STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315506	A. BUILDING _____ B. WING _____	C 09/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (WASHINGTON TWP)	**378 FRIES MILL ROAD SEWELL, NJ 08080**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification/Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 09/26/23 through 09/30/23. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 09/26/23 through 09/30/23 Survey Census: 107 Sample Size: 28 Supplemental Residents: 0 No deficiencies were issued related to: Complaint #s: Intake NJ157575, NJ162176, NJ162496, NJ163214, NJ164593, NJ164637, NJ164966, NJ165006, NJ165017, and NJ165625. F689J: Based on observations, interviews, record review and policy review, it was determined that the facility failed to ensure resident safety related to "lights over headboard are smoking when turned on" for (Resident (R)73 and R51). The lights were found to be smoking by staff on 8/31/2023 and not repaired until 9/28/2023. This failure placed R73 and R51, as well as all residents, at risk of an electrical fire and in an Immediate Jeopardy situation. On 09/29/23 at 2:40 PM, the Administrator, Director of Nursing (DON), Regional Clinical Nurse Consultant, and Facility Nurse Consultant were informed of the Immediate Jeopardy (IJ) at F689, due to the facility's failure to ensure resident safety related to "lights over headboard were smoking when turned on." This placed all	F 000		

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

Electronically Signed | 10/20/2023

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F 000	Continued From page 1 residents in the facility at risk of an electrical fire. The facility provided an acceptable plan for removal of the IJ on 09/30/23 at 11:55 AM. The survey team validated the IJ was removed on 09/30/23 at 2:40 PM, following the facility's implementation of the plan for removal of the IJ. The deficient practice remained at F689 (Free of Accidents Hazards) at a D, (no actual harm with potential for more than minimal harm that is not immediate jeopardy) scope and severity following the removal of the immediate jeopardy.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other	F 578		11/6/23

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F 578	Continued From page 2 entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and facility policy review, the facility failed to ensure a resident's right to formulate or refuse an Advance Directive upon admission relating to healthcare in the event that the resident becomes incapacitated for one of two residents (Resident (R) R35) reviewed for Advanced Directives. The facility failed to follow up with R35's responsible party to obtain copies of R35's Advance Directives. Findings include: Review of R35's undated "Admission Record" provided by the facility revealed [redacted] was admitted to the facility on [redacted] with a [redacted]. Review of R35's annual "Minimum Data Set (MDS)" located in the electronic medical record (EMR) under the "MDS" tab with an "Assessment Reference Date (ARD)" of 06/07/23 revealed a	F 578	F578 D Request/Refuse/Discontinue Treatment: Formulate Advance Directive Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: R35 was offered to formulate an advanced directive. [redacted] declined. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The Social Worker or Administrator will audit the residents in the center to ensure all residents have been offered the right to formulate or refuse an advanced directive. Residents /Responsible Parties who request to formulate an Advanced Directive will be assisted in completing	

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F 578	Continued From page 3 "Brief Interview of Mental Status (BIMS)" score of Ex Order 26 out of 15, indicating the resident had *Ex Order 26. 4B1*. Review of R35's "Care Plan," initiated on 12/09/20, indicated Ex Order did not have an Advance Directive in place, but that Ex Order code status was "Ex.Order 26 *Ex Order 26. 4B1*." Review of R35's "Order Summary Report" provided by the facility, included an order for Ex.Order 26 and *Ex Order 26. 4B1*, dated 12/09/20. Review of R35's paper chart and EMR did not include a copy of an Advance Directive. During an interview on 09/28/23 at 11:41 AM R35 revealed Ex Order did not know what an Advance Directive was. During an interview on 09/30/23 at 5:00 PM the Director of Nursing (DON) confirmed that there was an order for Ex.Order 26, but no Advance Directive on file. During an interview on 09/30/23 at 6:36 PM the Administrator stated he was not able to locate the admission packet/agreement that confirmed the resident, or Ex Order responsible party were offered the opportunity and education to formulate an Advance Directive. Additionally, no Advance Directive documentation was available to support the resident's decision for DNR. The Administrator did not state what his expectation was for obtaining a copy of the Advance Directive for the resident. Additionally, the Administrator stated that the Social Worker would have assisted the resident in formulating an Advance Directive in 2020 was no longer working at the	F 578	one. This will be documented in the care plan. Residents who refuse to formulate an advanced directive will be educated. This will be documented in the care plan. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Social Worker was educated on the process of offering all residents the right to formulate of refuse an advanced directive upon admission. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: The Administrator or designee will conduct audits on advanced directives for new admissions weekly x four weeks, then bi-weekly x four weeks, and them monthly x one month. Findings of the audits will be reviewed by the Quality Assurance Committee monthly.	

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F 578	Continued From page 4 facility but would have educated and provided the opportunity for Advance Directives. Review of the facility's policy titled, "Communication of Code Status," revised 11/2022, indicated "It is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement procedures to communicate a resident's code status to those individuals who need to know this information ..." NJAC 8:39-4.1(a)2 NJAC 8:39-9.6(a) NJAC 8:39-35.2(d)14	F 578		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure two (Resident (R)22 and R257) out of 28 sampled residents had an accurate "Minimum Data Set (MDS)" assessment. Failure to code the "MDS" correctly could potentially lead to inaccurate federal reimbursements, inaccurate assessment, and inaccurate care planning of the resident. Findings include: 1. Review of R22's undated "Admission Record" provided by the facility indicated [redacted] was originally admitted to the facility on [redacted] and	F 641	F641 D Accuracy of Assessments Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident 22's MDS was corrected related to reflect that [redacted] wears [redacted] Resident 257's MDS was corrected to reflect the use of [redacted] and the care plan was reviewed for accuracy. Address how the facility will identify other	11/6/23

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F 641	Continued From page 5 re-admitted Ex Order 26. 4B1 with a *Ex Order 26. 4B1* . Review of R22's "Care Plan" located in the electronic medical record (EMR) under the "Care Plan" tab, revised 05/21/23, indicated R22 had lost *Ex Order 26. 4B1* 05/21/23, with interventions to encourage the resident to wear *Ex Order 26. 4B1* for meals. Review of R22's admission "MDS" located in the EMR under the "MDS" tab with an "Assessment Reference Date (ARD)" of Ex.Order 26.4(b)(1) revealed a "Brief Interview for Mental Status (BIMS)" score of Ex Ord out of 15, indicating Ex Order had *Ex Order 26. 4B1* . R22's *Ex Order 26. 4B1* status indicated Ex Order had no broken or loosely fitting *Ex Order 26. 4B1* , and that Ex Order had all of *Ex Order 26. 4B1* . Additionally, R22's quarterly "MDS" assessments with ARD's of 03/22/23 and 06/22/23 also indicated that Ex Order had all Ex Order , and no *Ex Order 26. 4B1* . Review of R22's "Order Summary Report" provided by the facility, included an order for *Ex Order 26. 4B1* diet and *Ex Order 26. 4B1* . Review of R22's "Progress Note," dated 09/11/23, located in the EMR under the "Progress Note" tab revealed the resident wore *Ex Order 26. 4B1* . Review of R22's "Nursing Assessment" located in the EMR under the "Assessments" tab, dated 09/11/23, indicated the resident wore *Ex Order 26. 4B1* . Review of R22's "Dietary Assessment" located in the EMR under the "Assessments" tab, dated 09/21/23, indicated the resident had no *Ex Order 26. 4B1* .	F 641	residents having the potential to be affected by the same deficient practice: Residents with NJ Exec. Order 26:4.b.1 and residents on *Ex Order 26. 4B1* had their MDS' audited for accuracy. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The MDS Coordinator was educated by the Director of Nursing on the accuracy of MDS coding. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting The Regional MDS Coordinator or designee will complete an audit of all MDS Submissions for residents tht have NJ Exec. Order 26:4.b.1 and receive *Ex Order 26. 4B1* to confirm the accuracy of the3 MDS. The audits will be conducted weekly for 4 weeks, then bi-weekly x 4weeks , and then monthly x 1 month. Findings will be reported monthly x 3 to QAPI Committee. After 3 months QAPI Team will review the need to continue monthly reporting/ auditing and or change to existing plan.	

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F 641	Continued From page 6	F 641		

Review of R22's "Atlas- NSG [Nursing] Quarterly Annual Significant Change Evaluation - V 4," dated 09/14/23, indicated the resident wore Ex Order 20. 4B1.

Review of R22's Ex.Order 26.4(b) note located in the paper chart revealed the Ex Order 26. 4B1 evaluated Ex Order on 08/18/23 and stated that Ex Order 26. 4B1 did not fit. Ex Order was also noted to have been seen on 05/11/23 for Ex Order 26. 4B consult for Ex Order 26. 4B1, and on 07/26/23 for Ex.Order 26.4(b)(1) for Ex Order 26. 4B1.

During an observation and interview on 09/26/23 at 1:11 PM R22 revealed Ex Order had no Ex Order 26. and that the Ex Order 26. 4B1 that Ex Order currently had did not fit correctly, causing Ex Order to gag. The resident showed this surveyor that Ex Order had no Ex Order 26. 4B1 and that Ex Order had a container with Ex Order that did not fit correctly.

During an interview on 09/28/23 at 11:14 AM R22 revealed Ex Order had mentioned to staff that Ex Order were too big and that they make Ex Order gag.

During an interview on 09/29/23 at 3:57 PM the Unit Manager Ex Order 26. 4B confirmed that R22 had been seen by the Ex Order 26. 4B1 multiple times for Ex Order 26. 4B1.

During an interview on 09/30/23 at 3:43 PM the MDS Coordinator (MDSC)2 confirmed that R22 did not have any Ex Order 26. , had Ex Order 26. 4B1 per nursing progress notes, and that the "MDS" assessments should have reflected Ex Order 26. 4B1 status. Additionally, the MDSC2 stated that the protocol was to review nursing progress notes and nursing assessments for Ex Order 26. 4B1 status. The quarterly nursing assessment located in the EMR under

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F 641	Continued From page 7 the assessments was not completed for the "MDS" nurse to review and reference. 2. Review of R257's "Admission Record" located in the EMR under the "Profile" tab indicated he was originally admitted to the facility on [redacted] and re-admitted on [redacted] with a primary diagnosis of [redacted] Review of R257's "Care Plan" located in the EMR under the "Care Plan" tab, initiated on 03/21/23 included the use of [redacted] medications. Review of R257's quarterly "MDS" located in the EMR under the "MDS" tab revealed a "BIMS" score of [redacted], indicating [redacted] was [redacted]. The assessment indicated that [redacted] took [redacted] medications for the past seven days during the look-back period, however, it indicated that no [redacted] were received during the look-back period. Review of R257's "Physician Orders" located in the EMR under the "Orders" tab included multiple orders for [redacted] tablet once daily as of 03/18/23. During an interview on 09/29/23 at 5:48 PM the MDSC1 confirmed that R257 had been taking [redacted] medications and that the "MDS" coding was incorrect. Review of the RAI Manual," dated 10/01/19, indicated ". . . It is important to note here that information obtained should cover the same observation period as specified by the MDS items	F 641		

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F 641	Continued From page 8 on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary team] completing the assessment ..." NJAC 8:39-11.2(g)	F 641		
F 656 SS=D	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 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)-	F 656		11/6/23

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F 656	Continued From page 9 (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 interview, record review, and facility policy review, the facility failed to ensure a comprehensive care plan was in place for the diagnosis of [redacted] for one (Resident(R)102) of 28 sample residents reviewed for care plans. This had the potential for the resident to have unmet care needs. Finding include: Review of R102's undated "Face Sheet" located in the electronic medical record (EMR) under the "Profile" tab indicated the resident was admitted on [redacted] with diagnoses including [redacted]. Review of R102's "Care Plan," dated 08/24/23, located in the EMR under the "Care Plan" tab revealed the resident's diagnosis of [redacted] was not included in the comprehensive care plan.	F 656	F656 D Develop/Implement Comprehensive Care Plan Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident 102□s comprehensive care plan was updated to include the [redacted] diagnosis. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Residents with a diagnosis of [redacted] had their care plans audited to ensure the	

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F 656	Continued From page 10 During an interview on 09/30/23 at 11:54 AM, the Director of Nursing (DON), upon review of R102's diagnosis and care plan, confirmed R102's care plan did not address [redacted] diagnosis of [redacted]. Review of the facility's policy titled "Comprehensive Care Plans," dated 09/23, revealed " It is the policy of this facility to develop and implement a person-centered care plan for each resident, consistent with resident rights, that includes objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment." NJAC 8:39-11.2(e)	F 656	diagnosis was on the care plan. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The nurses were educated by the Director of Nursing on Comprehensive Care Plans related to [redacted]. The Director of nursing or designee will complete audits on comprehensive care plans to ensure that if the resident has a diagnosis of [redacted] that it is on the care plan. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting? The Director of Nursing or designee will conduct the audits weekly x four weeks, then bi-weekly x four weeks, and them monthly x one month. Findings of the audits will be reviewed by the Quality Assurance Committee monthly x3.	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record	F 689	F689J	11/6/23

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F 689	Continued From page 11 review, and policy review, it was determined that the facility failed to ensure resident safety related to "lights over headboard are smoking when turned on" for (Resident (R)73 and R51). The lights were found to be smoking by staff on 8/31/2023 and not repaired until 9/28/2023. This failure placed R73 and R51, as well as all residents, at risk of an electrical fire and in an Immediate Jeopardy situation. Additionally, the facility failed to provide a safe smoking environment for 10 residents (Resident (R) 17, R24, R48, R52, R55, R60, R65, R72, R159, and R160) of the facility identified as smokers. The facility's Administrator was informed on 09/28/23 at 6:54 PM that Immediate Jeopardy existed related to the failure to ensure overhead lights were not smoking when turned on for R73 and R51 resulting in the potential for an electrical fire. The facility provided an Immediate Jeopardy Removal Plan that was accepted on 09/30/23 at 9:39 AM. The survey team validated implementation of the removal plan through interviews and record review. Immediate Jeopardy was removed on 09/30/23 at 2:40 PM. After removal of the Immediate Jeopardy, the deficiency remained at a "D" scope for isolated potential for more than minimal harm. Findings include: 1. Review of the facility policy titled, "Maintenance Services," revised 08/01/17, revealed " ... The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times ... Maintaining the building free from hazards ...Maintaining all mechanical, electrical, and patient care equipment in safe operating	F 689	*Free from Accident Hazards/Supervision/Devices Related to light: On 9/28/2023 as a precaution, resident number 51 and 73 were relocated to room [redacted]. The center was placed on fire watch as a precaution. The electrician arrived on 9/28/23. He evaluated the light. He reported that ballast number one (the ballast with no electricity going to it) was not functional at all. He reported that ballast number two (powers the light on top of the fixture) was fully functional and just needed a bulb. The Administrator, Maintenance Director, and electrician conducted an audit in the center on 9/28/2023 to evaluate if there were any lights malfunctioning. None were identified. No other residents were affected. The Administrator, Maintenance Director, and electrician conducted an audit in the center on 9/28/2023 to evaluate if there were any lights malfunctioning. None were identified. The Administrator began in-servicing all staff on 9/28/2023 on environmental safety, lighting, electrical equipment, TELS reporting, fluorescent lights, night lights, and fire watch. In-servicing will continue until all staff are in-serviced. New staff will be in-serviced upon hire including agency staff. The administrator will conduct audits on overbed lights to check for malfunctioning. The Administrator or designee will conduct the audits on resident over bed lights weekly x four weeks, then bi-weekly x four weeks, and them monthly x one month to ensure that if any malfunctioning	

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F 689	Continued From page 12 condition ...The Director of Maintenance is responsible for maintaining the following records/reports: ...work order requests ..." a. Review of R73's "Admission Record" located in the paper chart, indicated [redacted] was originally admitted to the facility with a primary diagnosis of *Ex Order 26. 4B1* [redacted]. Review of R73's "Orders," located in the electronic medical record (EMR) under the "Orders" tab, included *Ex Order 26. 4B1* [redacted] with transfers dated 08/11/23. Review of R73's "Care Plan," located in the EMR under the "Care Plan" tab and revised on 06/15/23, included Ex.Order 26.4(b)(1) [redacted] and use of Ex.Order 26.4(b)(1) [redacted] such as *Ex Order 26. 4B1* [redacted]. Review of R73's admission "Minimum Data Set (MDS)" located in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) of 05/16/23, indicated a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15, indicating [redacted] was *Ex Order 26. 4B1* [redacted]. R73 required extensive, two-person assistance with [redacted] and transfers. 2. Review of R51's "Admission Record," located in the EMR under the "Profile" tab, indicated she was originally admitted to the facility with a primary diagnosis of primary *Ex Order 26. 4B1* [redacted]. Review of R51's "Care Plan" located in the EMR under the "Care Plan" tab, revised 08/07/23, did not include Ex.Order 26.4(b)(1) [redacted] status. Review of R51's annual "MDS" with an ARD of	F 689	lights were identified, that they were remedied timely. Findings of the audits will be reviewed by the Quality Assurance Committee monthly x 3. Related to smoking area: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The open ashtray can with the plastic bag was removed. The doorbell was fixed to sound louder in 2 locations for reentry. A vendor was contacted, and an additional means of entry was installed. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: No other residents were affected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Housekeeping Director and staff who attend to the smoking area were educated by the Administrator on the proper use of smoking receptacles. The staff member assigned to the smoking times will monitor the area to ensure proper use of receptacles. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting The Maintenance Director or designee will complete audits of the smoking area to ensure that no plastic bags are in the receptacles. Audits will be conducted	

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F 689	Continued From page 13 07/28/23, located in the EMR under the "MDS" tab revealed a " BIMS" score of [redacted] out of 15, indicating [redacted] was *Ex Order 26. 4B1*. R51 required Ex.Order 26.4(b)(1) [redacted] assist for *Ex Order 26. 4B1* and transfers. During an interview on 09/27/23 at 5:58 PM, R51 stated [redacted] forgot to mention to the surveyor during the initial interview that the light above [redacted] roommate's bed [R73] did not work and that it had *Ex Order 26. 4B1* when somebody turned it on and that now there was a sign on it to not touch the light. An observation on 09/26/23 at 12:07 PM, revealed a sign above R73's bed stating, *Ex Order 26. 4B1* [redacted] During an interview on 09/26/23 at 12:07 PM, R73 confirmed that [redacted] required Ex.Order 26.4(b)(1) from staff with all transfers and that staff use a *Ex Order 26. 4B1* to get [redacted] out of bed. During an observation on 09/28/23 at 12:25 PM, a sheet of notebook paper above R73's bed, taped to the wall below the malfunctioning light revealed, *Ex Order 26. 4B1* [redacted] Review of a work order dated 08/31/23 at 3:05 AM, provided by the facility revealed, *Ex Order 26. 4B1* [redacted] in room for R73. During an interview on 09/28/23 at 11:51 AM, Certified Nursing Assistant (CNA)2 confirmed that R73's light over [redacted] bed was not working and that when they tried to use it the light smoked and that it had been that way for about a month. CNA2 confirmed that R73 required Ex.Order 26.4(b)(1) with	F 689	weekly x 4 weeks, then bi-weekly x 4 weeks, and then monthly x 1 month. Findings will be reported to the QAPI Committee monthlyx3. After 3 months QAPI Team will review the need to continue monthly reporting/ auditing and or change to existing plan.	

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F 689	Continued From page 14 transfers and a [redacted].	F 689		

During an interview on 09/28/23 at 12:11 PM, CNA1 confirmed that R73's light over [redacted] bed was not working and that [redacted] had heard from other staff that it had previously sparked so [redacted] did not turn it on. Additionally, CNA1 confirmed there was a sign above R73's bed stating to not use the light. Additionally, CNA1 stated that R73 required [redacted] with bed transfers and a [redacted].

During an interview on 09/28/23 at 12:25 PM, R51 and R73 stated that about three weeks ago one of the CNAs turned on the light and [redacted] got shocked. The Maintenance Director had come to check the light the following week and told them he would be back but had not returned. The residents stated due to the light not working above the bed for R73, staff and residents were having to use the overhead light to the room, or the light above the bed for R51.

During an interview on 09/28/23 at 12:51 PM, Registered Nurse (RN)1 confirmed that R79 was [redacted] and required [redacted] with all transfers and repositioning. Additionally, she was aware of the light not working above R73's bed, but she did not know why.

During an interview and observation on 09/28/23 at 2:49 PM, the surveyor asked the Maintenance Director if he had followed up on the light in R73's room. Initially the Maintenance Director did not know what room the surveyor was referring to so the surveyor and Maintenance walked to the room together. R73 was in bed and we announced that we were in the room to check on the light and the heat. Once the Maintenance

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F 689	Continued From page 15 Director entered the room, he recalled the malfunctioning light. R73 stated "It doesn't work" [referring to the light]. The Maintenance Director went over to the light and picked up the top metal covering over the light fixture and then the light illuminated. During an interview on 09/28/23 at 3:08 PM, the Maintenance Director stated he was aware that staff reported the light sparking that was located over R73's bed on 08/31/23, via the online TELS program (maintenance requests). Four surveyors were present for his statement. When asked what precautions had been put in place, he stated there was a hand-written sign hanging above the bed stating to not use the light and that he had disconnected the light from the circuit on 08/31/23. He was not able to explain how he disconnected the light or electricity going to the light fixture, and did not have any documentation to reflect he had disconnected the electricity going to the light. He then went on to say that when he pulled the light string on 09/28/23 at 2:49 PM he saw a spark come out near the location of the string coming out of the light unit. When asked if a replacement light had been ordered, he was unable to locate the order, and stated he was in the process of ordering a new light fixture. He stated that he was currently in the process of disconnecting the circuit from the light and that every Monday he chooses a hall to check the lights. He confirmed he had not checked the light unit above bed for R73 since 08/31/23. Additionally, the Maintenance Director acknowledged that an unknown person had put in a bulb on an unknown date, and he didn't understand why. On 09/29/23 at 9:30 AM the Maintenance Director notified the survey team that an electrician made a visit on 09/28/23	F 689		

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F 689	Continued From page 16 around 9:30 PM and noted two separate ballasts for the light fixture above the bed (for R73). One ballast had a frayed wire, and the other ballast was fine. The electrician provided a written statement to the facility verifying that the power going to the light fixture was disconnected when he made the visit on evening of 09/28/23. During an interview on 09/28/23 at 5:55 PM, R73 stated on 08/25/23 Ex.Order 2 saw the light spark, and R51 stated Ex.Order smelled something burning but could not tell where the smell was coming from due to the privacy curtain being pulled for privacy of R73 and that this occurred on the evening shift and that staff put up the sign stating to not use the light. R51 stated Ex.Order was afraid of the light fixture causing an electrical fire. During an interview on 09/28/23 at 6:18 PM the Administrator stated he was not aware of the malfunctioning light above R73's bed until the surveyors notified him. Review of the facility's "Smoking Policy," dated 07/23, revealed "It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and nonsmoking residents." The policy explanation and compliance guidelines included "provision of ashtrays made of noncombustible material and safe design; accessible metal containers with self-closing covers into which ashtrays can be emptied; residents who smoke will be further assessed to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all; any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in	F 689		

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F 689	Continued From page 17 designated smoking areas (weather permitting), at designated times, and in accordance with his/her care plan; smoking materials of residents requiring supervision with smoking will be maintained by nursing staff." The facility identified 10 residents who smoked (R17, R24, R48, R52, R55, R60, R65, R72, R159, and R160). All 10 residents smoked on the outdoor smoking patio. a. Review of R17's quarterly "Minimum Data Set (MDS)," located under the "MDS" tab in the electronic medical record (EMR) with an assessment reference date (ARD) of 08/11/23, revealed a "Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, indicating R17 was Ex.Order 26.4(b)(1) Review of R17's "smoking assessment," located under the "assessment" tab with an ARD of 06/14/23, revealed R17 required no supervision for smoking. b. Review of R24's quarterly "MDS," located under the "MDS" tab in the EMR with an ARD of 07/10/23, revealed a "BIMS" score of [redacted] out of 15, indicating R24 was *Ex Order 26. 4B1* [redacted]. Review of R24's "smoking assessment," located under the "assessment" tab with an ARD of 09/13/23, revealed R24 required no supervision for smoking. c. Review of R48's admission "MDS," located under the "MDS" tab in the EMR with an ARD of 09/21/23, revealed a "BIMS" score of [redacted] out of 15, indicating R48 was *Ex Order 26. 4B1*. Review of R48's "smoking assessment," located under the "assessment" tab with an ARD of 09/14/23, revealed R48 required no supervision for smoking.	F 689		

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F 689	Continued From page 18	F 689		

d. Review of R52's admission "MDS," located under the "MDS" tab in the EMR with an ARD of 09/08/23, revealed a "BIMS" score of [redacted] out of 15, indicating R52 was *Ex Order 26. 4B1*. Review of R52's "smoking assessment," located under the "assessment" tab with an ARD of 08/08/23, revealed R52 required no supervision for smoking.

e. Review of R55's quarterly "MDS," located under the "MDS" tab in the EMR with an ARD of 08/12/23, revealed a "BIMS" score of [redacted] out of 15, indicating R55 was *Ex Order 26. 4B1*. Review of R55's "smoking assessment," located under the "assessment" tab with an ARD of 09/13/23, revealed R55 required no supervision for smoking.

f. Review of R60's annual "MDS," located under the "MDS" tab in the EMR with an ARD of 08/17/23, revealed a "BIMS" score of [redacted] out of 15, indicating R60 was *Ex Order 26. 4B1*. Review of R60's "smoking assessment," located under the "assessment" tab with an ARD of 02/19/23, revealed R60 was a "safe smoker."

g. Review of R65's admission "MDS," located under the "MDS" tab in the EMR with an ARD of 08/10/23, revealed a "BIMS" score of [redacted] out of 15, indicating R65 was *Ex Order 26. 4B1*. Review of R65's "smoking assessment," located under the "assessment" tab with an ARD of 08/10/23, revealed R65 required no supervision for smoking.

h. Review of R72's admission "MDS," located under the "MDS" tab in the EMR with an ARD of 07/05/23, revealed a "BIMS" score of [redacted] out of

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F 689	Continued From page 19 15, indicating R72 was *Ex Order 26. 4B1*. Review of R72's "smoking assessment," located under the "assessment" tab with an ARD of 06/28/23, revealed R72 required no supervision for smoking. i. Review of R159's admission "MDS," located under the "MDS" tab in the EMR with an ARD of 09/25/23, revealed a "BIMS" score of [redacted] out of 15, indicating R159 was *Ex Order 26. 4B1*. Review of R159's "smoking assessment," located under the "assessment" tab with an ARD of 09/18/23, revealed R159 required no supervision for smoking. j. Review of R160's admission "MDS," located under the "MDS" tab in the EMR with an ARD of 09/18/23, revealed a "BIMS" score of [redacted] out of 15, indicating R160 was *Ex Order 26. 4B1* [redacted] Review of R160's "smoking assessment," located under the "assessment" tab with an ARD of 09/11/23, revealed R160 required no supervision for smoking. Observation on 09/28/23 at 1:10 PM, of the designated smoking area revealed the area was an outside covered patio which contained three self-extinguishing tower ashtrays; one open ashtray with a trash can, lined with a plastic trash bag, underneath; a smoking blanket; a fire extinguisher; and a large open trash can, lined with a plastic bag. Ten residents were waiting in a lounge for the staff member, assigned to monitor the smoking time. When the staff member, Licensed Practical Nurse (LPN)3, arrived, she said "no one goes out without a smoking apron on." When smoking, the 10 residents said they put their cigarette butts in the open ashtray, when it gets full, we dump it in the bottom trashcan."	F 689		

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F 689	Continued From page 20 The ashtray and trashcan were noted to be metal. Observation on 09/29/23 at 9:10 AM, of the designated smoking area revealed the open ashtray with cigarette butts inside and the plastic bag lined trashcan underneath. Nine residents were outside smoking. LPN3 and the residents were asked how they were able to get back into the building as there was no keypad on the inside of the door to get outside. R55 said "we're supposed to push the doorbell, but it's broken, you just have to knock really loud." On 09/29/23 at 10:47 AM, the surveyor, Administrator, Maintenance Director (MD), and Director of Housekeeping (DH) observed the open trashcan on the smoking patio. The DH lifted the plastic bag out of the trashcan. The bag contained approximately five inches of cigarette butts in the bottom. As the DH lifted the bag completely out of the trashcan, the bag ripped as it was burned/melted on the bottom. The DH said he would remove the trashcan and "they can use the other one," which was an actual trashcan with a plastic liner. The Administrator said he would "find a more permanent/safe solution." Observation on 09/29/23 at 6:20 PM revealed the open ashtray and trash can had been removed, however the large open trashcan with a plastic liner remained on the smoking patio. During an interview on 09/29/23 at 6:22 PM, LPN3 revealed she did not like that they could not open the door to get back into the building if needed "for a medical concern." NJAC 8:39-4.1(a)11 NJAC 8:39-27.1(a)	F 689		

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F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility contract review, the facility failed to provide timely transportation of residents to the [redacted] center for one of two (Residents (R)1) reviewed for [redacted] This had the potential to cause disruption of R1's treatment and pose a significant health risk. Findings include: Review of R1's "Face Sheet," provided by the facility, revealed R1 was admitted to the facility on [redacted] with diagnoses which included end stage [redacted] Review of R1's comprehensive "Care Plan" located in the resident's electronic medical record (EMR) under the "Care Plan" tab revealed a "Focus" initiated on 07/09/21 and revised on 07/12/23 that specified R1 needs [redacted] interventions included "Encourage R1 to go for the scheduled [redacted] appointments" and "pt may go to [redacted]." The "Care Plan" did not address transportation from the facility to the [redacted] center. Review of R1's quarterly "Minimum Data Set	F 698	F698 [redacted] The facility failed to provide timely transportation of resident to the [redacted] center. This had the potential to cause disruption of residents treatment and pose a significant health risk. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The transportation center was called and addressed about arriving late to the facility to transport resident to her appointment. [redacted] center gave reassurance that the same issue would not be repeated. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Other resident in the facility that are receiving [redacted] will be audited to ensure that they are transported to the [redacted] center on time, so that they do not miss any of their chair time. Address what measures will be put into place or systemic changes made to	11/6/23

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PROMEDICA SKILLED NURSING & REHAB (WASHINGTON TWP)	**378 FRIES MILL ROAD SEWELL, NJ 08080**

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F 698	Continued From page 22 (MDS)" with an Assessment Reference Date (ARD) of 05/19/23 in the EMR under the "MDS" tab revealed R1 was readmitted to the facility on Ex.Order 26.4(b)(1) and received Ex Order 26. 4B1. R1 had a "Brief Interview for Mental Status (BIMS)" score of Ex Orde out of 15 which indicated Ex Order 26. 4B1. Review of R1's "Physician Orders," located in the resident's EMR under the "Orders" tab, revealed a current order for the resident to receive Ex Order 26. 4B1 on Tuesday/Thursday/Saturday, pick up time 4:30 AM and chair time 5:30 AM. During an interview on 09/26/23 at 3:40 PM R1 stated that transportation had been late taking Ex Orde to the Ex Order 26. 4B1 center. Ex Order 2 stated this was the second week of being late. Ex Order 2 stated they are supposed to leave the facility at 4:30 AM to make it to the chair time at 5:30 AM. Today Ex Order 1 stated Ex Order didn't get to the Ex Order 26. 4B1 center until 6:10 AM. Subsequently Ex Order missed out on part of Ex.Order 3 During a phone interview on 09/30/23 at 1:18 PM the Unit Manager (UM on R1's unit) stated that "It [transport] is late, they continuously pick Ex Orde up late." The UM revealed she thought the Ex Order 26. 4B1 center filed a complaint against the transportation company. She further revealed R1 was supposed to be picked up at 4:30 AM because Ex Order 26. 4B1 time was 5:30 AM. The transportation company told the UM to fax over another form to change the time, she faxed it over and they still came at 5:50 AM. The UM revealed she tried to take care of this issue on her own and not bother nursing and administration with it. She stated that in the last few weeks they have been running late, and that they will shorten the treatment time, which she thought was about six to eight hours. The	F 698	ensure that the deficient practice will not recur: Education will be provided to the unit secretary and nurses to notify the DON and physician in the event of the transportation company arriving late to transport residents to their Ex Order 26. 4B1 appointments, so that the issue is addressed with the transportation company, and an alternative plan can be made. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting? The Director of nursing or designee will conduct the audits weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 month. Findings of the audits will be reviewed by the Quality Assurance Committee monthly x 3.	

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F 698	Continued From page 23	F 698		

transportation company sent a letter to the patient about this issue.

Review of R1's "Response Letter" from the transportation broker company, provided by the Assistant Director of Nursing (ADON) revealed that a complaint was filed by the resident on 09/19/23 indicating that the transportation provider was a "No Show." The investigation revealed that R1 had a 4:30 AM pickup for a 5:30 AM medical appointment. The member contacted the broker [name of broker] at 11:30 AM stating the provider [name of provider] was late causing the member's life sustaining treatment to be cut short. The provider would be advised that continual no shows may result in a reduction in trip volume.

During an additional interview on 09/30/23 at 1:34 PM, R1 stated that transportation was late again. [redacted] stated they told [redacted] there were issues with dispatch. [redacted] stated [redacted] time was 5:30 AM and [redacted] got there at 6:10 AM

During an interview on 09/30/23 at 1:39 PM the ADON stated that the transportation company was not dependable, they came late. She stated insurance paid for certain transport options. She revealed they confirmed the pickup time (name of company) and she had noticed a couple times that you had to call. She stated she did not think they would have stopped the [redacted] early. The ADON stated the [redacted] center hasn't called to report that. She stated she'd like to hope that they had enough chairs.

During an interview on 09/30/23 at 3:23 PM the Director of Nursing (DON) stated "It was just brought to my attention that the transportation to

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F 698	Continued From page 24 Ex Order 26. 4B1 was running late. The Administrator and I will reach out to the Ex.Order 26.4(b)(1) company, and we will have a conversation." The DON stated she was not sure how arriving late or not at all would impact R1's treatment, but she thought they might perform the Ex Order 26. 4B1 the next day. She stated that the Ex Order 26. 4B1 transport arriving late was a concern for her. During an interview on 09/30/23 at 4:59 PM the Administrator stated that they had some issues with the current transport provider and corporate was trying to provide some services to our area. "This is a dead zone for ambulance providers." He stated he became aware of the official complaint today. He stated that the Ex Order 26. 4B1 center had a responsibility to Ex Order 26. 4B1, not aware of R1 missing any Ex Order 26. 4B1 times. Review of the facility's dialysis contract titled, "Long Term Care Facility Outpatient Dialysis Services Coordination Agreement," dated 10/05/18, revealed in pertinent part, "The Long Term Care Facility shall be responsible for arranging for suitable and timely transportation of the Ex.Order 26.4(b) Residents to and from the Ex.Order 26.4(b) Ex Order 26. 4B1 Unit, including the selection of the mode of transportation, qualified personnel to accompany the Ex.Order 26.4(b) Residents." NJAC 8:39-2.9(c)1	F 698		
F 803 SS=F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of	F 803		11/6/23

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F 803	Continued From page 25 residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure that menus were being followed, that the menus reflected input received from residents and resident council, and were reviewed by the facility's dietitian for nutritional adequacy for 107 out of 107 residents residing in the facility who receive meals from the kitchen. Specifically, menu items were substituted without notifying the residents, incorrect serving utensils were being utilized on the tray line leading to smaller portion sizes being served, standardized recipes were not being utilized, and current menus had not been reviewed by the dietitian. This had the potential to lead to nutrient deficiencies for all 107	F 803	F803 F Menus Meet Res Needs/Prep in Advance/Followed Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The center is ensuring that: " menus are being followed; " menus reflect input received from residents and resident council; " the procedure for menu substitution is being followed;	

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F 803	Continued From page 26 residents. Findings include: 1. Review of the "Resident Council Meeting minutes" revealed the following comments from anonymous residents: On 04/27/23 residents stated they were not receiving soda although they were putting it on their tickets. Residents stated the eggs did not taste like eggs and the pork was not cooked consistently. One resident was concerned about portion size. Suggested having a way to have coffee on units that was available most of the day. A resident stated that the tuna the other night did not taste like tuna and would like soda back. Other residents agreed. A resident stated that the omelet was cold and hard, and she stated there was too much inconsistency. A resident stated that some residents did not receive coffee at breakfast or lunch. Multiple residents mentioned that they have not consistently been receiving evening snacks. On 08/24/23 "Food Service Committee moved to Tues, Aug 29th, 2023, at 10am."The residents stated that this morning and yesterday's milk was sour. The following comments were noted: pancakes were hard, they would like liquid creamer for coffee (not powder) and Lactaid (not milk), sometimes trays are missing utensils, some would like double portions, one day last week they ran out of white and wheat bread. 2. Review of the weekly menu date 09/26/23 revealed the lunch meal for regular diet residents was scheduled to be meatloaf with beef brown gravy, scalloped potatoes, seasoned beets, and	F 803	" the correct serving utensils, are being used; " proper portion sizes are being served; " standardized recipes are being used; and " the dietitian is reviewing current menus to ensure nutritional adequacy. " The kitchen is supplying bedtime snacks Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents were identified as having the potential to be affected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Dietary Manager, dietary staff, and dietitian were educated on following menus, that menus should reflect input received from residents and resident council, the procedure for menu substitution, correct serving utensils, proper portion sizes, using standardized recipes, ensuring bedtime snacks are available, and the procedure for the dietitian□s review of current menus to ensure nutritional adequacy. The Administrator or designee will complete the following audits: " menus being followed; " menus reflect input received from residents and resident council;	

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F 803	Continued From page 27 chilled peaches. Observations of the residents' trays revealed that the kitchen did not serve meatloaf or scalloped potatoes, but rather it appeared to be a Salisbury steak and mashed potatoes. Additionally, beets were not seen on the residents' trays. 3. During an interview with a resident group meeting on 09/28/23 at 10:30 AM residents commented that the kitchen did not follow what was on the menu, or what was chosen by the residents. They stated that the "food is terrible," "they don't receive what they request" and last week they received spoiled milk. A food committee was scheduled to meet that afternoon. (But was subsequently canceled) During an interview on 09/28/23 at 10:57 AM the Registered Dietitian (RD) stated she was not surprised about the food complaints. "We have several residents and patients that complain about cold food and not getting what they order." She stated that she has tried the food and it depended on who was cooking, and that the kitchen should have been following the recipes. She stated sometimes the food was bland and other days it tasted good. "Breakfast is always challenging as far as temperature." She also stated that at some point she noticed that evening snacks were not coming up. The RD stated all residents should have been offered a snack, but there had been changes over time. She thought the kitchen didn't want to send the snacks, "they just didn't want to do it." She stated she tried to put (nighttime) HS snack orders in for residents on insulin and it would have been placed under nourishment in the electronic medical record (EMR), but there was no guarantee that they would have received it. The RD stated that right	F 803	" procedure for menu substitution is being followed; " correct serving utensils are being used; " proper portion sizes are being served; " standardized recipes are being used; " dietitian reviewing current menus to ensure nutritional adequacy; and " kitchen is supplying bedtime snacks. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting The Administrator or designee will conduct the audits weekly x 4 weeks, then bi-weekly x 4 weeks, and then monthly x 1 month. Findings of the audits will be reviewed by the Quality Assurance Committee monthly x 3.	

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F 803	Continued From page 28 before the current Dietary Manager (DM) started, she received a lot of complaints about portion sizes. She stated the morning cook was helping fill in with the ordering etc. She stated she thought the kitchen was giving smaller portions, but she was not sure why. She stated the staff may have been using the wrong utensils. During an interview on 09/28/23 at 11:49 AM the DM was asked about the recipes used on the menus and why the meatloaf didn't look like meatloaf. The DM stated that they just "google the recipes." When asked about where the menus were derived from, he stated he thought they only had corporate menus. The DM stated that lunch for Tuesday was indeed a Salisbury steak as opposed to meatloaf which was on the menu. He said they used pre-portioned meat. 4. During an observation and interview during tray line on 09/28/23 at 12:05 PM the DM was asked about portion sizes on the tray line. He observed that the rice had a yellow scoop in it. The DM stated that this scoop was approximately 1.75 ounces. Though the rice was not on the menu, the standard serving for starches were four ounces. The cook stated "I have been giving double scoops" though this was not directly observed previously. During an interview on 09/29/2023 at 2:55 PM the Registered Dietitian (RD) she was asked if there was a nutrition analysis of the current menu. The RD stated, "That's a good question." She stated that she had modified the previous menu (under the previous owners) but that the input that she provided to Atlas did not go on that. They ended up using a menu from the food service provider.	F 803		

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F 803	Continued From page 29 During an interview on 09/29/23 at 3:00 PM the DM stated he swapped out the lunch meal of meatloaf on Tuesday and replaced it with the Salisbury steak because the ground beef wasn't thawed in time. He also stated he substituted the cranberry juice, which they had run out of on Wednesday night and gave the residents a fruit punch instead. He was not sure why they ran out of juice. The DM stated he was out of lactose free milk, which was why residents were not getting it. He said he did not know the correct number of lactose free milks to order and thus sometimes it could have been short. During an interview on 09/30/23 at 9:14 AM the RD stated she had spent time working on the menu, analyzing (nutritionally) and she took the tomato sauce off the renal diet. She stated she did not want to sign off on the new menus because the people doing the menus were not dietitians. When asked if she had a diet manual, she stated "I'm not aware that I have a diet manual" but she would follow up. No diet manual was provided. The RD reviewed the nutrition analysis provided by the vendor, specifically a diabetic renal diet. She stated that it may not have been enough protein if they were on dialysis and that she might have needed to increase the protein if that was the case. The RD went on to state that the sodium was a little high on the diabetic renal diet. The RD stated that if the kitchen substituted a menu item, the resident should have been notified of the substitution. She stated it did not seem like a good system. She stated they got the menu and wrote their meals on it and then they received a tray ticket that did not have the meal on it. During an interview on 09/30/23 at 3:59 PM the	F 803		

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DM stated that if allergy info was passed on to him, he took it and gave it to a diet aide to put it in the system. He stated most likely he'd have to do an education with the staff regarding allergies if they were not catching the items with eggs in it. He stated he had been working with the staff on portions. The DM stated he hasn't heard anything about food being overcooked. He thought since he had been here satisfaction among the residents had increased. He stated since he had been at the facility, he did not recall anything else being out of stock, but he tried to let the residents know what was wrong. He stated this was the first time he heard that residents filled out food items and then did not receive the food items. He stated that yesterday the trays were late because the baked potatoes were not done. He acknowledged dietary did not have broth available when residents were coming back from dialysis.

During an interview on 09/30/23 at 4:54 PM the Administrator stated he terminated the old foodservice director in response to the residents making the same complaints over and over and they weren't getting addressed by dietary. He stated he was happy with the progress the new DM had made so far. He stated they handled it as a team, IDT (Interdisciplinary).

Review of the facility's policy titled "Food Preparation Guidelines," dated 03/23, "Policy Explanation and Compliance Guidelines: 1. The cook, or designee, shall prepare menu items following the facility's written menus and standardized recipes ...5. Staff shall accommodate resident allergies, intolerances, and preferences, providing appropriate alternatives when needed. a. Alternatives shall be appealing and of similar nutritive value to the food

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F 803	Continued From page 31 that is being substituted. b. Alternatives shall be consistent with the usual and/or ordinary food items provided by the facility. 6. Staff shall offer residents appropriate alternatives when they choose not to consume food/drink that is initially served or when a different food/drink choice is requested ...d. Other liquids, such as broth, popsicles, or ice cream will be offered as needed to encourage fluid intake ...8. Nursing staff shall communicate diet orders and changes in diet orders to the Food and Nutrition Services Department through the designated in-house communication form. 9. Resident preferences and allergies shall be obtained during the resident assessment process and added to the resident's dietary tray card." NJAC 8:39-17.1(b) NJAC 8:39-17.2(b)(d)	F 803		
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure palatable food was served to 11 (Resident (R) 96, R160, R95, R77, R10, R51, R54, R90, R60, R1 and R53) of 107 total residents.	F 804	F804 Nutritive Value/Appear, Palatable/Prefer Temp Address how corrective action will be accomplished for those residents found to have been affected by the deficient	11/6/23

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F 804	Continued From page 32 Specifically, the food did not look appetizing, lacked flavor and was not at an appropriate temperature. Failure to provide palatable food to residents has the potential to affect nutritional status and quality of life. Findings include: 1. During an interview on 09/26/23 at 10:14 AM R96 stated he "doesn't like the food and that some staff refuse to microwave his food or get him hot water for his noodles." Review of R96's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/27/23 in the electronic Medical Record (EMR) under the "MDS" tab revealed R96 was admitted to the facility on Ex Order 26. 4B1. The "MDS" indicated R96 had a "Brief Interview for Mental Status (BIMS)" score of Ex Order out of 15, indicating the resident was Ex Order 26. 4B1. 2. During an interview on 09/26/23 at 10:27 AM R160 stated that Ex Order has only been eating peanut butter and jelly sandwiches because the food was horrible, and Ex Order needed to gain Ex Order 26. 4B1. Ex Order stated Ex Order 26. been requesting whole milk, but instead received Ex Order 26. 4B1, even though Ex Order was not Ex Order 26. 4B1. R160 stated Ex Order took pictures of Ex Order meals because Ex Order did not even know what they were. Review of R160's entry "MDS" with an ARD of Ex Order 26. 4B1 in the EMR under the "MDS" tab revealed R160 was admitted to the facility on Ex Order 26. 4B1. The BIMS score was left blank. 3. During an interview on 09/26/23 at 12:05 PM R95 stated Ex Order 26. 4B1	F 804	practice: The Food Service Director met with residents 96, 160, 95, 77, 10, 51, 54, 90, 60, 1, and 53 to obtain preferences, likes, dislikes, and concerns. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents or their responsible parties will be interviewed to ensure likes/dislikes/preferences and feedback on current meals and snacks has been obtained and care planned if appropriate. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Food service Director, dietary staff, and dietician were educated by the Administrator on palatable food, food appearing appetizing, food having flavor, appropriate food temperatures, and obtaining and honoring resident likes/dislikes/preferences. The Administrator/ FSD or designee will complete a food satisfaction survey on palatability, food appearing appetizing, food having flavor, food temperatures, likes, dislikes, and preferences. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting? The Administrator or designee will conduct the audits weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 month. Findings of the audits will be reviewed by the Quality Assurance Committee monthly x3.	

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Review of R95's admission "MDS" with an ARD of Ex Order 26. 4B1 in the EMR under the "MDS" tab revealed R95 was admitted to the facility on Ex Order 26. 4B1. R95 had a BIMS score of Ex Ord out of 15 which indicated Ex Order 26. 4B1.

4. During an interview on 01/23/23 at 10:29 R77 stated Ex Order 26. 4B1 Ex Ord is not supposed to get sweets, but Ex Ord will eat them if they send them, Ex Order 26. 4B1 there's a little improvement then it [the food] Ex Order 26. 4B1 eggs are always cold, Ex Ord ends up buying own food. Ex Ord has gotten sour milk. There are no snacks in the evening and no individual Jello cups. There's only orange juice at breakfast and Ex Ord has to buy Ex Ord own fresh fruit,

Review of R77's admission "MDS" with an ARD of Ex Order 26. 4B1 in the EMR under the "MDS" tab revealed R77 was admitted to the facility on Ex Order 26. 4B1. R77 had a BIMS score of Ex Ord out of 15 which indicated Ex Order 26. 4B1.

5. During an interview on 09/26/23 at 12:31 PM R10 stated Ex Order 26. 4B1 Ex Order 2 stated Ex Order would like a piece of bread.

Review of R10's admission "MDS" with an ARD of Ex Order 26. 4B1 in the EMR under the "MDS" tab revealed R10 was admitted to the facility on Ex Order 26. 4B1. R10 a BIMS score of Ex Ord out of 15 which indicated Ex Order 26. 4B1.

6. During an interview on 09/26/23 at 12:07 PM, R51 stated, Ex Order 26. 4B1

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F 804	Continued From page 34 Ex Order 2 stated Ex Order used to get soup, salad, dessert, beverages, and bread. Ex Order 2 stated Ex Order no longer received salad or bread and the portions were very small. R51 stated Ex Order frequently ordered Ex Order own food. Ex Order 2 stated Ex Order had Ex Order own cereal and peanut butter. Review of R51's annual "MDS" with an ARD of Ex Order 26. 4B1 in the EMR under the "MDS" tab revealed R51 was admitted to the facility on Ex Order 26. 4B1. R51 had a BIMS score of Ex Ord out of 15 which indicated Ex Order 26. 4B1. 7. During an interview on 09/26/23 at 12:45 PM, R54 stated Ex Order 26. 4B1 Ex Ord Ex Order 26. 4B1 Review of R54's quarterly "MDS" with an ARD of Ex Order 26. 4B1 in the EMR under the "MDS" tab revealed R54 was admitted to the facility on Ex Order 26. 4B1. R54 had a BIMS score of Ex Ord out of 15 which indicated Ex Order 26. 4B1. 8. During an observation and interview on 09/27/23 at 12:04 PM R90 was observed with two stuffed shells and nothing else on Ex Order plate. Ex Order 2 stated the shells were cold (the tray had just arrived) Ex Order added that the staff have told Ex Order that they can't heat the food up on the unit because there's no microwave. Ex Order 2 stated that Ex Order 26. 4B1 During an observation and interview on 9/28/23 at 8:05 AM R90 was observed with an eight-ounce fat free milk instead of a Ex Order 26. 4B1 milk. Ex Order 2 stated Ex Order won't use it because Ex Order was Ex Order 26. 4B1 . Ex Order tray ticket indicated Ex Order should have received Ex Order 26. 4B1 milk. A Ex Order 2 liquid was	F 804		

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F 804	Continued From page 35	F 804		

observed in a four-ounce plastic container which R90 stated *Ex Order 26. 4B1* [redacted] added that they received it last night at dinner as well. On 09/28/23 at 8:18 AM Licensed Practical Nurse (LPN) 1 verified that the milk was fat free, not *Ex Order 26. 4B1* milk. [redacted] stated that [redacted] knows that the *Ex Order 26. 4B1* milk comes in a green container.

9. During an interview on 09/26/23 at 12:48 PM, R60 stated *Ex Order 26. 4B1* [redacted] stated [redacted] thought it was precooked but when [redacted] first looked at the menu, it didn't look too bad. [redacted] stated [redacted] did not like there was hot food at both lunch and dinner. [redacted] stated [redacted] did not want to have two bad dinners in the same day. R60 stated they did have food meetings and it [the food] improved but there was still room for improvement. [redacted] received a cut up Salisbury steak and mashed potatoes for lunch."

Review of R60's annual "MDS" with an ARD of *Ex Order 26. 4B1* in the EMR under the "MDS" tab revealed R60 was admitted to the facility on *Ex Order 26. 4B1*. R60 had a BIMS score of [redacted] out of 15 which indicated *Ex Order 26. 4B1*.

10. During an interview on 09/26/23 at 03:44 PM, R1 stated that *Ex Order 26. 4B1* [redacted] stated [redacted] also could not get broth when [redacted] came back from *Ex Order 26. 4B1*." On 09/27/23 at 11:33 AM R1 stated [redacted] received an egg on a hamburger roll for breakfast and that she would have just liked real eggs and bacon.

Review of R1's quarterly "MDS" with an ARD of *Ex Order 26. 4B1* in the EMR under the "MDS" tab revealed R1 was admitted to the facility on

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F 804	Continued From page 36 Ex Order 26. 4B1. R1 had a BIMS score of Ex Ord out of 15 which indicated Ex Order 26. 4B1. During an observation and interview on 09/27/23 at 12:01 PM R1 was observed with two "baked chicken legs" (the standard portion on the menu) and nothing else on Ex Order plate. Review of Ex Order tray ticket indicated that R1 is on a Ex Order 26. 4B1 diet and should have received "double meat." Ex Order 2 did not receive starch on Ex Order plate whatsoever or a dessert which was indicated as sherbet on the menu. R1 stated Ex Order 26 11. During an interview on 09/27/23 at 12:48 PM R53 stated that the lunch was cold. Review of R53's quarterly "MDS" with an ARD of Ex Order 26. 4B1 in the EMR under the "MDS" tab revealed R53 was admitted to the facility on Ex Order 26. 4B1. R53 had a BIMS score of Ex Ord out of 15 which indicated Ex Order 26. 4B1. During an observation and interview on 9/28/23 at 8:20 AM R53 was observed with only a fruit punch and a yogurt on Ex Order breakfast tray. Ex Order 2 stated this was the only thing Ex Order liked to eat here. Review of the "Food Committee Minutes" from the meeting on 08/29/23 at 10:00 AM and provided by the Registered Dietitian (RD) on 09/30/23 revealed the following comments from residents: Everyone agreed that breakfast foods (like pancakes and eggs) were cold. -R51 said Ex Order 26 and Ex Order 26. 4B1 -R257 said Ex Order 26. 4B1	F 804		

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F 804	Continued From page 37 Ex Order 26. 4B1 -R 23 said Ex Order wanted regular sugar packets, and more salt and pepper packets. -R58 said Ex Order did not want gravy on the entrée but wanted it on the potatoes. -R81 said Ex Ord wanted bacon and sausage at breakfast. -R1 said Ex Order 26. 4B1 During an interview on 09/27/23 at 12:11 PM the Assistant Director of Nursing (ADON) stated that they could take the food to the kitchen to heat it up if a resident wanted, but that they did not have a microwave on the unit. During an interview on 09/28/23 at 10:57 AM the RD stated that she was not surprised about the food complaints. "We have several residents and patients that complain about cold food and not getting what they order." She stated that she had tried the food and it depended on who was cooking. She stated sometimes the food was bland and other days it tasted good. "Breakfast is always challenging as far as temperature." She stated she thought the kitchen was giving smaller potions. She stated she was not sure why; the staff may have been using the wrong utensils. During an interview on 09/28/23 at 12:01 PM, the DM stated that he was actively checking into what happened with the spoiled milk. He was not sure if it came from the manufacturer spoiled or if there was some other reason.. On 09/28/23 at 12:29 PM, a regular test tray was obtained from the kitchen. The DM took the following temperatures of the test tray food items after they delivered to the northside unit: roast beef - 145.6 degrees Fahrenheit (F), carrots - 146 degrees F, mashed potatoes 177 degrees F. The DM brought the tray to the conference room. The	F 804		

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survey team then tasted the test tray. The roast beef tasted within acceptable palatability standards; however, the mashed potatoes and seasoned carrots were found to be bland, the potatoes had a gummy texture, and the carrots had a mushy texture.

During an interview on 09/28/23 at 12:51 PM Registered Nurse (RN)1 stated that residents frequently complained about receiving cold or overcooked food.

During an interview on 09/29/23 at 3:00 PM the DM stated that he swapped out the lunch meal of meatloaf on Tuesday and replaced it with the Salisbury steak because the ground beef wasn't thawed in time. He also stated he substituted the cranberry juice, which they had run out of on Wednesday night and gave the residents a fruit punch instead. He stated he was out of Ex Order 26. 4B1 [redacted] milk and that was why residents were not getting it. The milk delivery came in yesterday [Thursday]. He stated he did not know the correct number of Ex Order 26. 4B1 milks to order and thus sometimes it could have been short. He stated he had been doing an ongoing education with the staff and felt the meal service had improved over the past five to six weeks.

During an interview on 09/30/23 at 3:59 PM the DM stated if he received information on a resident's allergy he communicates it to a dietary aide. He stated he had been working with the staff on portions. He stated he hasn't heard anything about food being overcooked. He stated he thought since he had been here satisfaction among the residents had increased. The DM stated this was the first time he heard that residents were filling out food items and then not

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F 804	Continued From page 39 getting them. He stated the trays were late because the baked potatoes were not done. He confirmed they did not have broth available when residents were coming back from Dialysis. During an interview on 09/30/23 at 4:54 PM the Administrator stated he terminated the old foodservice director in response to the residents making the same complaints over and over and they weren't getting addressed by dietary. He stated he was happy with the progress the new DM had made so far. Review of the facility's policy titled "Food Preparation Guidelines, "dated 03/23, "Food and drinks shall be palatable, attractive, and at a safe and appetizing temperature. Strategies to ensure resident satisfaction include: a. Providing meals that are varied in color and texture. b. Using spices or herbs to season food in accordance with recipes. c. Serving hot foods/drinks hot and cold foods/drinks cold. d. Addressing resident complaints about foods/drinks. e. Honoring resident preferences, as possible, regarding foods and drinks." NJAC 8:39-17.4(a)2	F 804		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat	F 806		11/6/23

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F 806	Continued From page 40 food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to follow the prescribed diet and honor preferences, food allergies, and intolerances for three (Residents (R)1, R90, and R161) of 10 residents sampled for food preferences, out of 28 sample residents. This had the potential for the residents having negative health consequences. Findings include: 1. Review of R1's "Face Sheet," found in the electronic medical record (EMR) under the "Admission Record" tab, revealed R1 was originally admitted to the facility on Ex Order 26. 4B1 with the following diagnoses: Ex Order 26. 4B1 [redacted]. Review of R1's "Nutrition Care Plan," dated 11/16/20, located in the EMR under the "Care Plan" tab, indicated R1 Ex Order 26. 4B1 [redacted]. Refuse Ex Order [redacted] Interventions included: Honor food preferences; likes Greek yogurt, Provide Ex Order 2[redacted] diet as ordered." Review of the annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of Ex Order 26. 4B1 in the EMR under the "MDS" tab revealed R1 was admitted to the facility on Ex Order 26. 4B1. R1 had a Brief Interview for Mental Status (BIMS) score of Ex Ord[redacted] out of 15 which indicated Ex Order 26. 4B1. Ex Order [redacted] preferences for	F 806	F806 Resident Allergies, Preferences and Substitutes Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident 1 provided meal per request, double meat, protein, broth after Ex Order 26. 4B1 and preferences updated. Resident 90 was provided Ex Order 26. 4B1 milk, and cranberry juice and preferences updated. Resident 161 will not receive eggs or egg related products. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents□ diets/ preferences/ allergies to be reviewed and updated by the dietician. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Food Service Director, dietary staff, and dietitian were educated on following prescribed diets, honor preferences, following food allergies and intolerances, and reviewing the tray line and tray ticket process including reading the diet cards and choice menus. The Administrator/ FSD or designee will complete a food satisfaction survey on palatability, food appearing appetizing,	

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F 806	Continued From page 41 customary routines revealed that it was very important for the residents to have snacks available between meals. Review of R1's "Physician Orders" dated 09/22/23, located in the EMR under the "Physician Orders" tab revealed that the resident was on a '*Ex Order 26. 4B1* Diet, *Ex Order 26. 4B1* liquids. Extra gravy on all proteins for diet." During an interview on 09/26/23 at 3:44 PM R1 stated that [redacted] meals were not tasty, and [redacted] received small portions (even though [redacted] should get double portions of meat) [redacted] also stated [redacted] did not always feel like eating when [redacted] got back from [redacted], and [redacted] just wanted to get some broth and [redacted] could not get broth. During an observation on 09/27/23 at 12:01 PM R1 was observed with two "baked chicken legs" (the standard portion on the menu) and nothing else on [redacted] plate. Review of [redacted] tray ticket indicated that R1 was on a *Ex Order 26. 4B1* [redacted] diet and should have received "double meat." [redacted] did not receive starch on [redacted] plate or a dessert which was indicated as sherbet on the menu. R1 stated "this happens all the time." During an observation and interview on 09/29/23 at 6:26 PM R1 was observed receiving [redacted] dinner tray. The Registered Dietitian (RD) and Certified Nursing Assistant (CNA) 4 were also in the room. The resident received one slice of roast turkey breast, a small portion of vegetables and no starch on [redacted] plate. The RD stated that R1 should have received double portions of meat on the tray. The resident asked for potatoes and the RD	F 806	food having flavor, food temperatures, likes, dislikes, and preferences. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting The Administrator or designee will conduct the audits weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 month. Findings of the audits will be reviewed by the Quality Assurance Committee monthly x 3.	

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stated [redacted] would go get some for [redacted], and that [redacted] would liberalize [redacted] diet going forward since [redacted] potassium levels have been within normal limits at [redacted].

During an interview on 09/28/23 at 11:00 AM the RD stated that she knew R1 had issues with the food, *Ex Order 26. 4B1* [redacted] numbers were good, [redacted] were good. [redacted] was supposed to get double meat, *Ex Order 26. 4B1* [redacted]. The RD stated right before the Dietary Manager (DM) started working, the RD received a lot of complaints about portion sizes. The morning cook, was helping fill in with the ordering etc. She stated she thought they were giving smaller potions, not sure why, they may have been using the wrong utensils. She stated R1 did not like the liquid protein, [redacted] did not like the [redacted], and [redacted] did not like *Ex Order 26. 4B1*. The RD stated [redacted] did get a protein bar when [redacted] was at [redacted] *Ex Order 26. 4B1*.

2. Review of R90's "Face Sheet," located in the EMR under the "Admission Record" tab, revealed R90 was admitted to the facility on [redacted].

Review of R90's current "Nutrition Care Plan," located in the EMR under the "Care Plan" tab, indicated R90 had [redacted] in nutritional status r/t [related to] *Ex Order 26. 4B1* [redacted] with [redacted]. Interventions included: "Honor food preferences, offer routine snacks prn [as needed/requested], provide [redacted] and [redacted] for [redacted] healing, RD [Registered Dietitian] to evaluate and make diet change recommendations PRN."

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F 806	Continued From page 43 Review of the admission "MDS" with an ARD of Ex Order 26. 4B1 in the EMR under the "MDS" tab revealed R90 was admitted to the facility on Ex Order 26. 4B1. R90 had a BIMS score of Ex Order 26. 4B out of 15 which indicated Ex Order 26. 4B1. Ex Order preferences for customary routines were left blank. Review of R90's "Physician Orders" located in the EMR under the "Physician Orders" tab revealed that the resident was on a 'Ex Order 26. 4B1 dated 09/22/23. During an observation on 9/28/23 at 8:05 AM R90 was observed with an eight-ounce Ex Order 26. 4B1 milk and a four-ounce plastic container of a Ex Order 26. 4B1 on Ex Order breakfast tray. Ex Order 2 stated Ex Order won't use the milk because Ex Order is Ex Order 26. 4B1. Ex Order tray ticket indicated Ex Order should have received Ex Order 26. 4B1 milk and a 4-ounce cranberry juice. R90 stated the Ex Order 26. 4B1 Ex Order 26. 4B1 Ex Order added that they received it last night at dinner as well. On 09/28/23 at 8:18 AM Licensed Practical Nurse (LPN) 1 verified that the milk was Ex Order 26. 4B1, not Ex Order 26. 4B1 milk. Ex Order 2 stated that Ex Order knows that the Ex Order 26. 4B1 milk comes in a green container. During an interview on 09/28/23 at 11:49 AM the DM stated that this morning they ran out of cranberry juice (or that maybe they ran out last night once informed that a resident said they had gotten the fruit punch last night) and he used fruit punch instead. He stated that there was a resident who was no longer here who was getting multiple cranberry juices and that maybe that was why he ran out. He stated he also didn't order enough juice for the week.	F 806		

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	315506	A. BUILDING _____ B. WING _____	C 09/30/2023

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F 806	Continued From page 44 During an interview on 09/29/23 at 3:00 PM the DM stated he was out of Ex Order 26. 4B1 milk, and that was why residents were not getting it. He stated the milk delivery came in yesterday [Thursday], he did not know the correct number of Ex Order 26. 4B1 milks to order and thus sometimes it could have been short. The DM stated he had been showing his staff how to do the proper kitchen techniques and educating them on checking the tray ticket to make sure residents were getting what they should get. He added that he had not followed up with R1 about Ex Order broth, but that he did not have broth available if it was after 2:00 PM. During an interview on 09/30/23 at 9:14 AM and after the RD reviewed the nutrition analysis provided by the vendor, specifically a Ex Order 26. 4B1 diet. She stated that it may not be enough protein if residents were on Ex Order 26. 4B1 and that she might need to increase the protein if that was the case. "There's a disconnect between the menu, dietary manager (software) and the tray line." The RD went on to state that the sodium was a little high on the Ex Order 26. 4B1 diet. She stated if R1 had received the proper portions it would have been sufficient. The RD stated if they substituted something the residents should have been notified that it was a substitution. She stated it did not seem like a good system. She stated the residents got the menu, they wrote the meals they want on it, and they only received a tray ticket which did not have the meal on it. 3. Review of R161's "Census" located in the EMR under the "Clinical" tab, revealed an admission date of Ex Order 26. 4B1. Review of the "Dietary Assessment," located	F 806		

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F 806	Continued From page 45	F 806		

under the "Assessments" tab, dated 09/15/23, revealed the resident had an [redacted].

Review of R161's admission MDS" located in the EMR under the "MDS" tab with an ARD of [redacted], revealed a BIMS score of [redacted] out of 15, indicating R161 was [redacted].

During an interview on 09/26/23 at 1:00 PM, R161 stated [redacted] when asked about the facility meals. R161 stated [redacted]

During an interview on 09/27/23 at 4:04 PM, a family member (F)2 was interviewed while visiting R161. F2 said [redacted]

Observation of the breakfast room tray, on 09/28/23 at 8:08 AM, revealed R161 was served two donuts and a small juice. The DM was assisting with room tray deliveries and delivered R161's breakfast to [redacted]. The surveyor reviewed the diet card, with the DM, prior to delivery. The diet card noted [redacted] When asked, the DM said, "[redacted] ordered Danishes," and delivered the tray to R161. R161 told the DM [redacted] ordered "toast with jelly" which was provided.

During an interview on 09/28/23 at 4:38 PM, with R161, F1, F2, and F3, F3 said, [redacted] R161 said, [redacted]

During an interview on 09/30/23 at 12:06 PM, the

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F 806	Continued From page 46 RD stated she had changed the resident's diet card to include all baked goods along with the identified Ex Order 26. 4B1, met with the resident and family members, and updated the "Care Plan" on 09/29/23. When asked what Ex Order expectation was for the 15-day delay in identifying a harmful Ex Order 26 for R161, the RD said they needed to do better. During an interview on 09/30/23 at 4:02 PM, the DM denied knowledge of R161's Ex Order 26. 4B1 despite it being written on the diet card which was on the tray he delivered to the resident on 09/27/23. The DM said, "I don't receive the diet cards or choice menus, so I would not see the notations written by R161's family." The DM said he was not notified by his staff of the allergy. Review of the facility's policy titled "Food Preparation Guidelines" dated 03/2023, read in pertinent part, "Strategies to ensure resident satisfaction include: a. Providing meals that are varied in color and texture. b. Using spices or herbs to season food in accordance with recipes. c. Serving hot foods/drinks hot and cold foods/drinks cold. d. Addressing resident complaints about foods/drinks. e. Honoring resident preferences, as possible, regarding foods and drinks. Staff shall accommodate resident allergies, intolerances, and preferences, providing appropriate alternatives when needed. 6. Staff shall offer residents appropriate alternatives when they choose not to consume food/drink that is initially served or when a different food/drink choice is requested." NJAC 8:39-17.4(a)1,2(e)	F 806		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		11/6/23

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F 812	Continued From page 47 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 facility policy review, the facility failed to ensure cold and dry storage food items were labeled properly and not expired and did not contain stagnant rainwater. This had the potential to affect 107 of 107 residents who received food from the kitchen. Findings include: 1. The initial kitchen inspection was conducted on 09/26/23 from 9:41 AM through 10:19 AM with the Dietary Manager (DM). The following concerns were noted: a. In the walk-in refrigerator an unlabeled jug of	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The marinara sauce was dated. The egg salad was labeled. The Tuna salad was labeled. A discard date was added to the BBQ sauce. The peaches where labeled. An use by date was added to liquid eggs. The lasagna was covered labeled and dated. The Peanut butter was labeled and dated. A discard date was added to the	

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F 812	Continued From page 48 red liquid was dated 09/23. The DM stated that this was marinara sauce and that the date was the "open" date. He stated that different foods had different use-by dates. A large unlabeled plastic container dated 09/25 with a use by date of 10/02 was observed. The DM stated that this food item was egg salad. A large unlabeled plastic container had an open date of 09/26 and a use by date of 09/30. The DM stated that the food item was tuna salad. A gallon container of barbeque sauce had an opened date of 09/24/23 and no discard date. A two-gallon container of an unlabeled food item had an open date of 09/18 and a use by date of 09/28. The DM stated that the food item was peaches. A 32-ounce carton of liquid eggs carton had an open date of 09/26 and no use by date. b. In the walk-in freezer an unlabeled, undated sheet pan with non-freezer safe loose aluminum foil cover containing an unknown food item was observed. The DM stated that the food item was lasagna and that someone must not have covered the lasagna correctly. c. In the dry storage area two boxes dated 09/16/23 containing brownish/black bananas were observed with fruit flies flying around them. When asked if the bananas were past their use by date, the DM stated that he had to check with the cook to see if she wanted to make banana bread. The DM was unclear about pest control in terms of the kitchen. He stated that there were some gnats in the storage room. A four-pound opened container of peanut butter was observed with no opened date and no discard date. A 45-pound container of canola oil dated 08/24/23, no discard date observed. An opened package of breadcrumbs was observed with an opened date	F 812	canola oil. A Discard date was added to breadcrumbs. The Roof leak was repaired, and the trash can was removed. The Bananas were removed. The Items in the nourishment refrigerator were discarded. Residents 50, 30, 77, 41 were made aware. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: A Facility audit for dates, labels, and resident names was conducted. No other residents were affected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The FSD, Dietary Staff, dietitian, and nursing staff were educated on the Use and storage of food brought in by family and visitors policy, and the labeling and storage of food in the kitchen policy. The Administrator/ FSD or designee will complete audits related to labeling and dating items in the refrigerators. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting? The Administrator or designee will conduct the audits weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 month. Findings of the audits will be reviewed by the Quality Assurance Committee monthly x3.	

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F 812	Continued From page 49	F 812		

of 05/26/23 and no discard date,

d. In the right-side corner of the dry storage area an open plastic trash bin was observed. The bin contained about five inches of stagnant rainwater that had leaked into the dry storage area from the roof. The DM stated that maintenance had set up a garbage to catch the rainwater over the weekend and it was here when he had arrived.

2. During a kitchen observation on 09/28/23 at 11:49 AM inn the dry storage area the trash bin with standing water had been removed. The DM stated that maintenance was aware of the water leak coming from the roof.

On 09/29/23 at 9:11 AM during an observation with the Registered Dietitian (RD) the nourishment room on the southside unit was observed. The refrigerator contained an undated Styrofoam box of food with Resident (R) 50's room number on it, a half full quart of soup dated 09/28 with R30's room number on it and no discard date was noted. The freezer contained an undated bag of frozen grapes with R1's room number on it.

On 09/30/23 at 9:57 AM a follow-up observation of the nourishment rooms was conducted with the RD. In the southside nourishment room refrigerator, two unlabeled submarine sandwiches dated 09/30/23 were noted in the refrigerator. A Licensed Practical Nurse (LPN) 2 in the nourishment room revealed she did not know who put the sandwiches in, but she did state that when a family brought in food for the resident, they [nursing] had to label and put a date on it. Inside the refrigerator an undated, unlabeled Styrofoam take out box was noted; an undated Wawa bag of

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F 812	Continued From page 50 unknown food contents and an unknown resident's name was noted. The RD stated the resident had probably been discharged. There were two undated, unlabeled, red-lidded plastic containers on the top shelf that looked to contain a type of pasta and an undated cardboard box of leftover pizza with R77's room number on it was noted. A submarine sandwich was noted in the refrigerator for a discharged resident and an unlabeled ShopRite bag containing a wrap and chips was noted. Undated takeout items with R41's room number were noted, an undated, unlabeled bag of take out was noted, an unlabeled, undated brown paper bag with takeout in it was noted. The door of the refrigerator had an 8-ounce chocolate milk with an expiration date of 09/16/23 and a bulging 32-ounce carton of prune juice dated 08/11/23 with about a quarter of the carton left. The freezer contained an opened, undated pint of ice cream for an unknown resident, and an unlabeled, undated pint of water ices. On 09/28/23 at 9:01 AM during an interview with the Maintenance Director (MD) about the kitchen roof leak he stated, "we already have estimates for it, and it is being addressed. At most it's been a week, week and a half." He stated that the roof only leaked when there was an issue, estimates were waiting to be approved. On 09/29/23 at 3:08 PM the DM stated, "every product is different in how you label it, it depends on if you open it and when you use it by." He stated he would look for a policy on labeling. Review of the policy titled "Use and storage of Food Brought in by Family or Visitors," dated 03/23, revealed "It is the right of the residents of	F 812		

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F 812	Continued From page 51 this facility to have food brought in by family or other visitors, however the food must be handled in a way to ensure the safety of the resident ...All food items that are already prepared by the family or visitor brought in must be labeled with content and dated. A. The facility may refrigerate labeled and dated prepare items in the nourishment refrigerator b. the prepared food must be consumed by the resident within 3 days c. if not consumed within 3 days, food will be thrown away by facility staff." Review of the paper "Food Preparation Guidelines" policy dated 03/2023, revealed. "It is the policy of this facility to prepare foods in a manner to preserve or enhance a resident's nutrition and hydration status ...Food shall be prepared by methods that conserve nutritive value, flavor and appearance. This includes but is not limited to storing food in a manner to minimize exposure to light and air ..." NJAC 8:39-17.2(g) NJAC 8:39-19.7(d)	F 812		

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on facility document review it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey. 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:	S 560	S560 No residents were affected by this practice. All residents have the potential to be affected by this practice. Daily meetings will occur Monday through Friday and will include Director of Nursing, Administrator, Staffing Coordinator to review open shifts positions and recruitment. Facility Administrator, DON, Human Resource will obtain more staff through hiring bonuses, advertising, use of agency when necessary, Incentives for picking up shift such as bonuses, and	11/6/23

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

Electronically Signed | 10/20/23

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S 560	Continued From page 1 One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a certified nurse aide and shall perform nurse aide duties; and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The facility was deficient in CNA/total staffing for residents on shifts as follows: 1. For the 2 weeks of Complaint staffing from 08/21/2022 to 09/03/2022, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: -08/21/22 had 12 CNAs for 104 residents on the day shift, required at least 13 CNAs. -08/22/22 had 12 CNAs for 104 residents on the day shift, required at least 13 CNAs. -08/23/22 had 12 CNAs for 103 residents on the day shift, required at least 13 CNAs. -08/25/22 had 11 CNAs for 103 residents on the day shift, required at least 13 CNAs. -08/26/22 had 12 CNAs for 103 residents on the day shift. Required at least 13 CNAs. -08/27/22 had 12 CNAs for 110 residents on the day shift, required at least 14 CNAs. -08/28/22 had 11 CNAs for 110 residents on the day shift, required at least 14 CNAs. -08/29/22 had 11 CNAs for 110 residents on the day shift, required at least 14 CNAs. -08/30/22 had 11 CNAs for 108 residents on the day shift, required at least 13 CNAs. -08/31/22 had 12 CNAs for 108 residents on the	S 560	flexibility with schedules. Scheduler/ Designee will audit weekly staffing for each shift for CNA□s and Nurses to identify trends related to scheduling/ staffing. Staffing Manager/ Designee will provide weekly audits to DON. The Administrator Weekly audits x 4 weeks, then bi-weekly x 4, then monthly x 1 month will be provided to NHA/ Designee for review. Findings will be reported monthly x 3 to QAPI Committee. After 3 months QAPI Team will review the need to continue monthly reporting/ auditing and or change to existing plan.	

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PROMEDICA SKILLED NURSING & REHAB (W/	378 FRIES MILL ROAD SEWELL, NJ 08080

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S 560	Continued From page 2 day shift, required at least 13 CNAs. -09/01/22 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -09/02/22 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -09/03/22 had 11 CNAs for 108 residents on the day shift, required at least 13 CNAs. 2. For the 2 weeks of Complaint staffing from 12/11/2022 to 12/24/2022, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts as follows: -12/11/22 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. -12/12/22 had 11 CNAs for 104 residents on the day shift, required at least 13 CNAs. -12/14/22 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs. -12/15/22 had 12 CNAs for 104 residents on the day shift, required at least 13 CNAs. -12/17/22 had 12 CNAs for 104 residents on the day shift, required at least 13 CNAs. -12/18/22 had 12 CNAs for 104 residents on the day shift, required at least 13 CNAs. -12/19/22 had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs. -12/20/22 had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs. -12/21/22 had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs. -12/22/22 had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs. -12/23/22 had 12 CNAs for 111 residents on the day shift, required at least 14 CNAs. 3. For the 14 weeks of Complaint staffing from 02/26/2023 to 06/03/2023, the facility was deficient in CNA staffing for residents on 93 of 98	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08004	A. BUILDING: _____ B. WING _____	C 09/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (W/	378 FRIES MILL ROAD SEWELL, NJ 08080

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3 day shifts and deficient in total staff for residents on 2 of 98 overnight shifts as follows: -02/26/23 had 11 CNAs for 117 residents on the day shift, required at least 15 CNAs. -02/27/23 had 11 CNAs for 117 residents on the day shift, required at least 15 CNAs. -02/28/23 had 12 CNAs for 117 residents on the day shift, required at least 15 CNAs. -03/01/23 had 13 CNAs for 117 residents on the day shift, required at least 15 CNAs. -03/02/23 had 13 CNAs for 117 residents on the day shift, required at least 15 CNAs. -03/03/23 had 13 CNAs for 117 residents on the day shift, required at least 15 CNAs. -03/04/23 had 12 CNAs for 115 residents on the day shift, required at least 15 CNAs. -03/05/23 had 12 CNAs for 114 residents on the day shift, required at least 14 CNAs. -03/06/23 had 10 CNAs for 112 residents on the day shift, required at least 14 CNAs. -03/07/23 had 12 CNAs for 112 residents on the day shift, required at least 14 CNAs. -03/08/23 had 12 CNAs for 112 residents on the day shift, required at least 14 CNAs. -03/09/23 had 10 CNAs for 111 residents on the day shift, required at least 14 CNAs. -03/11/23 had 12 CNAs for 111 residents on the day shift, required at least 14 CNAs. -03/13/23 had 13 CNAs for 117 residents on the day shift, require at least 117 CNAs. -03/14/23 had 12 CNAs for 116 residents on the day shift, required at least 14 CNAs. -03/15/23 had 13 CNAs for 116 residents on the day shift, required at least 14 CNAs. -03/16/23 had 11 CNAs for 111 residents on the day shift, required at least 14 CNAs. -03/17/23 had 11 CNAs for 111 residents on the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08004	A. BUILDING: _____ B. WING _____	C 09/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (W/	378 FRIES MILL ROAD SEWELL, NJ 08080

(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 day shift, required at least 14 CNAs. -03/18/23 had 12 CNAs for 111 residents on the day shift, required at least 14 CNAs. -03/19/23 had 11 CNAs for 111 residents on the day shift, required at least 14 CNAs. -03/20/23 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -03/21/23 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs. -03/22/23 had 11 CNAs for 108 residents on the day shift, required at least 13 CNAs. -03/23/23 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -03/24/23 had 11 CNAs for 114 residents on the day shift, required at least 14 CNAs. -03/25/23 had 11 CNAs for 113 residents on the day shift, required at least 14 CNAs. -03/26/23 had 12 CNAs for 112 residents on the day shift, required at least 14 CNAs. -03/27/23 had 12 CNAs for 112 residents on the day shift, required at least 14 CNAs. -03/28/23 had 12 CNAs for 112 residents on the day shift, required at least 14 CNAs. -03/29/23 had 12 CNAs for 112 residents on the day shift, required at least 14 CNAs. -03/30/23 had 12 CNAs for 115 residents on the day shift, required at least 14 CNAs. -03/31/23 had 13 CNAs for 115 residents on the day shift, required at least 14 CNAs. -04/01/23 had 13 CNAs for 115 residents on the day shift, required at least 14 CNAs. -04/02/23 had 12 CNAs for 116 residents on the day shift, required at least 14 CNAs. -04/04/23 had 13 CNAs for 116 residents on the day shift, required at least 14 CNAs. -04/05/23 had 12 CNAs for 116 residents on the day shift, required at least 14 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08004	A. BUILDING: _____ B. WING _____	C 09/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (W/	378 FRIES MILL ROAD SEWELL, NJ 08080

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 5 -04/06/23 had 12 CNAs for 116 residents on the day shift, required at least 14 CNAs. -04/07/23 had 13 CNAs for 115 residents on the day shift, required at least 14 CNAs. -04/08/23 had 13 CNAs for 112 residents on the day shift, required at least 14 CNAs. -04/09/23 had 12 CNAs for 112 residents on the day shift, required at least 14 CNAs. -04/10/23 had 12 CNAs for 112 residents on the day shift, required at least 14 CNAs. -04/12/23 had 11 CNAs for 111 residents on the day shift, required at least 14 CNAs. -04/12/23 had 7 total staff for 111 residents on the overnight shift, required at least 8 total staff. -04/13/23 had 12 CNAs for 109 residents on the day shift, required at least 14 CNAs. -04/14/23 had 11 CNAs for 108 residents on the day shift, required at least 13 CNAs. -04/15/23 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs. -04/16/23 had 10 CNAs for 106 residents on the day shift, required at least 13 CNAs. -04/17/23 had 11 CNAs for 105 residents on the day shift, required at least 13 CNAs. -04/18/23 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -04/19/23 had 11 CNAs for 104 residents on the day shift, required at least 13 CNAs. -04/20/23 had 12 CNAs for 104 residents on the day shift, required at least 13 CNAs. -04/21/23 had 12 CNAs for 104 residents on the day shift, required at least 13 CNAs. -04/22/23 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs. -04/23/23 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs. -04/24/23 had 11 CNAs for 107 residents on the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08004	A. BUILDING: _____ B. WING _____	C 09/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (W/	378 FRIES MILL ROAD SEWELL, NJ 08080

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 6 day shift, required at least 13 CNAs. -04/25/23 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs. -04/26/23 had 12 CNAs for 107 residents on the day shift, required at least 13 CNAs. -04/27/23 had 9 CNAs for 107 residents on the day shift, required at least 13 CNAs. -04/28/23 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. -04/29/23 had 11 CNAs for 105 residents on the day shift, required at least 13 CNAs. -05/01/23 had 11 CNAs for 105 residents on the day shift, required at least 13 CNAs. -05/02/23 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -05/03/23 had 11 CNAs for 105 residents on the day shift, required at least 13 CNAs. -05/04/23 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. -05/05/23 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -05/06/23 had 11 CNAs for 108 residents on the day shift, required at least 13 CNAs. -05/07/23 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs. -05/08/23 had 10 CNAs for 109 residents on the day shift, required at least 14 CNAs. -05/09/23 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs. -05/10/23 had 9 CNAs for 108 residents on the day shift, required at least 13 CNAs. -05/11/23 had 11 CNAs for 108 residents on the day shift, required at least 13 CNAs. -05/12/23 had 11 CNAs for 108 residents on the day shift, required at least 13 CNAs -05/12/23 had 7 total staff for 108 residents on the overnight shift, required at least 8 total staff. -05/13/23 had 12 CNAs for 115 residents on the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08004	A. BUILDING: _____ B. WING _____	C 09/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (W/	378 FRIES MILL ROAD SEWELL, NJ 08080

(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 7 day shift, required at least 14 CNAs. -05/14/23 had 10 CNAs for 114 residents on the day shift, required at least 14 CNAs. -05/15/23 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs. -05/16/23 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs. -05/17/23 had 11 CNAs for 110 residents on the day shift, required at least 14 CNAs. -05/18/23 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs. -05/19/23 had 13 CNAs for 110 residents on the day shift, required at least 14 CNAs. -05/20/23 had 13 CNAs for 116 residents on the day shift, required at least 14 CNAs. -05/21/23 had 12 CNAs for 116 residents on the day shift, required at least 14 CNAs. -05/22/23 had 11 CNAs for 116 residents on the day shift, required at least 14 CNAs. -05/23/23 had 13 CNAs for 116 residents on the day shift, required at least 14 CNAs. -05/24/23 had 12 CNAs for 116 residents on the day shift, required at least 14 CNAs. -05/25/23 had 11 CNAs for 111 residents on the day shift, required at least 14 CNAs. -05/26/23 had 11 CNAs for 109 residents on the day shift, required at least 14 CNAs. -05/27/23 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. -05/28/23 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. -05/29/23 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs. -05/30/23 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs. -05/31/23 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08004	A. BUILDING: _____ B. WING _____	C 09/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (W/	378 FRIES MILL ROAD SEWELL, NJ 08080

(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 8 -06/01/23 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs. -06/02/23 had 10 CNAs for 106 residents on the day shift, required at least 13 CNAs. -06/03/23 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs. 4. For the 2 weeks of Complaint staffing from 06/11/2023 to 06/17/2023, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: -06/11/23 had 11 CNAs for 109 residents on the day shift, required at least 14 CNAs. -06/12/23 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs. -06/13/23 had 11 CNAs for 108 residents on the day shift, required at least 13 CNAs. -06/14/23 had 11 CNAs for 108 residents on the day shift, required at least 13 CNAs. -06/16/23 had 13 CNAs for 111 residents on the day shift, required at least 14 CNAs. -06/17/23 had 12 CNAs for 111 residents on the day shift, required at least 14 CNAs. -06/18/23 had 12 CNAs for 111 residents on the day shift, required at least 14 CNAs. -06/19/23 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs. -06/20/23 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs. -06/21/23 had 11 CNAs for 102 residents on the day shift, required at least 13 CNAs. -06/22/23 had 10 CNAs for 102 residents on the day shift, required at least 13 CNAs. -06/23/23 had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs. -06/24/23 had 10 CNAs for 106 residents on the day shift, required at least 13 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08004	A. BUILDING: _____ B. WING _____	C 09/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (W/	378 FRIES MILL ROAD SEWELL, NJ 08080

(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 9 5. For the week of Complaint staffing from 09/03/2023 to 09/09/2023, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -09/03/23 had 11 CNAs for 110 residents on the day shift, required at least 14 CNAs. -09/05/23 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. -09/06/23 had 11 CNAs for 105 residents on the day shift, required at least 13 CNAs. -09/08/23 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -09/09/23 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. 6. For the 2 weeks of staffing prior to survey from 09/10/2023 to 09/23/2023, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows: -09/10/23 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs. -09/11/23 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs. -09/12/23 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs. -09/13/23 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs. -09/15/23 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs. -09/16/23 had 10 CNAs for 98 residents on the day shift, required at least 12 CNAs. -09/17/23 had 10 CNAs for 98 residents on the day shift, required at least 12 CNAs. -09/18/23 had 10 CNAs for 98 residents on the day shift, required at least 12 CNAs. -09/19/23 had 11 CNAs for 98 residents on the day shift, required at least 12 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08004	A. BUILDING: _____ B. WING _____	C 09/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (W/	378 FRIES MILL ROAD SEWELL, NJ 08080

(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 10 -09/21/23 had 10 CNAs for 103 residents on the day shift, required at least 13 CNAs. -09/22/23 had 11 CNAs for 103 residents on the day shift, required at least 13 CNAs. -09/23/23 had 10 CNAs for 103 residents on the day shift, required at least 13 CNAs.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315506 Y1	A. Building B. Wing Y2	11/21/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (WASHINGTON TWP)	378 FRIES MILL ROAD SEWELL, NJ 08080

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 F0578	Correction	ID Prefix F0641	Correction	ID Prefix F0656	Correction
Reg. # 483.10(c)(6)(8)(g)(12)(i)-(v)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	11/06/2023	LSC	11/06/2023	LSC	11/06/2023
ID Prefix F0689	Correction	ID Prefix F0698	Correction	ID Prefix F0803	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.60(c)(1)-(7)	Completed
LSC	11/06/2023	LSC	11/06/2023	LSC	11/06/2023
ID Prefix F0804	Correction	ID Prefix F0806	Correction	ID Prefix F0812	Correction
Reg. # 483.60(d)(1)(2)	Completed	Reg. # 483.60(d)(4)(5)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	11/06/2023	LSC	11/06/2023	LSC	11/06/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
9/30/2023	☐ 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
08004 Y1	A. Building B. Wing Y2	11/21/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (WASHINGTON TWP)	378 FRIES MILL ROAD SEWELL, NJ 08080

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 11/06/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
9/30/2023	☐ 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
	315506	A. BUILDING **01** B. WING _____	**09/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (WASHINGTON TWP)	**378 FRIES MILL ROAD** **SEWELL, NJ 08080**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 09/27/23. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/27/23 and the facility and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Promedica Skilled Nursing and Rehab is a one-story, Type V protected building that was built in 2011. The facility is divided into seven smoke compartments. The diesel generator powers 75% of the building per the Maintenance Director. The number of occupied beds was 110 out of 120 at the time of the survey.	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the	K 222		11/6/23

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

Electronically Signed | 10/20/2023

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
	315506	A. BUILDING **01** B. WING _____	**09/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (WASHINGTON TWP)	**378 FRIES MILL ROAD** **SEWELL, NJ 08080**

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K 222	Continued From page 1 use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.	K 222		

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K 222	Continued From page 2 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: . Based on observations and interviews, the facility failed to meet the delayed egress locking requirements of NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.6.1. This deficient practice had the potential to affect 76 residents. Findings Include: An observation on 9/27/23 at 11:38 AM of the exit door, located by Ex Order 26. 4B1, revealed the delayed egress door hardware was not functioning properly. When the Maintenance Director applied force to activate the release of the delayed egress locks, the cross bar fell off the door. An observation on 9/27/23 at 11:20 AM of the exit door, located by Ex Order 26. 4B1, revealed the delayed egress signage was missing.	K 222	K222 Exit Door located by Ex Order 26. 4B1 was repaired. The cross bar, locking mechanism, and hardware repaired and functioning properly. Delayed Egress signage was placed on door. All other exit doors in the facility were audited to ensure proper function of crossbar and locking mechanism. The maintenance director educated to check exit doors monthly for proper function. Exit doors added to TELS for routine maintenance checks. The Administrator or designee will conduct the audits weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 month. Findings of the audits will be reviewed by the Quality Assurance Committee monthy.	

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K 222	Continued From page 3 During an interview at the time of the observations, the Maintenance Director confirmed the push bar was loose and not functioning properly and the missing signage on the delay egress doors. NJAC 8:39-31.1(c), 31.2(e)	K 222		
K 372 SS=F	. Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: . Based on observations and interviews, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 8.5.6.1 and 8.5.6. 2. This deficient	K 372	The penetration in the smoke barrier located in the resident lounge by Ex Order 26. [redacted], the penetration located in the activity room by the dining room, and the penetration located inside the resident day room by Ex Order 26. 4B1 at a conduit point were all sealed with the appropriate fire rated material capable of restricting the transfer	11/6/23

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K 372	Continued From page 4 practice had the potential to affect all 110 residents. Findings include: An observation on 09/27/23 at 10:35 AM of the smoke barrier, located in the Resident Lounge by Ex Order 26. 4B1, revealed a two-inch unsealed gap at a conduit penetration above the ceiling tile. An observation on 09/27/23 at 11:04 AM of the smoke barrier, located in the Activity Room by the Dining Room, revealed a three-inch unsealed gap around a wire penetration above the ceiling tile and copy machine. An observation on 09/27/23 at 11:28 AM of the smoke barrier, located inside the Resident Day Room by Ex Order 26. 4B1, revealed a two-inch unsealed gap at a conduit penetration above the ceiling tile. During an interview at the time of the observations, the Maintenance Director confirmed the unsealed gaps and penetrations and stated the facility was unaware of the unsealed gaps and penetrations in the smoke barriers. NJAC 8:39-31.1(c), 31.2(e)	K 372	of smoke and in accordance with NFPA 101 Life Safety Code. Maintenance director audited above the ceiling tiles throughout the facility for potential other areas of penetration. Any penetrations found will be sealed with the appropriate fire rated material in accordance with the NFPA 101 Life Safety Code.The maintenance director educated to the smoke barrier regulations. Maintenance Director or designee will audit by routinely checking for penetrations above the ceiling. The Maintenance Director or designee will conduct the audits weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 month. Findings of the audits will be reviewed by the Quality Assurance Committee monthly.	
K 712 SS=F	. Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire	K 712		11/6/23

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K 712	Continued From page 5 conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: . Based on record review and interview, the facility failed to document fire drills at least quarterly per shift, as required by NFPA 101 Life Safety Code (2012 Edition), Section 19.7.1. This deficient practice had the potential to affect all 110 residents. Findings include: Record Review of the facility's "Fire Drill Record" forms revealed documentation for Fire Drills for the first quarter of 2023 was missing for all shifts. According to documentation provided by the facility during the survey, fire drills were conducted as follows: First Shift (7:00 AM - 3:00 PM): 07/18/23 at 2:21 PM 04/18/23 at 10:30 AM 11/27/22 at 11:52 AM Second Shift (3:00 PM - 11:00 PM): 08/04/23 at 6:41 PM 05/06/23 at 5:30 PM 11/30/22 at 8:28 PM Third Shift (11:00 PM - 7:00 AM):	K 712	Documentation was found that fire drills were done and records will be readily available. Facility has contracted with a fire drill company who is under contract to randomly conduct fire drills as required by the NFPA 101 Life Safey Code. The maintenance Director educated to the requirements for fire drills and the Administrator will audit monthly to ensure ongoing compliance. The Administrator or designee will conduct the audits monthly x 4 Findings of the audits will be reviewed by the Quality Assurance Committee monthly.	

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K 712	Continued From page 6 09/02/23 at 12:50 AM 06/07/23 at 2:15 AM 12/01/22 at 4:34 AM During an interview on 09/26/23 at 9:00 AM Maintenance Director confirmed fire drills were missing and stated the facility recently changed Maintenance Staff and was not aware of the missing fire drill records. Post Survey the Administrator sent additional information via email on 09/27/23 at 3:47 PM from the fire alarm company showing an alarm was activated on 3/16/23 at 4:00 AM, 02/14/23 at 8:30 PM, and 03/16/23 at 4:00 AM at the facility, but there was not documentation indicating a fire drill was conducted and the staff participated in the drill. NJAC 8:39.31.2(e)	K 712		
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	K 918		11/6/23

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K 918	Continued From page 7 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 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 record reviews and interview, the facility failed to maintain the generator in accordance with NFPA 110 Emergency Power and Standby Power Systems (2010 Edition), Section 8. This deficient practice had the potential to affect all 110 residents. Findings include: A record review of the facility's Generator Inspection & Testing Log revealed documentation of the monthly test under load of the diesel generator was missing for June 2023 and July 2023.	K 918	The generator monthly test logs are up to date. Generator testing added to TELS routine maintenance order logs with a reminder set for Maintenance Director to ensure they aren□t missed. Maintenance Director Educated on maintaining the generator in accordance with NFPA 110 Emergency Power and Standby Power Systems. The facility will audit to ensure ongoing compliance. The Administrator or designee will conduct the audits monthly x 4 Findings of the audits will be reviewed by the Quality Assurance Committee monthly.	

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K 918	Continued From page 8 A record review of the facility's Generator Inspection & Testing Log revealed missing documentation for May 2023, June 2023, and July 2023. The gap in documentation occurred between 05/20/23 and 07/11/23. During an interview on 09/27/23 at 9:45 AM, the Maintenance Director confirmed there was documentation missing for the generator. He stated the facility recently changed Maintenance Staff and was not aware of the missing documentation. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	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
315506 Y1	A. Building 01 - MANOR CARE WASHINGTON TWP. B. Wing Y2	11/21/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (WASHINGTON TWP)	378 FRIES MILL ROAD SEWELL, NJ 08080

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 K0222	11/06/2023	LSC K0372	11/06/2023	LSC K0712	11/06/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	11/06/2023	LSC		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	
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?
9/30/2023	☐ YES ☐ NO