STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315202	A. BUILDING _____ B. WING _____	C 05/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOPATCONG CENTER	390 RED SCHOOL LANE PHILLIPSBURG, NJ 08865

(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 Complaint #s: NJ00152409 NJ00155111 NJ00163946 Census: 105 Sample Size: 5 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT SURVEY.	F 000		
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 food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: C #: NJ00163946 Based on observation, interviews, and record review, as well as review of pertinent facility documents on 5/16/23, 5/17/23, and 5/22/23, it was determined that the facility failed to a.) ensure that Resident #1 did not receive [redacted] that the resident was allergic to, and b.) check the	F 806	1. How the Corrective action will be accomplished for the residents found to have been affected The potato salad was removed from Resident #2□s tray on 5/16/23 and the resident was offered an alternate option which did not contain [redacted]	7/17/23

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

Electronically Signed | 06/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315202	A. BUILDING _____ B. WING _____	C 05/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOPATCONG CENTER	390 RED SCHOOL LANE PHILLIPSBURG, NJ 08865

(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 806	Continued From page 1 dietary menu for [redacted] allergy for 2 of 4 sampled residents (Resident #2 and Resident # 3) reviewed for food allergy. This deficient practice was evidenced by the following: During the tour of the unit on 5/16/23 at 8:56 am, the Unit Manager/Licensed Practical Nurse (UM/LPN #1) revealed that Resident # 2 had [redacted] allergies which included but was not limited to [redacted] and Resident #3 had food allergies to included but was not limited to [redacted] Review of the facility's Allergy Report, dated [redacted] reflected that Resident #2 was allergic to [redacted] and Resident #3 was allergic to [redacted] 1. According to the admission record (AR), Resident #2 was admitted on [redacted] with [redacted] allergies which included but was not limited to [redacted] The Minimum Data Set (MDS), an assessment tool dated [redacted] revealed a Brief Interview for Mental Status (BIMS) of [redacted] which indicated [redacted]. The Care Plan (CP) and Order Summary Report (OSR), reflected Resident #2 was allergic to [redacted] The surveyors reviewed the meal ticket menu options offered to Resident #2: The meal ticket menu, for Tuesday, lunch, dated [redacted] reflected that Resident #2 was allergic to "[redacted]" The meal ticket	F 806	On 5/17/23 the nurse checked Resident #3□s tray and removed the [redacted] 2. How the facility will identify other residents having the potential to be affected All residents with allergies have the potential to be affected by this practice. 3. What measures will be put into place or systematic changes made to ensure the deficient practice will not recur Dietary Aide #2 received corrective action on 5/16/23 related to the [redacted] being placed on the resident□s meal tray. CNA # 1 was re-inserviced on 5/16/23 on the need to check the meal tray against the meal ticket for accuracy prior to bringing the meal tray to the resident. CNA# 1 was given corrective action for failing to check the meal tray ticket and tray for accuracy when resident #3 were given [redacted] on 5/17/23. Dietary District manager re-inserviced Dietary staff on the Policy & Procedure for Allergies, and ensured Meal Tickets are followed to ensure residents do not receive [redacted] items they are allergic to. The Dietary District manager performed an audit on 5/16/23 on the Meal tracker and PCC to ensure all allergies are listed correctly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315202	A. BUILDING _____ B. WING _____	C 05/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOPATCONG CENTER	390 RED SCHOOL LANE PHILLIPSBURG, NJ 08865

(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 806	Continued From page 2 menu revealed "Selection 1 [redacted] Salad" was circled. During the meal observation on 5/16/23 at 12:15 pm, the surveyors observed Resident #2's ticket was at the nurse's station with a bowl of [redacted] (untouched). The UM/LPN#1 stated that the [redacted] was removed from Resident #2's room because the Certified Assistant Nurse (CNA #1) realized that the resident was allergic to [redacted] and the "[redacted] (DEPS)" was circled as indicated on Resident #2's menu/ticket. The UM/LPN further stated that CNA #1 also visualized that the [redacted] had pieces/chunks [redacted]. During an interview with the surveyor on 5/16/23 from 12:18 pm and 12:30 pm, the Registered Dietitian (RD) stated that the resident could fill out his/her meal ticket menu by her/himself. The RD stated that according to Resident #2, he/she made a mistake of circling the DEPS and cannot eat the DEPS because he/she was allergic to "[redacted] The RD further stated that Resident #2 can have [redacted] that are mixed with bread but not [redacted]." The RD explained that Resident #2 can have food that contained [redacted] such as "French toast" but not straight [redacted] During an interview with the surveyor on 5/16/23 at 12:20 pm, Resident #2 stated that he/she made of mistake of choosing the "DEPS." Resident #2 refused to answer further questions. During an interview with the surveyor on 5/16/23 at 2:03 pm, Dietary Aid (DA #1), who performed the final check and placed Resident #2's tray to the meal truck stated that he was aware that	F 806	Employees who assist in meal tray delivery were re-inserviced on the Meal Service Policy and procedure, checking meal trays for accuracy prior to serving. They were in-serviced on the Policy & Procedure for Allergic/adverse reactions, and Anaphylaxis reactions. The Dietary District Manager implemented a new process where residents having allergies have their meal tickets printed on a different colored paper, as an additional alert to staff to review the ticket for accuracy. Employees that are involved with meal service have been in-serviced on this new process. 4) How the facility will monitor its corrective actions to ensure compliance. The Dietary account manager put a Daily Dietary Allergy Audit form in place to monitor proper execution of corrective action. The Food Service Director or designee completed daily allergy audits for 4 weeks to ensure on-going compliance. The Food Service Director or Designee will perform random weekly audits on all 3 meals for 4 weeks to ensure on-going compliance, and will perform monthly audits for 6 months to ensure on-going compliance. The Unit Manager or designee audited meal trays to ensure the resident meal trays were accurate and did not contain any food items the resident was allergic to. These audits were completed daily for 1 week, then done weekly for 4 weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315202	A. BUILDING _____ B. WING _____	C 05/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOPATCONG CENTER	390 RED SCHOOL LANE PHILLIPSBURG, NJ 08865

(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 806	Continued From page 3 Resident #2 was allergic [redacted] and he did not place the DEPS on Resident #2's tray. DA #1 was unable to explained how the DEPS was placed to Resident # 2's tray, left the kitchen, and was delivered to his/her room. During an interview with the surveyor on 5/16/23 at 2:18 pm, DA #2, who delivered the food truck to the [redacted] floor, stated that she did not place the DEPS on to Resident #2's tray. DA #2 further stated that after the final tray check in the kitchen by the line checker, she does not add/remove any items from the tray. During an interview with the surveyor on 5/16/23 at 2:32 pm, CNA #1 stated that she took Resident #1's tray and brought it to the resident's room. CNA #1 stated she saw the menu which indicated Resident #1 was allergic to [redacted] the DEPS was circled. CNA #1 immediately removed the DEPS and gave it the facility's Dietitian. CNA #1 further stated that Resident #2 did not touch or eat the DEPS. Review of the "[redacted] Salad", Corporate Recipe, undated, reflected that the recipe contained "[redacted] ...1/4 each [serving]...1. Prepare Hard [redacted] per recipe. 2. [redacted] ...5. In a mixing bowl, combine remain ingredients stirring well to blend. Pour over potatoes and vegetables mixture, stirring to Review of the job description titled "Line Checker," indicated "...check trays for accuracy and place on truck" 2. According to the facility's AR, Resident #3 was admitted on [redacted], with diagnosis that included but was not limited to: [redacted]	F 806	The UM or designee will continue with monthly audits for 90 days to ensure ongoing compliance. The Food Service Director/Account manager will report the results of their audits to the QAPI Committee on a monthly basis for 90 days, or until substantial compliance is achieved. The Unit Manager or designee will report the results of their audits to the QAPI Committee on a monthly basis for 90 days, or until substantial compliance is achieved. The Administrator/DON or Designee will report findings to the Performance Improvement Committee monthly for three months. The Performance Improvement Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315202	A. BUILDING _____ B. WING _____	C 05/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOPATCONG CENTER	390 RED SCHOOL LANE PHILLIPSBURG, NJ 08865

(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 806	Continued From page 4	F 806		

The MDS dated [redacted] revealed a BIMS of [redacted], which indicated resident cognition was [redacted]

During an interview with the surveyor on 5/17/23 at 12:19 pm, CNA #2 stated that when passing tray to residents, staff must check the ticket/menu to make sure it is accurate and does not have foods that the residents are allergic to. CNA #1 further stated that she did not check Resident #3's tray and meal ticket menu today ([redacted]) for accuracy because she was distracted.

During an interview with the surveyor on 5/17/23 at 1:06 pm, the UM/LPN #1 stated that the staff must check the meal ticket for accuracy. She further stated that if the meal ticket was not check for accuracy, the staff may deliver foods that were not according to the resident's preference and/or may received foods that they are allergic to and can cause complications.

The job description for "line Checker" indicated "11:30 [am] Start lunch line, check trays for accuracy and place on truck..."

Review of the facility's policy titled "Meal Service," dated 6/1/21, reflected "...Person-centered meal service includes the delivery date of a safe, sanitary, and comfortable environment for meals which accommodates patient/resident (hereafter "patient") preference and personal choice...3.2 when serving meals in the patient 's room..3.2.2 Assure the correct meal is served to the patient..."

NJAC 8:39 - 17.4 (1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315202	A. BUILDING _____ B. WING _____	C 05/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOPATCONG CENTER	390 RED SCHOOL LANE PHILLIPSBURG, NJ 08865

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		7/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315202	A. BUILDING _____ B. WING _____	C 05/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOPATCONG CENTER	390 RED SCHOOL LANE PHILLIPSBURG, NJ 08865

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 6 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: C #: NJ00152409 NJ00163946 NJ00155111 Based on interviews, medical record review, and review of other pertinent facility documents on 5/16/23, 5/17/23, and 5/22/23, it was determined that the facility staff failed to consistently document in the "Documentation Survey Report" (DSR) the Activities of Daily Living (ADL) status	F 842	1) How the Corrective action will be accomplished for the residents found to have been affected. Resident # 1 and 3 were not negatively affected by this practice. Resident # 5 was discharged from the facility on [redacted] 2) How the facility will identify other residents having the potential to be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315202	A. BUILDING _____ B. WING _____	C 05/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOPATCONG CENTER	390 RED SCHOOL LANE PHILLIPSBURG, NJ 08865

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 7 and care provided to the resident according to facility policy and protocol for 3 of 5 residents (Resident #2, Resident #3, and Resident #5) reviewed for documentation. This deficient practice was evidenced by the following: Review of a facility policy titled "Activities of Daily Living (ADLS)," revised 5/1/23, reflected "...5. Documentation of ADL care is recorded in the medical record and is reflective of the care provided by nursing staff. ADL care will be documented in real time, as close to the time that care was provided and information obtained as possible. ADL care is documented every shift by the nursing assistant. 5.1 The licensed nurse will document ADL care they provided, when applicable..." 1. According to the Admission Record (AR), Resident #1 was admitted on [redacted], with diagnosis that included but were not limited to: [redacted]. The Minimum Data Set (MDS), an assessment tool, dated [redacted] revealed a Brief Interview of Mental Status (BIMS) of [redacted] which indicated the resident's cognition was [redacted] and the resident needed [redacted] with ADLs including [redacted]. A Care Plan (CP), initiated on [redacted] and revised on [redacted] included that the resident was dependent for ADL care. Review of Resident #1's DSR (ADL Record) and the progress notes (PN) for the month [redacted], and [redacted], lack any documentation to indicate that the care for [redacted] was provided and/or the resident refused care on	F 842	affected All residents had the potential to be affected by this practice. 3) What measures will be put into place or systematic changes made to ensure the deficient practice will not recur. Nursing staff were re-educated on the Policy & Procedure for Nursing Documentation, and specifically on consistently charting in the medical record on the residents ADL status and care provided for each shift. The Unit Manager or designee will perform weekly audits of the ADL documentation compliance report for 4 weeks, then monthly for 2 months to ensure the Nursing staff are consistently documenting the care provided and ADL status for all residents. 4) How the facility will monitor its corrective actions to ensure compliance The Unit Manager or designee will report the results of these audits to the QAPI Committee on a monthly basis for 90 days, or until substantial compliance is achieved. The Administrator/DON or Designee will report findings to the Performance Improvement Committee monthly for three months. The Performance Improvement Committee will evaluate and determine the effectiveness of the plan to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315202	A. BUILDING _____ B. WING _____	C 05/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOPATCONG CENTER	390 RED SCHOOL LANE PHILLIPSBURG, NJ 08865

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 8 the following dates and shifts; 7:00 am-3:00 pm shift on 3/9/23, 3/15/23, 3/17/23, 3/25/23, 3/26/23, 4/8/23, 4/9/23, 4/22/23, 4/23/23, 5/6/23, and 5/20/23. 3:00 pm-11:00 pm shift on 3/13/23, 4/1/23, 4/7/23, 4/10/23, 4/15/23, 4/16/23, 4/21/23, 4/24/23, 5/5/23, 5/12/23, 5/14/23, and 5/19/23. 11:00 pm-7:00 am shift on 3/14/23, 3/17/23, 3/25/23, 3/26/23, 5/14/23, 5/15/23, and 5/20/23. 2. According to AR, Resident #3 was admitted on [redacted] with diagnoses that included but was not limited to: [redacted] The MDS, dated [redacted], revealed a BIMS of [redacted] which indicated the resident's cognition was [redacted] and the resident needed [redacted] with ADLs. The CP, revised on [redacted], included that Resident #3 required assistance for ADL care. Review of Resident #3's DSR and PN for the month of [redacted] and [redacted], lacked documentation that the care was provided and/or the resident refused care for [redacted] on the following dates and shifts; 7:00 am-3:00 pm shift on 4/1/23, 4/8/23, 4/22/23, 5/6/23, 5/15/23, 5/18/23, 5/20/23, and 5/21/23. 3:00 pm-11:00 pm shift on 4/1/23 to 4/4/23, 4/7/23, 4/14/23, 4/21/23, 4/25/23, 4/26/23, 4/28/23, 5/1/23, 5/3/23, 5/6/23, 5/9/23, 5/12/23 to 5/16/23, 5/19/23, and 5/21/23. 11:00 pm-7:00 am shift on 4/14/23, 4/27/23, 4/28/23, 5/3/23, 5/4/23, 5/6/23, 5/9/23, 5/10/23, 5/13/23, 5/14/23, 5/16/23 to 5/18/23, and 5/20/23.	F 842	ensure substantial compliance is achieved and determine if further monitoring and evaluation is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315202	A. BUILDING _____ B. WING _____	C 05/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOPATCONG CENTER	390 RED SCHOOL LANE PHILLIPSBURG, NJ 08865

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 9 3. According to AR, Resident #5 was admitted on [redacted] 1, with diagnoses that included but was not limited to: [redacted] The MDS, dated [redacted], revealed a BIMS of [redacted] which indicated the resident's cognition was [redacted] and the resident needed [redacted] with ADLs. Review of Resident #5's DSR and PN for the month of [redacted] lacked documentation that the care was provided and/or the resident refused care for toileting and bed mobility on the following dates and shifts; 7:00 am-3:00 pm shift on 3/12/22 to 3/14/22, 3/16/22, 3/17/22, and 3/20/22 to 3/2822. 3:00 pm-11:00 pm shift on 3/17/22, 3/21/22, and 3/24/22 to 3/28/22. 11:00 pm-7:00 am shift on 3/19/22, 3/22/22, and 3/24/22 to 3/28/22. During an interview with the surveyor on 5/16/23 at 9:08 am and 5/17/23 at 1:06 pm, the Unit Manager/Licensed Practical Nurse (UM/LPN) stated that Certified Nursing Assistants (CNAs) were responsible for documenting the ADL care provided into the Point of Care (POC), a mobile-enabled app that runs on wall-mounted kiosks or mobile devices that enables care staff to document activities of daily living at or near the point of care to help improve accuracy and timeliness of documentation. The UM/LPN further stated that the CNAs need to document in the DSR even if the care was not provided due to refusal. She explained that the documentation must be completed in the residents' DSR by the end of each shift to show that the care was	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315202	A. BUILDING _____ B. WING _____	C 05/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOPATCONG CENTER	390 RED SCHOOL LANE PHILLIPSBURG, NJ 08865

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 10	F 842		

provided to the residents. UM/LPN also stated that she was responsible to make sure that the residents' DSR was completed at the end of the shift, however, UM/LPN could not explain why there were blanks in the sampled resident's DSR.

During an interview with the surveyor on 5/16/23 at 10:10 am, CNA #1, who took care of Resident #2 during 7:00 am to 3:00 pm shift, stated that CNAs are responsible for documenting the ADL care provided into the POC at the end of the shift. CNA #1 further stated that she would document even if the care was not provided due to refusal.

During an interview with the surveyor on 5/3/23 at 10:57 am, Licensed Practical Nurse (LPN #1) stated that the CNA's were expected to document ADL care provided to the resident by the end of the shift in the DSR. She explained that Nurses and the Unit Managers (UM) were to check the documentation to ensure that the DSR is completed at the end of the shift. LPN #1 could not explain why there were blanks in the resident's DSR but stated that they should have been completed to show that the care was/was not provided from the CNAs.

NJAC 8:39-35.2(d)(9)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062105	A. BUILDING: _____ B. WING _____	C 05/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOPATCONG CENTER	390 RED SCHOOL LANE PHILLIPSBURG, NJ 08865

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint #s: NJ00152409 NJ00155111 NJ00163946 Census: 105 Sample: 5 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 interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. This deficient practice was evidence by the following. shifts reviewed.	S 560	1) How the Corrective action will be accomplished for the residents found to have been affected. No residents were affected by this practice.	7/17/23

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

Electronically Signed — 06/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062105	A. BUILDING: _____ B. WING _____	C 05/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOPATCONG CENTER	390 RED SCHOOL LANE PHILLIPSBURG, NJ 08865

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 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. A review of the "Nurse Staffing Report" completed by the facility for the weeks of 1/29/23 to 2/11/23 and 4/30/23 to 5/13/23, revealed the staffing to resident ratios did not meet the minimum requirement. The facility was deficient in CNA staffing for residents as follows: For the 2 weeks of staffing from 01/29/2023 to 02/11/2023, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts, deficient in CNAs to total staff on 4 of 14 evening	S 560	2 How the facility will identify other residents having the potential to be affected. All residents had the potential to be affected by this practice. 3) What measures will be put into place or systematic changes made to ensure the deficient practice will not recur. Facility staff including Administrator, DON, HR coordinator, scheduling manager, Market HR and recruiters will continue all recruiting functions through various forums to increase the number of CNA applicants. Facility staff will continue weekly staffing calls with regional support team to recruit CNAs for open positions. Facility will continue to hold job fairs and to recruit for open CNA positions. The Facility started a CNA class in May 2023 which is still in progress and has scheduled another CNA class for September 2023. The HR Coord/designee, Staffing coordinator and DON will maintain a listing of current recruiting efforts. 4) How the facility will monitor its corrective actions to ensure compliance. The HR Coordinator will present the results of the current recruitment efforts to the QAPI meeting on a monthly basis for 3 months or until substantial compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062105	A. BUILDING: _____ B. WING _____	C 05/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOPATCONG CENTER	390 RED SCHOOL LANE PHILLIPSBURG, NJ 08865

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 shifts, and deficient in total staff for residents on 8 of 14 overnight shifts as follows: -01/29/23 had 8 CNAs for 106 residents on the day shift, required 13 CNAs. -01/29/23 had 2 CNAs to 10 total staff on the evening shift, required 5 CNAs. -01/29/23 had 7 total staff for 106 residents on the overnight shift, required 8 total staff. -01/30/23 had 9 CNAs for 106 residents on the day shift, required 13 CNAs. -01/31/23 had 12 CNAs for 106 residents on the day shift, required 13 CNAs. -01/31/23 had 6 CNAs to 14 total staff on the evening shift, required 7 CNAs. -01/31/23 had 5 total staff for 106 residents on the overnight shift, required 8 total staff. -02/01/23 had 6 CNAs for 106 residents on the day shift, required 13 CNAs. -02/01/23 had 6 total staff for 106 residents on the overnight shift, required 8 total staff. -02/02/23 had 5 CNAs for 106 residents on the day shift, required 13 CNAs. -02/02/23 had 7 total staff for 106 residents on the overnight shift, required 8 total staff. -02/03/23 had 10 CNAs for 106 residents on the day shift, required 13 CNAs. -02/03/23 had 6 CNAs to 14 total staff on the evening shift, required 7 CNAs. -02/03/23 had 7 total staff for 106 residents on the overnight shift, required 8 total staff. -02/04/23 had 8 CNAs for 107 residents on the day shift, required 13 CNAs. -02/04/23 had 6 total staff for 107 residents on the overnight shift, required 8 total staff. -02/05/23 had 9 CNAs for 107 residents on the day shift, required 13 CNAs. -02/05/23 had 7 total staff for 107 residents on the overnight shift, required 8 total staff. -02/07/23 had 11 CNAs for 105 residents on	S 560	The administrator will audit these efforts weekly times 4 weeks, then monthly times 3 months to ensure the center team is following up on all CNA recruitment tasks. The Administrator/DON or Designee will report findings to the Performance Improvement Committee monthly for three months. The Performance Improvement Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062105	A. BUILDING: _____ B. WING _____	C 05/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOPATCONG CENTER	390 RED SCHOOL LANE PHILLIPSBURG, NJ 08865

(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	S 560		

the day shift, required 13 CNAs.
-02/08/23 had 8 CNAs for 105 residents on the day shift, required 13 CNAs.
-02/09/23 had 11 CNAs for 105 residents on the day shift, required 13 CNAs.
-02/10/23 had 10 CNAs for 105 residents on the day shift, required 13 CNAs.
-02/10/23 had 6 CNAs to 15 total staff on the evening shift, required 7 CNAs.
-02/11/23 had 12 CNAs for 106 residents on the day shift, required 13 CNAs.
-02/11/23 had 7 total staff for 106 residents on the overnight shift, required 8 total staff.

For the 2 weeks of staffing from 04/30/2023 to 05/13/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shift, deficient in CNAs to total staff on 5 of 14 evening shifts, and deficient in total staff for residents on 3 of 14 overnight shifts as follows:

-04/30/23 had 11 CNAs for 107 residents on the day shift, required 13 CNAs.
-05/01/23 had 8 CNAs for 107 residents on the day shift, required 13 CNAs.
-05/01/23 had 6 CNAs to 14 total staff on the evening shift, required 7 CNAs.
-05/02/23 had 11 CNAs for 107 residents on the day shift, required 13 CNAs.
-05/03/23 had 7 CNAs for 107 residents on the day shift, required 13 CNAs.
-05/04/23 had 10 CNAs for 109 residents on the day shift, required 14 CNAs.
-05/05/23 had 10 CNAs for 106 residents on the day shift, required 13 CNAs.
-05/05/23 had 6 CNAs to 15 total staff on the evening shift, required 7 CNAs.
-05/06/23 had 8 CNAs for 106 residents on the day shift, required 13 CNAs.
-05/07/23 had 10 CNAs for 106 residents on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062105	A. BUILDING: _____ B. WING _____	C 05/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOPATCONG CENTER	390 RED SCHOOL LANE PHILLIPSBURG, NJ 08865

(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	S 560		

the day shift, required 13 CNAs.
-05/07/23 had 7 total staff for 106 residents on the overnight shift, required 8 total staff.
-05/08/23 had 8 CNAs for 106 residents on the day shift, required 13 CNAs.
-05/08/23 had 7 total staff for 106 residents on the overnight shift, required 8 total staff.
-05/09/23 had 12 CNAs for 107 residents on the day shift, required 13 CNAs.
-05/09/23 had 7 CNAs to 16 total staff on the evening shift, required 8 CNAs.
-05/10/23 had 10 CNAs for 107 residents on the day shift, required 13 CNAs.
-05/10/23 had 7 total staff for 107 residents on the overnight shift, required 8 total staff.
-05/11/23 had 12 CNAs for 107 residents on the day shift, required 13 CNAs.
-05/11/23 had 7 CNAs to 17 total staff on the evening shift, required 8 CNAs.
-05/12/23 had 12 CNAs for 107 residents on the day shift, required 13 CNAs.
-05/12/23 had 7 CNAs to 16 total staff on the evening shift, required 8 CNAs.
-05/13/23 had 8 CNAs for 106 residents on the day shift, required 13 CNAs.

NJAC 8:39-5.1(a)

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
315202	A. Building B. Wing	7/18/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LOPATCONG CENTER	390 RED SCHOOL LANE PHILLIPSBURG, NJ 08865

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 F0806 Reg. # 483.60(d)(4)(5) LSC	Correction Completed 07/17/2023	ID Prefix F0842 Reg. # 483.20(f)(5), 483.70(i)(1)-(5) LSC	Correction Completed 07/17/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
5/22/2023	☐ 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
062105 Y1	A. Building B. Wing Y2	7/18/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LOPATCONG CENTER	390 RED SCHOOL LANE PHILLIPSBURG, NJ 08865

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 07/17/2023	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	
5/22/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO