fire alarm documentation provided by the RPOD from the fire alarm vendor to determine if the sensitivity test was performed. The reports were dated 3/15/23, 9/16/22, 3/25/22, and 9/23/21. The reports provided did not indicate any information on the testing of the smoke detectors for sensitivity. An interview was conducted with the RPOD, during document review and the RPOD, stated he was not sure if the required sensitivity test for the facility smoke detectors were performed. The RPOD further stated he would contact the facility fire alarm vendor to see if sensitivity report was performed, but at the LSC exit no further documentation was provided. The Maintenance Director was on vacation at the time of the Life Safety Code survey. The Administrator was informed of the findings at	K 345	Fire protection company immediately contacted to conduct smoke alarm sensitivity test of facility smoke detectors and replace any defective detectors. All residents can be effected by the deficient practice. Administrator educated Maintenance director regarding ensuring 2 year smoke alarm sensitivity testing. The administrator will audit Fire alarm sensitivity testing annually to ensure continued compliance is met for Sensitivity testing every 2 years. Results will be brought to the qapi meeting Quarterly, for review until compliance is acheived.	

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K 345	Continued From page 7 the Life Safety Code Exit conference on 8/31/23. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 70, 72	K 345		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on the interview and record review on 5/24/23, in the presence of the Regional Plant Operations Director (RPOD) and Maintenance Staff Member (MSM), it was determined A). that the facility failed to ensure the electric fire pump was properly tested monthly and documented as per NFPA 25. B.) Ensure fire sprinkler heads are maintained in optimal condition as per NFPA 13.	K 353	Maintenance director will immediately perform an electric fire pump test to include: Run the fire pump for at least 10 minutes Note the system's suction pressure and discharge pressure Note any strange noises or vibrations Check pump casing or bearings for signs of overheating Check the pump for any possible discharge Check volt and amp	11/11/23

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K 353	Continued From page 8 This deficient practice was evidenced by the following: A). During document review, the surveyor observed that the electric fire pump monthly test report provided date, on and off times, and marked OK with intials only, with no further information. The NFPA 25 requires that any electric motor-driven fire pump be operated every month. The test should be executed as follows: Run the fire pump for at least 10 minutes Note the system's suction pressure and discharge pressure Note any strange noises or vibrations Check pump casing or bearings for signs of overheating Check the pump for any possible discharge Check volt and amp readings record all results The RPOD and MSM confirmed the finding's during the observations and document review and indicated they did not know the procedure for documenting the fire pump requirements properly. B). At 12:20 PM, the surveyor observed that one (1) of two (2) fire sprinkler heads in the facility laundry room, located in the back of the 3 commercial clothes dryers, that the fire sprinkler head closest to the dryer entrance door, was observed to have a heavy coating of green oxidation. The RPOD and MSM confirmed the finding during the observations.	K 353	readings and record all results The fire sprinkler head closest to the dryer entrance door, with a heavy coating of green oxidation was replaced All residents can be effected by the deficient practice. The Maintenance director was educated by the Administrator regarding proper electric fire pump testing needing to include: Run the fire pump for at least 10 minutes Note the system's suction pressure and discharge pressure Note any strange noises or vibrations Check pump casing or bearings for signs of overheating Check the pump for any possible discharge Check volt and amp readings and record all results. The maintenance Director will Audit sprinkler heads in the facility on a quarterly basis to ensure they are not oxidized or damaged. Results will be brought to the QAPI meeting quarterly X3, or until compliance is achieved. Administrator is responsible to ensure cokmpliance.	

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K 353	Continued From page 9 The Administrator was notified of the findings at the Life Safety Code exit conference on 8/31/23. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 20: Standard for the Installation of Stationary Pumps for Fire Proctetion NFPA 13 Standard for the installation of Sprinkler systems NFPA 25: Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems	K 353		
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates	K 363		11/11/23

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K 363	Continued From page 10 of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/31/23, in the presence of the Regional Plant Operations Director (RPOD) and Maintenance Staff Member (MSM), it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring room doors closed completely to properly confine fire and smoke products and to properly defend occupants in place was identified in 34 of 57 resident room (RR) doors observed and was evidenced by the following: During the building tour on 8/31/23 from 9:15 AM to 1:45 PM, the surveyor in the presence of the RPOD and MSM toured the facility and observed the following compromised RR doors: RR # 429 door rubs into it's frame and the door	K 363	RR # 429 door repaired to not rub into it's frame and the door frame latch was replaced. RR # 428 door repaired to latch into its frame. RR # 427 repaired to align with the top of the frame, without 1/2" opening. RR # 424 door repaired to latch into its frame. RR # 421 repaired 1/4" hole in the door above the hardware. RR # 419 door repaired to not rub on the floor RR # 414 door hardware repaired to correct ¿ inch gap in door frame. RR # 412 ¿ inch door gap to frame repaired. RR # 411 door hardware repaired to correct ¿ inch gap in door frame RR # 327 door repaired to not rub into its frame. RR # 321 door repaired to not rub on	

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K 363	Continued From page 11 frame latch is missing. RR # 428 door will not latch into its frame. RR # 427 top of the door not alligned with the top of the frame, approximately 1/2" opening. RR # 424 door will not latch into its frame. RR # 421 approximately 1/4" hole in the door above the hardware. RR # 419 door rubs on the floor RR # 414 hardware issue and top gap door to frame approximately 1/2". RR # 412 top gap door to frame approximately 1/2". RR # 411 hardware issue and top gap door to frame approximately 1/2". RR # 327 door rubs into its frame. RR # 321 door rubs on floor. RR # 319 top gap door to frame approximately 1/2". RR # 317 top gap door to frame approximately 1/2". RR # 316 top gap door to frame approximately 1/2". RR # 312 door will not latch into its frame. RR # 311 door rubs into its frame. RR # 310 top gap door to frame approximately 1/2". RR # 304 door rubs on floor. RR # 301 door rubs into its frame. RR # 228 door rubs into its frame. RR # 227 door will not latch into its frame. RR # 226 door rubs into its frame. RR # 223 door rubs into the top of the door frame. RR # 222 door rubs into the top of the door frame. RR # 220 door rubs on the floor. RR # 217 door rubs on the floor. RR # 216 top gap door to frame approximately 1/2".	K 363	floor. RR # 319 half inch top gap door to frame repaired. RR # 317 Half inch top gap door to frame repaired. RR # 316 Half inch top gap door to frame repaired RR # 312 door repaired to latch into its frame. RR # 311 door repaired to not rub into its frame. RR # 310 half inch top gap door to frame repaired RR # 304 door repaired to not rub on floor. RR # 301 door repaired to not rub on floor. RR # 228 door repaired to not rub on floor. RR # 227 door repaired to latch into its frame. RR # 226 door repaired to not rub into its frame. RR # 223 door rubs into the top of the door frame. RR # 222 door repaired to not rub into the top of the door frame. RR # 220 door repaired to not rub on the floor. RR # 217 door repaired to not rub on the floor. RR # 216 ¿ inch top gap door to frame repaired RR # 215 door repaired to not rub into its frame. RR # 209 door repaired to not rub into its frame. RR # 207 door repaired to not rub into top of frame.	

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K 363	Continued From page 12 RR # 215 door rubs into its frame. RR # 209 door rubs into its frame. RR # 207 door rubs into top of frame. RR # 205 door rubs into top of frame. RR # 203 door will not latch into its frame. RR # 202 door rubs into its frame. RR # 201 top gap door to frame approximately 1/2". At the time of observations, the surveyor interviewed the RPOD and MSM, who both confirmed the above findings. The Administrator was informed of the findings at the Life Safety Code exit conference on 8/31/23. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	RR # 205 door repaired to not rub into top of frame. RR # 203 door repaired to latch into its frame. RR # 202 door repaired to not rub into its frame RR # 201 ¿ inch top gap door to frame repaired All residents can be affected by the deficient practice. Maintenance Staff were educated by Administrator regarding ensuring resident doors properly latch in door frame without rubbing and without gaps. The Maintenance Director will audit resident doors monthly x3 to ensure proper latching without gaps or rubbing. Results will be brought to the monthly QAPI meetings x3, or until compliance is achieved. Administrator is responsible to ensure compliance.	
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the	K 531		11/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315235	A. BUILDING **01** B. WING _____	**09/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE NURSING AND REHABILITATION CENTER	**325 JERSEY STREET** **TRENTON, NJ 08611**

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K 531	Continued From page 13 level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review on 8/30/23, in the presence of the Regional Plant Operations Director (RPOD) and Maintenance Staff Member (MSM), it was determined that the facility failed to ensure that there was documented evidence that all existing elevators; having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes conformed with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key.19.5.3, 9.4.2, 9.4.3). This deficient practice was identified for 3 of 3 elevators and was evidenced by the following: At 10:30 AM, the surveyor reviewed all LSC documentation provided by the RPOD and MSM. The monthly testing of the firefighters Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 was	K 531	All 3 facility elevators were immediately tested to include The Elevator Fire Service Recall Test log indicating verification of Phase I (firefighter's emergency control) and Phase II (firefighter's independent in-car manual control) including minimum of one floor operation, including findings documented. All residents can be effected by the deficient practice The maintenance Director was educated by the Administrator regarding the regulation that The monthly Elevator Fire Service Recall Test log needs to indicate verification of Phase I (firefighter's emergency control) and Phase II (firefighter's independent in-car manual control) including minimum of one floor operation, and documented monthly. The monthly elevator test log will be audited monthly X4 by Administrator to ensure proper verification compliance. Results will be brought to the monthly QAPI meeting x4 or until compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 531	Continued From page 14 provided, but did not indicate details, the report just indicated a check for each of the three elevators. The Elevator Fire Service Recall Test log did not indicate varification of Phase I (firefighter's emergency control) and Phase II (firefighter's independent in-car manual control) including minimum of one floor operation, including findings documented monthly. An interview was conducted with the RPOD and MSM, during the record review. They confirmed there was no current detailed firefighter's monthly service log for 3 of 3 elevator devices, just the report provided. The Administrator was informed of the findings at the Life Safety Code exit conference on 8/31/23. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.5.3 & 9.4.3 Fire Fighters Emergency Operations: 9.4.3.2 ASME/ANSI A17.3 Safety Code for Existing Elevators and Escalators.	K 531		
K 914 SS=F	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 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,	K 914		11/11/23

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K 914	Continued From page 15 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 8/30/23, in the presence of the facility's Regional Plant Operations Director (RPOD) and Maintenance Staff Member(MSM), 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 48 of 48 resident rooms observed by the following: From approximately 10:30 AM to 1:30 PM, the surveyor, RPOD and MSM, observed that resident rooms were provided with electrical receptacles that were less than hospital grade and required an annual electrical inspection. The annual electrical inspection from the facility vendor dated: 8/10/23 did not indicate any testing of resident room outlets. The RPOD and MSM, confirmed that the facility had non-hospital outlets installed in resident rooms, but could not provide any documentation or logs indicating the annual inspection was	K 914	The facility immediately conducted an inspection to functionally test electrical receptacles in residents' rooms that had nonhospital grade outlets for grounding, polarity, and blade tension. All residents can be affected by the deficient practice. Maintenance director Educated by the Administrator regarding regulation to functionally test electrical receptacles in residents' rooms that have nonhospital grade outlets for grounding, polarity, and blade tension on an annual basis. The maintenance director will audit all resident room electrical receptacles quarterly X4 to ensure any issues found are addressed. Findings will be brought to the Quarterly QAPI meeting to ensure compliance. Administrator is responsible to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315235	A. BUILDING **01** B. WING _____	**09/11/2023**

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K 914	Continued From page 16 conducted. The Administrator was informed of the findings at the Life Safety Code exit conference on 8/31/23. NJAC 8:39-31.2(e) NFPA 99	K 914		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and	K 918		11/5/23

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K 918	Continued From page 17 separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/31/23, in the presence of the Regional Plant Operations Director (RPOD) and Maintenance Staff Member (MSM), it was determined that A). The facility failed to ensure a remote manual stop station for 2 of 2 generators: one interior Kohler 150 KW diesel and one exterior Stamford 25 KW diesel, both providing emergency power to approximately 80% of Health Care facility. B). The facility failed to ensure the four-hour load bank test for the facility's exterior generator, met the minium requirements of NFPA 110. in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice was evidenced by the following: A). At 11:05 AM, the surveyor and RPOD and MSM, observed that the 2-generators were not provided with a remote manual stop station observed outside the area of the generator interior/exterior locations. An interview was conducted during the time of the observation with the RPOD and MSM, who both stated and confirmed that the interior and exterior generators, did not have a remote manual stop station to prevent inadvertent or unintentional operation that was located outside the area of the enclosure housing the prime mover for the current (2) generators in service.	K 918	The 2 facility generators were immediately installed with a remote manual stop station outside the area of the generator interior/exterior locations. The facility immediately conducted a four-hour load bank test for the facility's exterior generator, to meet the minimum requirements of NFPA 110 The maintenance director/designee will inservice facility management on using remote generator manual stop in case of emergency. Maintenance Director to be inserviced on generator load bank requirements to ensure compliance with minimum load requirements. Maintenance director will monitor generator tests monthly x3 than quartery x3 to ensure compliance with load bank tests. Results will be reviewed at the monthly QAPI meeting.	

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K 918	Continued From page 18 B). At 10:18 AM, The surveyor reviewed the document from the facility's generator vendor dated: 8/10/23. The document indicated the exterior generator failed the four-hour load bank test. The test completion notes indicated at 50% load the engine /generator could not handle it, RPM and frequency dropped below normal operating range, dropped load applied about 35-40 % load @ 61 amps and the generator/engine was able to carry that load for the remainder of the test, but the required 50% load and last hour 75-80% load was not met as per the document provided by the RPOD, and Administrator. The RPOD and Administrator indicated the document was the results of the four hour load bank test as per the completion notes, dated: 8/10/23. The Administrator was informed of the findings at the Life Safety Code exit conference on 8/31/23. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918		

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
315235 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	11/19/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE NURSING AND REHABILITATION CENTER	325 JERSEY STREET TRENTON, NJ 08611

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0131	11/11/2023	LSC K0321	11/18/2023	LSC K0345	11/11/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	11/11/2023	LSC K0363	11/11/2023	LSC K0531	11/11/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0914	11/11/2023	LSC K0918	11/05/2023	LSC	
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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/11/2023	☐ YES ☐ NO