STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315210	A. BUILDING _____ B. WING _____	C 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	**66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205**

(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	F 000		

Standard Survey
C/O # NJ 153842, NJ 152080, NJ 152965, NJ 160360, NJ 166781, NJ 165272, NJ 165072, NJ 166760

Census: 109

Sample Size: 33 + 3 closed records

The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.

Based on observation, interviews, medical record review, and review of other pertinent facility documents, it was determined that the facility failed to A.) administer physician prescribed EX Order 26.4B1 residents as ordered for 8 of 24 residents (Residents #22, #24, #33, #73, #74, #81, #260, and #261) residing on 2 of 2 floors and B.) failed to follow a physician order for EX Order 26.4B1 on 1 of 3 residents reviewed for EX Order 26.4B1 (Resident # 35).

Failure to administer the prescribed EX Order 26.4B and/or EX Order 26.4B1) pu EX Order 26.4B1 residents at risk for EX Order 26.4B1 reactions (EX Order 26.4B1 that affects people with EX Order 26.4B1. Skipping doses or not taking enough EX Order 26.4B to EX Order 26.4B1 can lead to EX Order 26.4B1 hospitalization, and possible death).

This deficient practice resulted in an Immediate Jeopardy (IJ) situation which was identified on 10/30/2023, when the facility staff failed to administer physician prescribed EX Order 26.4B1

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

Electronically Signed | 11/21/2023

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

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F 000	Continued From page 1 The facility Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) were notified of the IJ on 10/30/2023 at 2:04 PM. A removal plan was received and was verified by the survey team on 10/31/2023 at 9:59 AM.	F 000		
F 658 SS=K	F 658 will continue at a scope and severity of "E". Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, medical record review, and review of other pertinent facility documents, it was determined that the facility failed to A.) administer physician prescribed EX Order 26.4B to EX Order 26.4B1 residents as ordered for 8 of 24 residents (Residents #22, #24, #33, #73, #74, #81, #260, and #261) residing on 2 of 2 floors and EX Order failed to follow a physician order for EX Order 26.4B1 on 1 of 3 residents reviewed for [redacted] (Resident # 35). Failure to administer the prescribed EX Order 26.4B and/or EX Order 26.4B1 EX Order 26 put EX Order 26.4B1 [redacted] Skipping doses or not taking enough EX Order 26.4B to EX Order 26.4B1 can lead to EX Order 26.4B1, hospitalization, and possible death). This deficient practice resulted in an Immediate Jeopardy (IJ) situation which was	F 658	The corrective action accomplished for patient(s) # #22, #24, #33, #73, #74, #81, #260, and #261 included physician notification and a NJ Exec. Order 26:4.b.1 [redacted] of each resident for signs of EX Order 26.4B1. Pending physician approval, facility obtained lab orders for residents whose MARs (Medication Administration Record) did not reflect administrations of EX Order 26.4B or NJ Exec. Order 26:4.b.1, as ordered by the physician. Resident representative(s) were notified. The center reviewed resident records and conducted an audit for residents receiving insulin. No other residents were affected. Any resident receiving insulin has the	12/5/23

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F 658	Continued From page 2 identified on 10/30/2023, when the facility staff failed to administer physician prescribed [EX Order 26.4B1]. The facility Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) were notified of the IJ on 10/30/2023 at 2:04 PM. A removal plan was received and was verified by the survey team on 10/31/2023 at 9:59 AM. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."	F 658	potential to be affected. The corrective action accomplished for patient #35 included notification to the physician and the family of the [EX Order 26.4B1] not recorded. A [NJ Exec. Order 26:4.b.1] was completed immediately which included obtaining a [EX Order 26.4B1] of the patient. The center reviewed residents with weekly weight orders and conducted an audit. No other residents were affected. Reviewed the medication administration record (MAR) to identify and prioritize education for the nurse that did not complete the MAR entry and clinical referral for education was initiated immediately. Measures that were put into place included facility educator, nurse supervisor and/or designee implemented in-service education to licensed nurses that included general medication administration, signing out medications once administered to avoid omissions, and review of how to check the electronic record if they did not sign-out for a medication after it was administered. A Point Click Care (PCC) system change was made to the electronic medication administration(eMAR) record to reflect that when a coverage of insulin does not meet the parameters in the order, the licensed nurse may now sign out the order utilizing a new designated code and	

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F 658	Continued From page 3 On 10/24/2023 at 10:25 AM during the initial tour of the facility, the surveyor observed Resident #22 lying in bed. Resident #22 did not respond to the surveyor's voice. The resident had eyes open and exhibited NJ Exec. Order 26:4.b.1. The resident was neat in appearance with no EX Order 26.4B1 EX Order 26.4B1 observed during this observation. On 10/30/2023 at approximately 10:15 AM the survey team asked the facility DON to provide a list of all residents in the facility who were prescribed EX Order 26.4B1 (NJ Exec. O). After receiving the list, the survey team reviewed the Medication Administration Record (MAR) dated 10/01/2023-10/31/2023 for each of the 24 identified residents that were prescribed EX Order 26.4B1 After reviewing the facility provided list, the survey team identified an additional (7) residents prescribed EX Order 26.4B that did not receive EX Order 26.4B and/or NJ Exec. Order 26:4.b.1 as physician prescribed. A.) 1. On 10/27/2023 the surveyor requested the past six months of the facility consultant pharmacist (CP) monthly medication regimen reviews (MRR) for an unnecessary medications survey task for Resident #22. According to the Admission Record (AR), Resident #22 (EX Orde floor) had been admitted to the facility with the following diagnoses but not limited to EX Order 26.4B1 . On 10/30/2023 the surveyor reviewed the EX Order 26.4B1 CP MRR for Resident #22. The following recommendation was made to the facility nursing staff: "Medication not charted on	F 658	not left blank. PCC Clinical Dashboard section "Med Passes in the Last 24 hours by assignment" are reviewed at change of shift by each nurse as part of shift-to-shift hand off to confirm all physician orders are documented. Nurse signature verifies dashboard review completion. The Administrator and designee reviewed weight policy with dietician and licensed nursing staff which included but was not limited to the capturing of weights and the documentation of such weights. Monitoring will be captured through Daily chart checks of residents receiving insulin for 14 days, then up to 10 records for 14 days, then up to 15 records monthly for two months. The audit will be confirming there is a signature of the insulin administered or a code entered in the event that the insulin was not able to be administered (example: parameters in the order). Orders to obtain weights will be reviewed weekly for one month for up to 10 residents, then 10 residents monthly for a period of two months. Results of the audits will be provided to the Administrator by the Director of Nursing and be presented for review by	

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F 658	Continued From page 4 MAR (medication administration record) see NJ Exec. Orde Please review & confirm documentation on paper/back up is available." On 10/30/2023 at 09:30 AM the surveyor reviewed the 10/1/2023-10/31/2023 MAR for Resident #22. The review revealed that on NJ Exec. Order 26:4.b.1 Resident #22 did not receive the following medications in the AM, as indicated by a blank on the MAR. Resident #22 did not receive EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4B1 times a day for DM, as ordered by physician on EX Order 26.4B1 on EX Order 26.4B1. Further review of the MAR for Resident #22 revealed that Resident #22 did not receive EX Orde checks at 0730, 1100, and 1600 on NJ Exec. Order 26:4.b.1, as per the following physician order, dated NJ Exec. Order 26:4.b.1: EX Order 26.4B1 EX Order 26.4B1) NJ Exec. Order 2 EX Order 26.4B1 meals and at bedtime for NJ Exec. Ord The surveyor reviewed the progress notes (PN) in the electronic medical record (EMR) for Resident #22. Review of the PN's revealed that no progress notes were documented for Resident #22 between EX Order 26.4B1. The last PN was written on EX Order 26.4B1 and	F 658	the Quality Assurance Improvement Committee (QAPI)monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at the QAPI Committee meeting.	

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the next entry in the PN was EX Order 26.4B1, which revealed that Resident #22 refused his/her lunch meal and 2 PM medication.

There was no documentation on NJ Exec. Order 26:4.b.1 to indicate why Resident #22 did not receive their physician prescribed medications for EX Order 26 as indicated by blanks on the MAR.

A review of the Care Plan for Resident #22 did not include a care plan for diagnosis of EX Order 26.4B1 EX Order 26.4B1.

2. According to the AR, Resident #24 was admitted to the facility with the following diagnoses but not limited to EX Order 26.4B1 EX Order 26.4B1

A review of the Order Summary Report (OSR), with Active orders As Of: EX Order 26.4B1, revealed the following physician orders:

EX Order 26.4B1

If NJ Exec. Order 26:4.b.1

notify MD, EX Order 26.4B1 before meals and at bedtime for NJ Exec. Orde The resident will self-check his/her EX Order 26.4B1 in the presence of the nurse by way of the EX Order 26.4B1 EX Order 26.4B1

EX Order 26.4B1 for

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EX Order 26.4B1.

EX Order 26.4B1 unit EX Order 26.4B1 every morning and at bedtime for EX Order 26.4B1

A review of the EX Order 26.4B1 MAR indicated the medications for Resident #24 and that Resident #24 was to receive EX Order 26.4B1 of EX Order 26.4B1 A further review of the MAR showed a blank on EX Order 26.4B1, indicating that the physician prescribed EX Order 26.4B1 was not administered as ordered.

A review of the Care Plan for Resident #24 revealed a Focus area of [Resident's Name] has a diagnosis of EX Order 26.4B1EX Order 26.4B1 dependent. Under the Goal section, "[Resident name] will be from further complications secondary to EX Order 26.4B1" Interventions included but were not limited to: Monitor EX Order 26.4B1 as ordered.

3. According to the AR, Resident #33 was admitted to the facility with the following diagnosis of but not limited to EX Order 26.4B1 EX Order 26.4B1

A review of the OSR with Active Orders as Of: EX Order 26.4B1, revealed the following physician order(s):

EX Order 26.4B1
EX Order 26.4B1 EX Order 26.4B1 NJ Exec. Order 26:4.b.1

EX Order 26.4B1 and at bedtime related to EX Order 26.4B1

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EX Order 26.4B1

EX Order 26.4B1

very EX Ord hours related to

EX Order 26.4B1

A review of the EX Order 26.4B1 MAR revealed that Resident #33 did not receive physician prescribed EX Order 26.4B1 on EX Order 26.4B1 and EX Order 26.4B1, as indicated by blanks on the MAR.

A review of the Care Plan for Resident #33 revealed a Focus area of I have EX Order 26.4B1 EX Order 26.4B1 Under the Goal section, I will have no complications related to EX Order 26.4B1 through the review date. Interventions included but were not limited to: EX Order 26.4B1 medication as ordered by physician.

4. According to the AR, Resident #73 was admitted to the facility with the following diagnosis of but not limited to EX Order 26.4B1 EX Order 26.4B1

A review of the EX Order 26.4B1 3 OSR revealed Resident #73 had the following physician order(s):

EX Order 26.4B1
EX Order 26.4B1) Inject
EX Ord unit EX Order 26.4B1 times a day for EX Order 26

EX Order 26.4B1
EX Order 26.4B1 NJ Exec. Order 26:4.b.1

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F 658	Continued From page 8 NJ Exec. Order 26:4.b.1 [redacted] regular [redacted] before meals and at bedtime for [redacted]. [redacted] Solution [redacted] Inject [redacted] unit [redacted] at bedtime for [redacted]. [redacted] Solution [redacted] Inject [redacted] unit [redacted] in the morning for [redacted]. A review of the [redacted] MAR revealed that Resident #73 did not receive [redacted] units [redacted], as indicated by a blank on the MAR; [redacted] as indicated by a blank on the MAR, [redacted] as indicated by a blank on the MAR, and [redacted] as indicated by a blank on the MAR. A further review of the MAR revealed that Resident #73 did not receive [redacted] as ordered and possible [redacted] on the following dates, as indicated by blanks on the MAR: [redacted]. A review of the Care Plan for Resident #73 revealed a Focus area of [Residents name] has a diagnosis of [redacted] Under the Goal section, I will be free of all signs/symptoms of [redacted] such as [redacted],	F 658		

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EX Order 26.4B1 X 90 days. Interventions section did not include documentation of EX Order 26.4B1 or EX Order 26.4B1 use.

5. According to the AR, Resident #74 was admitted to the facility with the following diagnosis of but not limited to EX Order 26.4B1 EX Order 26.4B1.

A review of the EX Order 26.4B1 OSR revealed the following physician orders for Resident #74:

EX Order 26.4B1)EX Order 26.4B1 EX Order 26.4B1 NJ Exec. Order 26.4.D)

EX Order 26.4B1 a day every EX Order 26.4B1.

EX Order 26.4B1 EX Order 26.4B1 NJ Exec. Order 26.4.)

EX Order 26.4B1

A review of the EX Order 26.4B1 MAR for Resident #74 revealed that Resident #74 did not receive EX Order 26.4B1 on the following dates and times and possible EX Order 26.4B administration:
EX Order 26.4B1

A review of the Care Plan for Resident #74

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revealed a Focus area of [Resident's name] has EX Order 26.4B1. Under the Goal section, I will have no complications related to EX Order 26.4B1 through the review date. Interventions included EX Order 26.4B1 Medication as ordered by doctor. Monitor/document for side effects and effectiveness.

6. According to the AR, Resident #81 was admitted to the facility with the following diagnosis of but not limited to EX Order 26.4B1 EX Order 26.4B1

A review of the OSR with active orders as of: EX Order 26.4B1, revealed that Resident #81 had the following physician orders:

EX Order 26.4B1 NJ Exec. Order 26:4.b.1 Notify MD if no EX Order 26.4B1

EX Order 26.4B1 nject 15 unit EX Order 26.4B1 for EX Order prime with each NJ Exec. Order 26:4.b.1 units of medication, discard then draw up correct amount as ordered for administration.

A review of the EX Order 26.4B1 MAR for Resident #81 revealed that Resident #81 did not receive EX Order checks and possible administration of EX Order 26.4B on the following dates and times: EX Order 26.4B1 .

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F 658	Continued From page 11 A review of the care plan for Resident #81 revealed a Focus are of I have EX Order 26.4B1 Under the Goal section, I will be free of all signs and symptoms of EX Order 26.4B1 such as EX Order 26.4B1 , EX Order 26.4B1 , EX Order 26.4B1 X 90 days. Interventions included but were not limited to: Access and record EX Order 26.4B1 as ordered. 7. According to the AR, Resident #260 was admitted to the facility with the following diagnosis of but not limited to EX Order 26.4B1 EX Order 26.4B1 A review of the OSR with active orders as of: EX Order 26.4B1 revealed the following physician order(s) for Resident #260: EX Order 26.4B1 EX Order 26.4B1) NJ Exec. Order 26 EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4B1) NJ Exec. Order 26 notify MD if NJ Exec. Order EX Order 26.4B1 before meals and at bedtime every EX Order 26.4B1 EX Order 26.4B1	F 658		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 12 EX Order 26.4B1	F 658		

A review of the EX Order 26.4B1 MAR for Resident #260 revealed that Resident #261 had blanks for the following medication date and times: EX Order 26.4B1 at EX Order 26.4B1 on 10/13, 10/14, 10/15, 10/16, and 10/17/2023. The MAR also revealed that Resident #260 did not receive EX Order 26.4B1 checks and possible EX Order 26.4B1 coverage, as indicated by blanks on the MAR on EX Order 26.4B1.

A review of the care plan for Resident #260 revealed a Focus area of [Resident's name] has EX Order 26.4B1. Under the Goal section, I will have no complications related to EX Order 26.4B1 through the review date. Intervention did not include EX Order 26.4B1 or use of EX Order 26.4B1

8. According to the AR, Resident #261 was admitted to the facility with the following diagnosis of but not limited to EX Order 26.4B1 EX Order 26.4B1

A review of the OSR with active orders as of: EX Order 26.4B1 revealed the following physician orders for Resident #261:

EX Order 26.4B1
EX Order 26.4B1
EX Order 26.4B1 in the afternoon for DM.

EX Order 26.4B1
(EX Order 26.4B1) Inject 5 unit EX Order 26.4B1

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EX Order 26.4B1 [EX Order 26.4B1] NJ Exec. Order 26

EX Order 26.4B1

Review of the EX Order 26.4B1 MAR for Resident #261 revealed that Resident #261 did not receive EX Order 26.4B1 sliding scale EX Order 26.4B as ordered, indicated by a blank on the MAR on EX Order 26.4B1 at 0900. On 1 NJ Exec. Order 26:4.b.1 Resident #261 failed to have physician ordered EX Orde checks performed at EX Order 26.4B1, which also potentially contributed to missed administration of EX Order 26.4B1 based on the physician order for EX Order 26.4B EX Order 26.4B1.

A review of the Care Plan for Resident #261 revealed a Focus area of I have a diagnosis of EX Order 26.4B1 EX Order 26.4B1. Under the Goal section, I will be free of all signs/symptoms of EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4B1, 90 days. Interventions included Access {sic} (assess) and record EX Order 26.4B1 as ordered.

On 10/30/2023 at 09:48 AM the surveyor conducted an interview with the Licensed Practical Nurse (LPN #2) who was assigned to the EX Order 26.4B1 unit of the facility. The surveyor asked LPN #2 what was the facility process for residents who EX Order 26.4B1 LPN #2 told the surveyor that a resident who EX Order 26.4B1 EX Order 26.4B1 will be documented on the MAR. "Specifically, the nurse documents their initials

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and codes the medication as refused." The surveyor then asked LPN #2 what a blank would indicate on the MAR for a medication. LPN #2 responded, "A blank would indicate that the medication was not given. If it's not documented, it's not done." The surveyor further asked LPN #2 what she would do if she came on shift and discovered that the previous shift nurse left blanks on the MAR for the 7 AM - 7 PM shift medications. LPN #2 responded, "Well, hopefully I am able to speak with them before change of shift. I would contact the nurse and ask them if the resident EX Order 26.4B1 or discuss it with my unit manager."

On 10/30/2023 at 10:10 AM the surveyor conducted an interview with the Licensed Practical Nurse/Unit Manager (LPN/UM) assigned to the EX Order 26.4B1 of the facility where Resident #22 resided. The surveyor asked the LPN/UM what is the facility process when a resident EX Order 26.4B1 during medication pass? The LPN/UM responded, "So, when a resident EX Order 26.4B1) we make several attempts to encourage the resident to be compliant with the medication administration. If the resident continues to refuse, then we notify the family and MD. In the MAR we should document the meds as refused using the appropriate number for refused and initialize. A progress note should briefly describe what happened during the refusal."

The surveyor asked the LPN/UM if the MAR should be left blank for a physician prescribed medication. The LPN/UM responded, "No. If it is left blank, we don't know what's going on. A blank indicates that the drug was not given. If it ain't

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documented, they didn't get it." The surveyor asked the LPN/UM what she would do if she observed a blank on a resident MAR. The LPN/UM told the surveyor, "I would reach out to the nurse on the previous shift and ask them what happened. Did you give the med, did you forget. What's going on?" The surveyor then asked the LPN/UM who is responsible for monitoring the MARs of facility residents. The LPN/UM responded, "We do a 24-hour chart check, it is the responsibility of the 11-7 nursing staff. We check the physical binder for new orders, and we also go into the EMAR to check for new orders. We do not look at the MAR we just check for new orders."

On 10/30/2023 at 2:04 PM, the surveyor interviewed the LNHA and DON. When interviewed the LNHA and DON agreed that a "blank" on a resident MAR would indicate that a drug was not administered.

On 10/31/2023 at 08:24 AM the facility LNHA while being interviewed told the survey team that they (nurses involved), should have realized on the Electronic Medication Administration Record (EMAR) that the dashboard will turn green when all medications are administered. If all medications have not been administered, the dashboard will be red. So, if it is red, you are not done and if it is green, you have given all your medications. "They [the nurses] should have known."

The surveyor reviewed the facility policy titled Insulin Administration, Revised September 2014. The policy revealed the following under the heading Documentation:

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F 658	Continued From page 16 1. The resident's blood glucose result, as ordered; 2. The dose and concentration of the insulin injection; 3. Size and gauge of the needle used for injection; 4. Injection site (presence or absence of any bruising, pain, redness, swelling or unusual marks in or near the injection site); 5. How well the resident tolerated the procedure. The following was revealed under the heading Reporting: 1. Notify your supervisor if the resident refuses the insulin injection. The surveyor reviewed the facility provided policy titled Administering Medications, Revised April 2019. The following was revealed under Policy Statement: "Medications are administered in a safe and timely manner, and as prescribed. The following was further revealed under the heading Policy Interpretation and Implementation: 2. The Director of Nursing Services supervises and directs all personnel who administer without unnecessary interruptions. 6. Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training.	F 658		

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F 658	Continued From page 17 20. For residents not in their rooms or otherwise unavailable to receive medications on the pass, the MAR may be "flagged." After completing the medication pass, the nurse will return to the missed resident to administer the medication. 21. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR and/or utilize the code that corresponds in the space provided for that drug and dose or utilize the appropriate code on the EMAR. 22. The individual administering the medication initials (written or electronic) the resident's MAR on the appropriate line after giving each medication and before administering the next ones. 23. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. The date and time the medication was administered; b. The dosage; c. The route of administration; d. The injection site (if applicable); e. Any complaints or symptoms for which the drug was administered; f. Any results achieved and when those were	F 658		

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F 658	Continued From page 18 observed; and g. The signature and title of the person administering the drug. B.) According to the Admission Record, Resident #35 was admitted to the facility with diagnoses including but not limited to: EX Order 26.4B1 EX Order 26.4B1 . A review of the current Order Summary Report (OSR) with Active Orders as of EX Order 26.4B1 , revealed a physician order with a start date of EX Order 26.4B1 for Weekly NJ Exec. Order 26:4.b.1 -dayshift in the EX Order 26.4B1 for EX Order 26.4B1 . A review of the Medication Administration Records for the months of EX Order 26.4B1 EX Order 26.4B1 , revealed the physician order for NJ Exec. Order 26:4.b.1 . The dates for every Monday were open blocks for the NJ Exec. Order 26:4.b.1 to be documented and all the blocks for the aforementioned timeframes were blank. There was no documentation to indicate that the NJ Exec. Order 26:4.b.1 had been completed as ordered. A review of Resident #35's NJ Exec. Order 26:4.b. on EX Order 26.4B1 indicated NJ Exec. Order [redacted] were obtained on EX Order 26.4B1 There was no documentation that NJ Exec. Order 26:4.b. were completed for EX Order 26.4B1 023, EX Order 26.4B1 EX Order 26.4B1 . During an interview with the surveyor on 10/27/2023 at 9:44 AM, Certified Nursing Assistant (CNA #1) revealed that NJ Exec. Order 26:4.b. are done monthly in the beginning of month. If the	F 658		

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nurse needs [NJ Exec. Order 26:4.b.1], we get them too. CNA #1 went on to say, we write them [NJ Exec. Order 26:4] s) down on a piece of paper and give to the nurse to document.

During an interview with the surveyor on 10/27/2023 at 09:52 AM, Registered Nurse /Unit Manager said the facility weights policy is done by 10th of the month. If there are any discrepancies, dietary reviews the weight. When asked who is responsible to do the weights, RN/UM replied, usually aides or nurses do weights. The nurse documents the weights in the Electronic Medical Record (EMR). If resident is on weekly weights, usually the order is put in EMR, and nurse can see the order when they do medication pass. When asked if the nurse is to document the weights on the MAR, RN/UM said, "Not necessarily do they have to chart weights in the MAR, they document the weight but there is a section in EMR where you document the weight." The surveyor asked UM where the weight dated [NJ Exec. Order 26:4.b.1] come from when the last weight the surveyor had is from [NJ Exec. Order 26:4.1]. The RN/UM said she just put the weight in the EMR today. The surveyor asked the RN/UM to read the dates of the weights in vitals/weights tab in the EMR. RN/UM read [NJ Exec. Order 26:4.b.1] RN/UM said might have dropped off (the order for [NJ Exec. Order 26:4] the MAR, it depends on duration. When asked by the surveyor if the [NJ Exec. Order 26:4.b] were required [NJ Exec. Order 26:4], RN/UM reviewed the OSR and said they were ordered in [NJ Exec. Or] and confirmed there is still an active order for [NJ Exec. Order 26:4.b.1]. "Yes, the [NJ Exec. Order 26:4.b] should have been done weekly."

During an interview with the surveyor on

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F 658	Continued From page 20 10/27/2023 at 10:23 AM, the Director of Nursing (DON) said the facility policy for weights is for admissions weight then weekly x 4 then monthly. The weights are documented in the EMR under the weight/vitals tab. When asked should the weights be documented on the MAR as well, the DON responded "Yes, they are to be documenting the weight on the MAR for weekly weights." They are to enter weight into EMR when they get it. When asked would weights be documented any in any other place, the DON said they may be written elsewhere on unit, and she will check and get back to the surveyor. On 10/31/2023 at 09:20 AM, the Don confirmed there were no NJ Exec. Order 26:4.b.1 for Resident #35. During an interview with the surveyor on 10/31/2023 at 10:21 AM, the Dietitian said weights are supposed to be taken on admission then follow up in 24 hours then weekly weights for 4 weeks for subacute then monthly weights. The Dietitian went on to say that Nursing is responsible to obtain the weights and they should be documented under weights. A review of a facility policy titled Weight Assessment and Intervention with a revised date of March 2022, revealed under the Policy Interpretation and Implementation section 1. Residents are weighed upon admission and at intervals established by the interdisciplinary team. A further review revealed 2. Weights are recorded in each unit's weight record chart and in the individual's medical record. NJAC 8:39-27.1(a)	F 658		
F 693	Tube Feeding Mgmt/Restore Eating Skills	F 693		12/5/23

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F 693 SS=D	Continued From page 21 CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to utilize facility protocols regarding EX Order 26.4B1 nutrition and care specifically by not labeling the NJ Exec. Order 26:4.b.1 [redacted] being used on a resident. The deficient practice was identified for 1 of 1 resident (resident #54) investigated for EX Order 26.4B1 On 10/24/2023 at 10:27 AM during the initial tour, the surveyor observed Resident #54 in bed. At that time, the surveyor observed a NJ Exec. Order 26:4.b.1	F 693	The NJ Exec. Order 26:4.b.1 bottle label for resident #54 was replaced. An audit was completed that reviewed residents receiving enteral nutrition feedings. No other residents were affected. Measures that were put into place include nursing leadership providing education to licensed nurses on the procedure for recording enteral nutrition administration,	

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F 693	Continued From page 22 NJ Exec. Order 26:4.b.1 hung from a pole adjacent to the resident's bed. At that time, the surveyor observed that the NJ Exec. Order 26:4.b.1 bottle did not have the resident's name, room number, date, start time, and rate of milliliters per hour as indicated by the manufacturer label. On 10/27/2023 at 10:31 AM, the surveyor observed Resident #54 in bed. At that time the surveyor observed a NJ Exec. Order 26:4.b.1 bottle hung from a pole that was connected to a pump. The pump was on at that time. The surveyor observed that the NJ Exec. Order 26:4.b.1 bottle did not have the resident's name, room number, date, start time, and rate of milliliters per hour as indicated by the label. A review of Resident #54's five-day Minimum Data Set (MDS; an assessment tool) dated for EX Order 26.4B1 revealed that he/she had a EX Order 26.4B1 EX Order 2 . A review of Resident #54's diagnosis in the electronic medical record (EMR) revealed a diagnosis of but not limited to a EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4B1 A review of Resident #54's physician's orders revealed an order for but not limited to EX Order 26.4B1 EX Order 26.4 one time a day of EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4B1 . The order revealed that the NJ Exec. Order 26:4.b.1 was to start at EX Order 26.4B1 and to come down at EX Order 26.4B1	F 693	placement, and product labeling as indicated by the manufacturer label with the date, time, rate, initials . Monitoring will be captured through observation audits that will be completed daily for 14 days for up to five residents, then weekly x 2 weeks for up to five residents, then monthly x 2 months for up to 5 residents. Results of the audits will be provided to the Administrator by the Director of Nursing and be presented for review to the Quality Assurance Improvement Committee (QAPI) monthly for a period of 3 months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at the The QAPI Committee meeting.	

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F 693	Continued From page 23 A review of Resident #54's Care Plan located in the EMR revealed a focus of the [redacted] related to NJ Exec. Order 26:4.b.1, dependence on NJ Exec. Order 26:4.b.1 [redacted] On 10/27/2023 at 10:59 AM, during an interview with the surveyor, the Registered Nurse/Unit Manager (RN/UM) stated, "The bottle should be dated with the time hung, patient name, and room number." At that time, the surveyor and RN/UM observed the NJ Exec. Order 26:4.b.1 that was currently running through the pump attached to Resident #54. At that time, the RN/UM stated, "They forgot to label the dang bottle!" On 10/31/2023 at 1:36 PM, during an interview with the surveyor, the Director of Nursing (DON) replied, "The date and time that it [nutritonal forumla] was hung, the rate, and initial." when the surveyor asked what should be included on the nutritional formula label. The DON replied, "No" when asked if the formula label should ever be blank. A review of the facility policy titled, "Enteral Tube Feeding via Continuous Pump" with a revised date of December 2022 revealed under subsection, "Initiate Feeding" that, "5. On the formula label document initials, date and time the formula was hung/administered, and initial that the label was checked against the order." § 8:39-27.1(a)	F 693		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse	F 727		12/5/23

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F 727	Continued From page 24 §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and review of Nurse Staffing Report sheets, it was determined that the facility failed to ensure a Registered Nurse (RN) worked 7 days a week for at least 8 consecutive hours a day for 4 of 10 weekends reviewed. This deficient practice was evidenced by the following: A review of the Nurse Staffing Reports completed by the facility for the weeks of 08/13/2023, 08/20/2023, 10/08/2023, and 10/15/2023 revealed the facility had no RN coverage for all shifts on 08/19/2023, 08/20/2023, 10/08/2023, and 10/21/2023. During an interview with the surveyor on 10/30/2023 at 12:51 PM, the Licensed Nursing Home Administrator (LNHA) confirmed "yes, are we missing Registered Nurse's for 24 hours on the staffing sheets. It is all weekends." The Director of Nursing said "Correct either it was a call out or RN not scheduled and couldn't find coverage" when asked if there were shifts on the	F 727	The Staffing Coordinator, Human Resource Manager, DON or designee reviewed RN staffing schedules and continue to project RN staff needs on day shifts daily. RN schedules were revised to provide coverage daily on day shift. No residents have been affected. The facility continues a robust recruitment program. Monetary incentives and special shift accommodation have been made for in-house staff. The center continues an on-call rotation for nursing management daily including weekends. Efforst are made daily to fill open shifts due to scheduled staff not being able to attend their scheduled shift. Facility utilizes staffing agencies for open shifts. The faciltiy has hired a weekend RN nurse supervisor effective 11/25/2023	

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	315210	A. BUILDING _____ B. WING _____	C 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 727	Continued From page 25 staffing sheets that showed no RN's worked. NJAC 8:39-25.2(h)	F 727	Immediate education was provided to the Staffing Coordinator, Human Resource Manager, DON and/or designee to monitor RN staffing daily. Staffing Coordinator/DON/designee will sign off on the schedule each day to ensure RN coverage meets the requirement. Monitoring will be captured through auditing. Projected and actual staffing will be audited every day for one month, then three times weekly for 4 weeks, weekly for 4 weeks. Audits to be completed by the Staffing Coordinator, Human Resource Manager, DON and/or designee daily. Results of the audits will be provided to the Administrator by the staffing coordinator. Results will be presented for review at the Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		12/5/23

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F 880	Continued From page 26 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under	F 880		

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F 880	Continued From page 27 the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record and other facility documentation, it was determined that the facility failed to store respiratory equipment in a manner to prevent the spread of infection for 3 of 3 resident's reviewed for EX Order 26.4B1 care, (Resident # 2, Resident #41, and Resident #53). This deficient practice was evidenced by the following: 1. During the initial tour of the EX Order 2 floor on 10/24/2023 at 10:26 AM, Resident #2's NJ Exec. Order 26:4. was observed to be wrapped around the side rail uncovered. The EX Order 26.4B1 was resting on top of the EX Order 26.4B1 on the bedside table, EX Order 26.4B1	F 880	EX Order 26.4B1 items were replaced and stored in a bag for resident #2 and #53. For resident #41 orders for EX Order 26.4B1 items were discontinued. An audit was completed that reviewed patients that have respiratory equipment. No other residents were affected. Measures that were put into place include the facility educator, nurse supervisor and/or designee provided education to licensed nurses on storage of respiratory equipment and supplies.	

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F 880	Continued From page 28 On 10/25/2023 at 8:48 AM, the surveyor observed Resident #2's EX Order 26.4B1 on the bed side table on top of the machine, uncovered and exposed. The EX Order 26.4B1 was wrapped around the side rail, EX Order 26.4B1 sed. According to the Admission Record, Resident #2 was admitted to facility with diagnoses including but not limited to EX Order 26.4B1 According to the most recent Minimum Data Set (MDS) an assessment tool dated EX Order 26.4B1 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of EX Order 26.4B indicating Resident #2 was EX Order 26.4B1. A review of the Order Summary Report (OSR) with Active Orders as of EX Order 26.4B1 revealed a physician order for EX Order 26.4B1 EX Order 26.4B1 inhale orally via EX Order 26.4B1 r every EX Orde hours for EX Order 26.4B1 The OSR also included a physician order for "If residents EX Order 26.4B1 or less administer EX Order 26.4B EX Order 26.4B1 with EX Order 26.4B1 if necessary, as needed for EX Orde EX Order 26.4B1 A further review of the OSR included a physician order to Change EX Order 26.4B1 EX Order 26.4B1 set-up bags every night shift every Mon for Infection control Date each items individually.	F 880	Education included but was not limited to the process of weekly dating, labeling, storage of respiratory equipment. Rounds will be conducted to observe up to 10 residents respiratory equipment storage weekly X 4 weeks, then 5 residents weekly X 1 month, then up to 10 residents monthly X 1 month by the facility Unit Manager/Supervisors and/or designee. Results of the audits will be provided to the Administrator by the Director of Nursing and be presented for review to the Quality Assurance Improvement Committee (QAPI) monthly for a period of 3 months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at the The QAPI Committee meeting	

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F 880	Continued From page 29 During an interview with the surveyor on 10/24/2023 at 12:19 PM, the surveyor asked does the staff puts his/her EX Order 26.4B1 in a bag when not in use. Resident #2 said "no they never put then EX Order 26.4B1 in a bag." Resident #2 responded "nope, not EX Order 26.4B1 when not being used" when asked if his/her EX Order 26.4B1 is bagged when not in use. 2. During the initial tour of the 2nd floor on 10/24/2023 at 10:06 AM, Resident #41's EX Order 26.4B1 [redacted] was observed to be stored on bed side table, uncovered and exposed on top of a carboard box and other items. On 10/25/2023 at 08:56 AM, Resident #41 was observed feeding self his/her breakfast. The EX Order 26.4B1 was observed to be on top a cardboard box on the bedside table uncovered and exposed. According to the Admission Record Resident #41 was admitted to the facility with diagnoses including but not limited to: EX Order 26.4B1 [redacted] According to the MDS dated NJ Exec. Order 26:4.b.1 [redacted], Resident #41 had a BIMS score of [redacted] indicating EX Order 26.4B1. A review of the OSR with active orders as of	F 880		

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F 880		F 880		

Continued From page 30

NJ Exec. Order 26:4.b.1, revealed a physician order for EX Order 26.4B1 using EX Order 26.4B1 at bedtime for EX Order 26.4B1 EX Order 26.4B1) related to EX Order 26.4B1

3. During the initial tour of the EX Order floor on 10/24/2023 at 10:10 AM, the surveyor observed Resident #53's EX Order 26.4B1 resting on top of the bedside table uncovered and exposed.

On 10/25/2023 at 9:02 AM, the surveyor observed Resident #53's EX Order 26.4B1 k hooked around EX Order 26.4B1 uncovered and exposed. Upon interview Resident #53 said "Not that I am aware of do they put the EX Order 26.4B1 in a bag." Resident went on to say "not really" when asked if he/she uses the EX Order 26.4B1 for treatments.

A review of a OSR with active orders as of EX Order 26.4B1 did not include an order for EX Order 26.4B1 treatments.

During an interview with the surveyor on 10/26/23 at 10:46 AM, Licensed Practical Nurse (LPN #1) was asked how oxygen tubing was to be stored when not in use. LPN #1 responded "well, if it is not being used, we usually don't open the package until it is ready to be used." The surveyor asked what if the tubing is already connected to the concentrator. LPN #1 said we get the tubing from supply room. The surveyor asked what is done with a nebulizer once the treatment has been administered. LPN #1 said "I don't have anyone on a nebulizer so I can't tell you."

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F 880	Continued From page 31 During an interview with the surveyor on 10/26/2023 at 10:55 AM, Registered Nurse/Unit Manager (RN/UM) said oxygen tubing is to be stored in a plastic baggy when not in use. When asked what is done after a nebulizer treatment is administered, RN/UM said it should be put back into the little bag it gets stored in. The surveyor questioned what the process for is storing a bipap mask when not being used. RN/UM said "They get wiped down and stored at the bedside. Yes, I believe they just get wiped down and left open to air." During an interview with the surveyor on 10/26/23 at 12:28 PM, the Director of Nursing (DON) said that the oxygen tubing is to be bagged when not in use. The DON went on to say that the nebulizer and bipap mask should also be bagged when not in use. A review of a facility policy titled Departmental (Respiratory Therapy)-Prevention of Infection with revised date of November 2011 revealed under the Steps in Procedure section 5. Keep the oxygen cannulae {sic} [cannula] and tubing used PRN (as needed) in a plastic bag when not in use. Under the Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol: section 7. Store circuit in plastic bag, marked with date and resident's name, between uses. NJAC 8:39-19.4(k)	F 880		

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	060102	A. BUILDING: _____ B. WING _____	C 11/02/2023

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S 000	Initial Comments COMPLAINT # NJ 152080, NJ 152965, NJ153842, NJ160360, NJ165072, NJ 1650272, NJ 166760, NJ 166781 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: COMPLAINT # NJ 152080, 152965, 153842, 165072, 1650272, 166760 Based on interview and review of other facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This deficient practice was identified for 51 of 70-day shifts. Findings include:	S 560	The Staffing Coordinator, Human Resource Manager, DON and/or designee have reviewed staffing daily and continue to project CNA staff needs to ensure CNA staffing meets the staffing to resident ratios. Immediate education was provided to the Staffing Coordinator, Human Resource Manager, DON and/or designee to monitor CNA staffing daily. Staffing	12/5/23

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

Electronically Signed | 11/21/23

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S 560	Continued From page 1 Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One 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 CNA 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. As per the "Nursing Staffing Report" completed by the facility for the weeks of 01/16/2022, 02/06/2022, 04/03/2022, 12/04/2022, 06/11/2023, 06/25/2023, 08/13/2023, 08/20/2023, 10/08/2023 and 10/15/2023 the staffing to residents' ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as documented below: 1. For the week of Complaint staffing from 01/16/2022 to 01/22/2022, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows: -01/16/22 had 11 CNAs for 106 residents on the	S 560	Coordinator/DON/designee will sign off on the schedule each day to ensure CNA staffing meets the staffing to resident ratios. No residents have been affected. The facility continues a robust recruitment program. Monetary incentives and special shift accommodation have been made for in-house staff. The center continues with an on-call rotation for nursing management after hours and on weekends All efforts are made to fill open shifts due to scheduled staff not being able to attend their scheduled shift. Facility utilizes staffing agencies for open shifts. Facility was approved as a clinical site for Certified Nurse Aide training effective November 16,2023. The Staffing Coordinator, Human Resource Manager and DON and/or designee will monitor projected and actual staffing ratios and HPPD, daily. Monitoring will be captured through daily audits every day for one month, then three times weekly for 4 weeks, weekly for 4 weeks. Results of the audits will be provided to the Administrator by the staffing coordinator. Results will be presented for review at the Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the	

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S 560	Continued From page 2 day shift, required at least 13 CNAs. -01/20/22 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. -01/21/22 had 13 CNAs for 110 residents on the day shift, required at least 14 CNAs. -01/22/22 had 11 CNAs for 110 residents on the day shift, required at least 14 CNAs. 2. For the week of Complaint staffing from 02/06/2022 to 02/12/2022, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts and deficient in total staff for residents on 2 of 7 evening shifts as follows: -02/10/22 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. -02/11/22 had 12 CNAs for 107 residents on the day shift, required at least 13 CNAs. -02/11/22 had 10 total staff for 107 residents on the evening shift, required at least 11 total staff. -02/12/22 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. -02/12/22 had 10.5 total staff for 107 residents on the evening shift, required at least 11 total staff. 3. For the week of Complaint staffing from 04/03/2022 to 04/09/2022, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -04/03/22 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. -04/05/22 had 12 CNAs for 107 residents on the day shift, required at least 13 CNAs. 4. For the week of Complaint staffing from 12/04/2022 to 12/10/2022, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows:	S 560	interdisciplinary team at QAPI Committee meeting.	

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S 560	Continued From page 3 -12/06/22 had 13 CNAs for 110 residents on the day shift, required at least 14 CNAs. -12/07/22 had 11 CNAs for 110 residents on the day shift, required at least 14 CNAs. -12/08/22 had 13 CNAs for 112 residents on the day shift, required at least 14 CNAs. -12/10/22 had 11 CNAs for 112 residents on the day shift, required at least 14 CNAs. 5. For the week of Complaint staffing from 06/11/2023 to 06/17/2023, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts and deficient in total staff for residents on 1 of 7 evening shifts as follows: -06/11/23 had 9 CNAs for 115 residents on the day shift, required at least 14 CNAs. -06/12/23 had 13 CNAs for 114 residents on the day shift, required at least 14 CNAs. -06/13/23 had 12 CNAs for 114 residents on the day shift, required at least 14 CNAs. -06/14/23 had 12 CNAs for 114 residents on the day shift, required at least 14 CNAs. -06/15/23 had 12 CNAs for 114 residents on the day shift, required at least 14 CNAs. -06/16/23 had 10.5 total staff for 113 residents on the evening shift, required at least 11 total staff. -06/17/23 had 10 CNAs for 111 residents on the day shift, required at least 14 CNAs. 6. For the week of Complaint staffing from 06/25/2023 to 07/01/2023, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows: -06/25/23 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs. -06/28/23 had 12 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
	060102	A. BUILDING: _____ B. WING _____	C 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 13 CNAs. -06/29/23 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -07/01/23 had 9 CNAs for 105 residents on the day shift, required at least 13 CNAs. 7. For the 2 weeks of Complaint staffing from 08/13/2023 to 08/26/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -08/13/23 had 11 CNAs for 103 residents on the day shift, required at least 13 CNAs. -08/14/23 had 7 CNAs for 103 residents on the day shift, required at least 13 CNAs. -08/15/23 had 8 CNAs for 103 residents on the day shift, required at least 13 CNAs. -08/16/23 had 8 CNAs for 109 residents on the day shift, required at least 13 CNAs. -08/17/23 had 9 CNAs for 103 residents on the day shift, required at least 13 CNAs. -08/18/23 had 10 CNAs for 109 residents on the day shift, required at least 14 CNAs. -08/19/23 had 7 CNAs for 109 residents on the day shift, required at least 14 CNAs. -08/20/23 had 7 CNAs for 109 residents on the day shift, required at least 14 CNAs. -08/21/23 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs. -08/22/23 had 8 CNAs for 107 residents on the day shift, required at least 13 CNAs. -08/23/23 had 9 CNAs for 107 residents on the day shift, required at least 13 CNAs. -08/24/23 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs. -08/25/23 had 12 CNAs for 107 residents on the day shift, required at least 13 CNAs. -08/26/23 had 9 CNAs for 107 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
	060102	A. BUILDING: _____ B. WING _____	C 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 8. For the 2 weeks of staffing prior to survey from 10/08/2023 to 10/21/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -10/08/23 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs. -10/09/23 had 7 CNAs for 108 residents on the day shift, required at least 13 CNAs. -10/10/23 had 8 CNAs for 108 residents on the day shift, required at least 13 CNAs. -10/11/23 had 9 CNAs for 108 residents on the day shift, required at least 13 CNAs. -10/12/23 had 10 CNAs for 111 residents on the day shift, required at least 14 CNAs. -10/13/23 had 13 CNAs for 111 residents on the day shift, required at least 14 CNAs. -10/14/23 had 9 CNAs for 111 residents on the day shift, required at least 14 CNAs. -10/15/23 had 8 CNAs for 110 residents on the day shift, required at least 14 CNAs. -10/16/23 had 9 CNAs for 110 residents on the day shift, required at least 14 CNAs. -10/17/23 had 9 CNAs for 110 residents on the day shift, required at least 14 CNAs. -10/18/23 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs. -10/19/23 had 9 CNAs for 110 residents on the day shift, required at least 14 CNAs. -10/20/23 had 8 CNAs for 110 residents on the day shift, required at least 14 CNAs. -10/21/23 had 13 CNAs for 111 residents on the day shift, required at least 14 CNAs. During an interview with the surveyor on 10/30/2023 at 09:28 AM, the Human Resource/Staffing Coordinator said the CNA ratio on day shift is 1/8, on 3-11 shift its 1/10 and 1/14	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060102	A. BUILDING: _____ B. WING _____	C 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 on 11-7 shift. When asked do you meet the requirements she replied "Sometimes we meet them. I do my best." A review of a facility policy titled Staffing with a revised date of October 2017, revealed under the Policy Interpretation and Implementation section 2. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care, in addition to State and Federal requirements.	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
315210 Y1	A. Building B. Wing Y2	12/14/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

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 F0658	Correction	ID Prefix F0693	Correction	ID Prefix F0727	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(g)(4)(5)	Completed	Reg. # 483.35(b)(1)-(3)	Completed
LSC	12/05/2023	LSC	12/05/2023	LSC	12/05/2023
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/05/2023	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?
11/2/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
060102		12/14/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 12/05/2023	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	
11/2/2023	☐ 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
	315210	A. BUILDING **01** B. WING _____	**11/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	**66 WEST JIMMIE LEEDS ROAD** **GALLOWAY TOWNSHIP, NJ 08205**

(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 11/02/2023. 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 11/02/23 was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy The Healthcare at Galloway is a three-story building that was built in 1996. It is composed of Type II - 111 protected construction. The facility is divided into eight - smoke zones. The generator does approximately 100 % of the building as per the Maintenance Director. The current occupied beds are 110 of 120.	K 000		
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.	K 511		11/7/23

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

Electronically Signed | 11/22/2023

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
	315210	A. BUILDING **01** B. WING _____	**11/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	**66 WEST JIMMIE LEEDS ROAD** **GALLOWAY TOWNSHIP, NJ 08205**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 511	Continued From page 1 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure that low voltage wiring under seven feet was in conduit in accordance with NFPA 70 National Electrical Code (2011 Edition) Article 760.130 (B) (1). This deficient practice had the potential to affect all 110 residents who resided at the facility. Findings include: An observation on 11/02/23 at 11:53 AM revealed low voltage wiring under seven feet for the fire alarm system was not protected in interior walls or in conduit in the maintenance room. During an interview at the time of the observation, the Maintenance Director verified the low voltage wiring was not protected in the walls or in conduit. NJAC 8:39-31.2(e) NFPA 70	K 511	Conduit was installed by an electrical contractor on 11/7/23 to enclose the low voltage wiring. The maintenance director inspected all areas with low voltage wiring below seven feet. No other areas were affected. Maintenance director reviewed the NFPA electrical code requirements. Monitoring of all low voltage wiring below seven feet has been added to the facility life safety rounding tool. Monitoring will be captured thru life safety rounds completed quarterly. Results of the audits will be provided to the Administrator by the Maintenance director and/or designee and will be presented for review at the Quality Assurance Improvement Committee (QAPI) meeting quarterly for a period of 4 quarters. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	
K 541 SS=F	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101	K 541		11/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315210	A. BUILDING **01** B. WING _____	**11/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	**66 WEST JIMMIE LEEDS ROAD** **GALLOWAY TOWNSHIP, NJ 08205**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 541	Continued From page 2 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure that the linen chute doors were at least one-hour fire rated in accordance with NFPA 101 Life Safety Code (2012 Edition) section 19.5.4.1. This deficient practice had the potential to affect all 110 residents who resided at the facility. Findings include: An observation on 11/02/23 at 12:48 PM and at	K 541	New 1 hour fire rated and tagged chute doors were installed on 11/13/2023. No other areas were affected. Maintenance director reviewed the NFPA Life safety code requirements for existing laundry chutes. Inspection of all fire doors and tags will be completed utilizing the NFPA door	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315210	A. BUILDING **01** B. WING _____	**11/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	**66 WEST JIMMIE LEEDS ROAD** **GALLOWAY TOWNSHIP, NJ 08205**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 541	Continued From page 3 1:25 PM revealed that the linen chute doors that were open to the corridors on the second and third floors did not have the required one-hour fire rated tag on the doors to indicate that the doors were fire rated. During an interview at the time of the observation, the Maintenance Director verified both linen chute doors were not equipped with the required one-hour fire rated tag. NJAC 8:39-31.2(e)	K 541	checklist tool. Monitoring will be captured thru life safety rounds completed quarterly. Results of the audits will be provided to the Administrator by the Maintenance director and/or designee and will be presented for review at the Quality Assurance Improvement Committee (QAPI) meeting quarterly for a period of 4 quarters. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the fire doors were inspected	K 761	Maintenance director reviewed the NFPA Life safety code requirements for	12/5/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315210	A. BUILDING **01** B. WING _____	**11/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	**66 WEST JIMMIE LEEDS ROAD** **GALLOWAY TOWNSHIP, NJ 08205**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 4 annually by an individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. This deficient practice had the potential to affect all 110 residents who resided in the facility. Findings include: An observation of the facility's fire doors on 11/02/23 from 11:30 AM to 3:00 PM revealed the doors lacked the required inspection tags to be placed on the doors after completed inspections. During an interview at the time of the observations, the Maintenance Director confirmed the fire doors were not inspected annually. NJAC 8:39-31.2(e) NFPA 80	K 761	maintenance , Inspection and testing of doors. Inspection of all fire doors and tags will be completed utilizing the NFPA door checklist tool. Monitoring will be captured thru life safety rounds completed quarterly. Results of the audits will be provided to the Administrator by the Maintenance director and/or designee and will be presented for review at the Quality Assurance Improvement Committee (QAPI) meeting quarterly for a period of 4 quarters. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315210	A. Building 01 - MAIN BUILDING 01 B. Wing	12/18/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0511	Correction Completed 11/07/2023	ID Prefix Reg. # NFPA 101 LSC K0541	Correction Completed 11/13/2023	ID Prefix Reg. # NFPA 101 LSC K0761	Correction Completed 12/05/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
11/2/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO