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	060412	A. BUILDING: _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CENTER FOR REHAB & SUB-ACUTE CAR	TWO COOPER PLAZA CAMDEN, NJ 08103

(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# 165731 CENSUS: 114 SAMPLE SIZE: 4 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 765	8:39-9.2(a) Mandatory Administration (a) The facility shall be directed by an individual who holds a current New Jersey license as a nursing home administrator. The administrator shall be administratively responsible for all aspects of the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, as well as review of pertinent facility documents, on 7/15/2023 and 7/16/2023, it was determined that the facility failed to ensure it had an Administrator of record that held a New Jersey license to provide oversight and authority over all services	S 765	S765 Element One □ Corrective Actions " The facility had a designated New Jersey Licensed Administrator (LNHA) of Record was on vacation from July 10, 2023 through July 17, 2023. The	7/21/23

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

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S 765	Continued From page 1 within the facility from 7/10/2023 to 7/15/2023. This deficient practice is evidenced by the following: On 7/15/23 at 1:06 PM, the surveyor called the facility's designated Administrator regarding a call made to the NJ Department of Health hotline. The Administrator stated that he had only been working at the facility for two weeks and acknowledged that the facility's air conditioning system was not functioning and was unsure of exact date and time it started. At 5:37 PM, on the same day, the surveyor observed a facility staff member walking up the hallway carrying a plastic, red dye analog thermometer. The surveyor stopped the staff member and exchanged introductions. The staff member stated that he was the Executive Director (ED) of the facility and had been employed there for only two weeks. The surveyor asked if he was the Licensed Nursing Home Administrator (LNHA) of the facility, and he stated that he had a LNHA license but not in New Jersey and was awaiting reciprocity in New Jersey. The surveyor asked him who the LNHA of the building was, and the Executive Director stated that he was "not sure" and that he would have to check. The ED stated that he was the designated administrator that had spoken to the surveyor on the phone earlier in the day. On 7/16/2023 Regional Licensed nursing home administrator revealed that the current LNHA was out of the country from 7/10/2023 to 7/30/2023.	S 765	Executive Director referred to in the CMS 2567 by the surveyor was a licensed Nursing Home Administrator awaiting New Jersey reciprocity and was new to the facility. In the absence of the designated LNHA the Regional LNHA licensed in New Jersey and the Director of Nursing were overseeing the facility. " The Regional Licensed Nursing Home Administrator was not present in the facility on Saturday July 15, 2023 due to religious observances but did come to the facility after sundown on July 15, 2023 and coordinated purchase and placement of portable air conditioner units, fans, and monitoring of all resident rooms and common area air temperatures. Element Two □ Identification of at Risk Residents " All residents have the potential to be affected by this practice. Element Three □ Systemic Changes " A permanent experienced New Jersey Licensed Nursing Home Administrator (previously hired) began employment on July 17, 2023 as scheduled was oriented and is working directly with the Licensed Nursing Home Administrator consultant. " The New Jersey Department of Health was notified of both the previously designated New Jersey licensed facility administrator and the new permanent administrator and provided with their license numbers as required upon hire. Element Four □ Quality Assurance " The credentials of the permanent licensed nursing home administrator were verified by the facility with the New Jersey Administrators Licensing Board records and confirmed he has a valid license in	

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S 765	Continued From page 2	S 765	New Jersey.	
S 870	8:39-9.4(e)(1) Mandatory Administration (e) The facility shall notify the Department immediately by telephone (609-633-8981, or 1-800-792-9770 after office hours), followed within 72 hours by written confirmation, of any of the following: 1. Interruption for three or more hours of physical plant services and/or other services essential to the health and safety of residents; This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 7/15/2023, it was determined that the facility failed to report to the New Jersey Department of Health that the air condition system was not working properly to maintain the temperature at 81 degrees Fahrenheit. This deficient practice was evidenced by the following: On 7/15/2023, during an on-site visit to the facility, the surveyor interviewed the Maintenance Director, who stated that the air condition system has not been working properly since 7/6/2023. The repair invoice dated 7/6/2023 revealed that the facility called on 7/5/2023 to the vendor about the air condition issue. The vendor did not come on-site to the facility until 7/6/2023. In an interview on the same day with the	S 870	S 870 Element One □ Corrective Actions " A call was placed by the facility Executive Director to the New Jersey Department of Health complaint line on July 15, 2023 regarding the excessive temperatures in some areas of the facility. " The Director of Nursing followed up with formal notification of the New Jersey Department of Health of the status of the heat emergency in the facility later in the day on July 15, 2023. " Documentation was sent to the Department of Health as required regarding the heat emergency at the facility. Element Two □ Identification of at Risk Residents	7/20/23

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S 870	Continued From page 3 Maintenance Director, he confirmed that the air conditioner problem with the facility was not reported to the DOH. The facility did not provided any documentation that this air conditioning problem was reported to DOH and there was no record at the Department indicating the event was reported as required.	S 870	" All residents have the potential to be affected by this practice. Element Three □ Systemic Changes " The process for notification of the New Jersey Department of Health when interruptions in services occur was reviewed with the Director of Maintenance, Director of Nursing, and the Administrator to ensure timely notification. " The chain of command was reviewed to ensure notification of a service interruption is reported timely to NJ Department of Health on weekends and off hours. " A weekend Manager on Duty schedule was implemented, and facility staff are notified who the manager is each weekend in the event of any interruption of services. The weekend Manager on Duty will be responsible for notifying the facility administration and the New Jersey Department of Health as appropriate. Element Four □ Quality Assurance " A root cause analysis of the emergency management communication with the New Jersey Department of Health was conducted and revisions made to the facility Emergency Preparedness Plan to assure proper communication in the event of future interruptions of services as required by Department of Health directives.	
S1090	8:39-13.1(c) Mandatory Communication (c) The facility shall notify any family promptly of an emergency affecting the health or safety of a resident.	S1090		7/20/23

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S1090	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based interviews and review of documentation, it was determined that the facility failed to promptly notify families of the residents that the air conditioning units were not functioning properly since 7/6/2023 as evident by the following: On 7/15/2023 and 7/16/2023, the surveyors were on-site to due to a heat emergency event that was left on the Department of Health hotline. Interviews with Executive Director, Director of Nursing and Maintenance Director revealed the air conditioning systems and PTAC units were not fully functioning in resident care areas on the 2nd and 3rd floors since 7/6/2023 and at the present time. On 7/16/2023, in the presence of the Regional Administrator, the surveyors asked if families were notified about the air conditioning systems not working at full capacity on the residential floors. The Administrative staff could not provide evidence that families were notified.	S1090	S 1090 Element One □ Corrective Actions " Families were notified of the air conditioner repair issue by the social worker with communication documented in the resident chart on July 16, 2023. " The facility medical director was notified of the need for repair of the air conditioning and evaluated the residents on July 17, 2023. " Residents were notified verbally on July 16, 2023 and additional scheduled Resident Council Meetings of the repairs to the air conditioning units. " Residents affected by increased temperatures were offered temporary room changes or temporary placement in cool common areas, those that refused to move were provided with portable air conditioning units on July 15, 2023. Element Two □ Identification of at Risk Residents " All residents have the potential to be affected by this practice. Element Three □ Systemic Changes " The facility Social Worker will notify responsible parties of any interruption in services that impacts residents as required by regulations. Notification will be documented with a record maintained in the resident medical record or by administration depending on delivery method □ phone, email, and/or letter. " The facility Social Worker/designee are notifying residents of potential heat waves and reminding residents of	

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S1090	Continued From page 5	S1090	precautions to take when temperatures are extreme outside and to ensure residents are able to control their room temperature to their liking and/or ask staff for assistance. Element Four □ Quality Assurance " The facility Social Worker/designee will review 10 resident charts times two weeks then 10 charts weekly for one month to ensure documentation of family and resident□s notification if any interruption of services should occur, including problems with air conditioning. Results will be reported by the Social Worker weekly at the Quality Assurance meeting, then monthly for further direction as needed.	

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F 000	INITIAL COMMENTS COMPLAINT# 165731 CENSUS: 114 SAMPLE SIZE: 4 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 VISIT. The following immediate jeopardy (IJ) situations were identified for F600, F658, and F835. During a Complaint surrvey conducted 7/15/23 through [redacted], the survey team identified the following: F600 scope and severity (s/s) of L: The survey team identified an immediate jeopardy situation for F600 (Free from Abuse/Neglect) which began on [redacted] The facility was notified of the immediate situation on [redacted] at 7:02 PM. An acceptable written Removal Plan was received on [redacted]. The surveyors verified the Removal Plan on [redacted] The immediacy was lifted on [redacted]. The facility failed to implement a system for identifying and monitoring residents and their room temperatures when their air conditioning systems on 2 of 2 resident floors were known to not be functioning or functioning at full capacity, when the outdoor temperature was [redacted] degrees Fahrenheit on [redacted] Residents on	F 000		

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F 000	Continued From page 1	F 000		

both floors were complaining of [redacted] and [redacted]. Room temperatures reached as high as [redacted] degrees Fahrenheit on [redacted]. The failure to monitor room temperatures impacted the facility's ability to self-identify a [redacted] emergency event and subsequently activate their emergency response plan to prevent [redacted] for the residents throughout their building.

Resident #1, who was dependent on staff and had known [redacted] had no air conditioning or fan and a room temperature exceeding [redacted] degrees Fahrenheit on [redacted]. The resident was hospitalized following an assessed change in [redacted]

Further, the facility's code cart was identified to not have the adequate supplies and the automated external defibrillator (AED) had pads on the [redacted] floor that expired on [redacted]

The non-compliance for F600 remained on [redacted] for no actual harm with the potential for more than minimal harm that is not immediate jeopardy.

F658 scope and severity (s/s) of J:

The survey team identified an immediate jeopardy situation for F658 (Services Provided Meet Professional Standards of Practice) which began on [redacted]. The facility was notified of the immediate situation on [redacted]. An acceptable written Removal Plan was received on [redacted] The surveyors verified the Removal Plan on

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F 000	Continued From page 2 [redacted]. The immediacy was lifted on [redacted] The facility failed to identify a [redacted] resident (Resident #1) who was complaining of [redacted] and respond in a manner that adheres to professional standards of nursing practice to assess, identify, respond, and call the physician at the time when the resident was verbalizing a change in condition caused from the enviornmental [redacted] There was no air conditioning in the resident's room, no fan, and the resident's room temperature exceeded [redacted] degrees Fahrenheit. Two LPN's and one RN who each saw Resident #1 stated that this was the resident's baseline. A night shift LPN stated that the resident might be admitted to [redacted] but was not yet on [redacted] service. The Nurse Practitioner arrived at 1:30 AM on [redacted] and assessed the resident and stated that this was not the resident's [redacted] or baseline and the resident had [redacted] and [redacted]. The resident was sent to the hospital during the early morning hours of [redacted] and subsequently admitted. The non-compliance for F658 remained on [redacted] for no actual harm with the potential for more than minimal harm that is not immediate jeopardy. F835 scope and severity (s/s) of L: The survey team identified an immediate	F 000		

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F 000	Continued From page 3 jeopardy situation for F835 (Administration) which began on [redacted]. The facility was notified of the immediate situation on [redacted] An acceptable written Removal Plan was received on [redacted] The surveyors verified the Removal Plan on [redacted] The immediacy was lifted on [redacted]. The facility's Licensed Nursing Home Administrator (LNHA) failed to: a.) safeguard the residents on the [redacted] floor from a heat-related emergency, b.) implement a system of monitoring and logging room temperatures when the air conditioning was known to not be functioning at capacity on the resident units on the [redacted] floors, c.) notify the New Jersey Department of Health (NJDOH) of the disruption of service, d.) identify high-risk residents and provide the necessary adequate cooling protections to prevent avoidable heat-related illness, e.) identify and activate their emergency response plan when temperatures in resident rooms exceeded requirements, and f.) ensure that that Director of Nursing (DON) and Executive Director covering the facility on [redacted] had knowledge and competence of the Emergency Preparedness (EP) plan, including knowledge of where the most up-to-date EP Plan was located when their facility was in a heat-related emergency. The non-compliance for F835 remained on [redacted] for no actual harm with the potential for more than minimal harm that is not immediate jeopardy.	F 000		
F 600 SS=L	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and	F 600		7/21/23

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F 600	Continued From page 4 Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: COMPLAINT# 165731 Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to: a.) identify [redacted] residents during their heat emergency and develop an individualized plan to prevent a [redacted] event when their air conditioning system and individual PTAC units were known to be shut down or not working at full capacity, b.) implement adequate and sustaining cooling measures to reduce the risk for serious harm, c.) initiate room temperature checks when air temperature on resident units were excessively humid and residents were [redacted] " and d.) appropriately activate their emergency response plan upon identification of their air conditioning malfunction in [redacted]-degree outdoor temperatures with no immediate plan to correct the HVAC malfunction. This resulted in an immediate jeopardy situation	F 600	F 600 Element One □ Corrective Actions " All Residents in the facility including Residents 1, 2, 3, 4, 6, 7, 8, 10, 11, 12, 13, were immediately assessed by the medical director for heat related signs and symptoms on [redacted]. They had previously been assessed by the Nurse Practitioner on [redacted]. " All Residents in the facility including Residents 1, 2, 3, 4, 6, 7, 8, 10, 11, 12, 13, were assessed every four hours [redacted] through [redacted] then every shift [redacted] through [redacted] by licensed nurses for signs or symptoms of heat illness. " Resident #1 was assessed by Nurse Practitioner on [redacted] and was sent to the Emergency Room (ER) and subsequently admitted with a diagnosis of [redacted]. Resident #1 had been placed on [redacted] services on [redacted]	

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F 600	Continued From page 5 for all residents residing on 2 of 2 floors of the facility (Floor). Resident #1 was dependent on staff and was identified by the Licensed Practical Nurse (LPN #3) to have a known The resident complained to the surveyor, " and Despite knowledge of the resident's diagnoses and limitations, the resident did not have functioning air conditioning or fan in their room and a room temperature exceeded degrees Fahrenheit on Resident #1 was assessed by a Nurse Practitioner and was sent to the Emergency Room due to a change in The facility's negligence to ensure room temperatures did not exceed degrees with knowledge of their malfunctioning HVAC system on and failure to implement measures to assess, monitor, and maintain the resident room temperatures on the floor from until surveyor intervention placed all residents at risk for , or from avoidable illness when resident room temperature readings were recorded as high as degrees Fahrenheit on the floor. Symptoms of when the body temperature can degrees F within minutes of exposure,	F 600	" Roommate of Resident #1 was assessed, offered a room change, or temporary placement in a temperate environment but the resident declined a room change and was provided with a portable air conditioner unit on " Additional carts were purchased on and hydration stations were placed on each unit. " Residents were provided with extra ice throughout the day as needed starting on . " The Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON) and staff were re-educated on about emergencies, identifying at risk residents, maintaining appropriate temperatures in facility, reporting interruption of services to the Department of Health, and activation of Emergency Response Plan. " The maintenance director was re-educated on about maintaining temperature logs of facility temperatures. " Nursing staff re-educated on July 16, 2023 about following procedure /policy for checking code cart and assessing functioning of Automatic External Defibrillator (AED) and expiration date of AED pads to be sure they are not expired. Checking the AED and pads was added to the code cart checklist and staff re-educated. " Nursing Staff re-educated on July 16, 2023 about recognizing and assessing for signs and symptoms of illness and reporting to	

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F 600	Continued From page 6 causing serious adverse health consequences, hospitalization and death. Further, in the event the code cart had to be utilized during the emergency on the [redacted] floor, an unlocked code cart check revealed that the cart was disorganized, had an incorrect number of [redacted]ls in the cart, expired Narcan, and there was no [redacted] devices despite it being signed off as verified by the nurse that day on [redacted]. In addition, the [redacted]) on the [redacted] floor had [redacted] that expired on [redacted], and there was no system in place for checking the functioning and expiration of the [redacted] device to ensure in the event of an emergency, the equipment would be viable and able to provide life sustaining support. The immediate jeopardy began on [redacted] and continued through [redacted], when resident room temperatures reached as a [redacted] 1 degrees Fahrenheit. The facility administration was notified of the immediate situation on [redacted] at 7:02 PM. The facility submitted a written removal plan on [redacted] 3 at 6:29 AM, and the immediacy was lifted on [redacted] through observation, interview, and review of facility documents. The evidence was as follows: On [redacted] at 1:06 PM, the surveyor called the facility's designated Administrator regarding a call made to the NJ Department of Health hotline. The designated Administrator stated that he had only been working at the facility for two weeks and acknowledged that the facility's air conditioning system was not functioning. He stated he was unsure of the	F 600	supervisor/designee any temperature abnormalities and transferring residents to appropriate temperate areas. " Emergency Preparedness Plan binders were placed on each unit, and front lobby desk, nursing office and Administrators□ office. Staff were re-educated on the location of Emergency Response Plan in the binder. " Temperature log was utilized to monitor and track room temperatures on [redacted] " All residents were assessed by nurse practitioner on [redacted] for signs and symptoms of heat related illness and a list of diagnosis was determined to identify at risk residents. Those diagnoses included, but are not limited to, [redacted] To further identify at risk residents, a BIMS score was obtained. Those residents unable to effectively communicate their feelings of comfort, unable to ambulate, with a BIMS<12 or shift/roll independently were placed on higher acuity level and assessed as a priority for [redacted] illness or discomfort. An at risk list of residents was created, and care plans updated. " All residents were assessed and documented on by facility Medical Director on [redacted] as required in the directed plan of correction with results sent to the New Jersey Department of Health. " All residents affected by increased room air temperatures were offered temporary room changes or temporary placement in cool common areas on [redacted]	

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F 600	Continued From page 7 exact date and time it started not working. He stated that some parts of the facility had air conditioning but other resident areas were limited. The surveyor asked about the current temperature readings in the facility, and he replied that he was not sure of any exact numbers or temperature ranges. The surveyor asked if any residents have been affected and he stated he was not sure, because he was not in the building. He added that they purchased 15 fans and water stations, and that they were assessing residents. He stated that they could move the residents into a cooler area but that there were no vacant rooms that had a functioning air conditioner unit, so there were no available resident rooms in which residents could be relocated. The designated Administrator stated that they were utilizing every working air conditioner unit available and that they are following their Emergency Heat Plan including hourly rounding and vital signs. He stated that if a resident has a change in condition or other signs/symptoms that would warrant a higher level of care, the physician would be notified. He added that the Director of Maintenance and Regional Maintenance were aware and were working on the HVAC issue. From 1:30 PM to 2:30 PM, the surveyor attempted to call the designated Administrator three separate times to request additional information regarding their heat emergency, but he did not answer or return the voicemail's left. On 7/15/23 at 2:44 PM, the surveyor called the facility and spoke to a Security Guard (SG #1) at the front desk regarding a call made to the NJ Department of Health hotline. The surveyor asked the security guard if he could connect this	F 600	[redacted] and [redacted]. " Facility purchased in room portable air conditioners and placed one in each resident room on [redacted]. " Facility rented six 5-ton portable air conditioner rentals and placed 2 on each floor in hallways/common areas on [redacted] " Temperatures were monitored every 2 hours until facility temperatures maintained at temperatures per regulation x 72 hours, then every shift indefinitely. " All Residents and responsible parties were notified about the heat emergency and provided with the option to change rooms to a cooler location if desired. Element Two □ Identification of at Risk Residents " All Residents have the potential to be affected by this practice. Element Three □ Systemic Change " The main air conditioning units were repaired and working without issue and the facility common areas and resident rooms within acceptable temperature range on [redacted]. The department of health was informed of the repairs. " PTAC units on special order are installed as received in resident rooms. In the interim every resident room continues to have a portable air conditioner unit easily controlled by residents and staff that have maintained appropriate air temperatures. " The Emergency Preparedness binder was updated by the facility administrator with the Administrator and Director of Nursing consultants□ input. Staff received re-education about changes in	

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F 600	Continued From page 8 surveyor to a nurse and he attempted for each floor but to no avail. At that time, the surveyor asked to speak to the Nursing Supervisor, and SG #1 stated that there was no nurse supervisor or maintenance worker in the building until [redacted]. He stated that the resident census today was [redacted] and that there was no functioning air conditioner on both the [redacted] floors since at least [redacted] and that the facility is only using fans to circulate the air. The surveyor asked if there were portable air conditioners in use, and the security guard indicated that there were none in use because it was "hot in the building." When asked if he was aware of any resident complaints regarding the issue, he replied, "Yes, the residents are complaining it is hot and humid up there." The surveyor asked if anyone was taking room temperatures, and he stated that no one was taking room temperatures that he was aware of, but that he was not involved in that process. The surveyor followed up if anyone had notified any local authorities regarding the [redacted] situation, and the security guard stated that he didn't get involved in notifying any police, fire or local Office of Emergency Management (OEM) if the residents are complaining of it being hot when the air conditioners are not working. The surveyor asked if he knew of any residents that had to go to the hospital regarding the heat, and the security guard stated that he didn't think so, but he wouldn't know for sure. He was unable to provide the surveyor with any phone numbers of the Director of Maintenance or any key personnel that would be able to speak to the issue any further. On 7/15/23 at 5:02 PM, the surveyor arrived at the facility for an unannounced visit to investigate the issue regarding the malfunctioning air	F 600	the plan. " The DON consultant assisted with re-evaluating each resident and creating a unit based triage list based on acuity level in the event of an emergency. The interdisciplinary team including unit managers and nursing management were involved in the process. " New code carts were purchased and placed on each unit with a checklist of contents and expiration dates and is checked daily. The [redacted] is installed by the code cart and its function and pads are included on the checklist. " Staff received re-education about communicating air temperature concerns to the supervisor for immediate action. Staff have been re-educated in checking room air temperatures and the use of portable air conditioner units and PTAC units. " The Director of Nursing consultant attends clinical meetings and has re-educated the Director of nursing and the nursing management team of their role and responsibilities during emergency situations. " The permanent Licensed Nursing Home Administrator (LNHA) of Record began employment on [redacted] replacing the temporary LNHA and the executive director. " The consultant Administrator and consultant Director of Nursing began services on [redacted] as required by the directed plan of correction and are onsite a minimum of 40 hours including weekends and off-shifts. " The contracted security guards were	

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F 600	Continued From page 9 conditioning system at the facility. The surveyor noted that the local outdoor temperature at that time was [redacted] degrees Fahrenheit and the weather was sunny and humid. The surveyor entered through the main lobby and noted a heavy duty floor fan blowing air across the floor with a long extension cord. The surveyor observed a Security Guard (SG #2) at the front desk and the surveyor asked the SG #2 about the fan on the floor, and he stated that he didn't know why it was there. He acknowledged that it was not there for a housekeeping reason. The surveyor asked if the facility had any issue with maintaining air temperatures in the building, and the SG #2 stated that he didn't know anything as he just started his shift and was filling in for someone else. At 5:07 PM, the surveyor interviewed the Registered Nurse/Supervisor (RN/S) who stated that he started the shift at 3 PM and that he took over for another nurse supervisor. At that time, the RN/S didn't want to answer any of the surveyor's questions and called the Director of Nursing (DON). At 5:09 PM, the surveyor conducted a phone interview with the DON. The DON stated that the air conditioning in the building was not functioning due to a "sparking" issue, and it had to be shut down, but that the facility had implemented hydration stations and ice in response. She stated that she "did not know the mechanics of the issue but the Regional Maintenance was on-site working on the issue." She stated that he should be on the roof right now looking at the issue. She stated they had been working on resolving it since [redacted] because there was no air conditioning in the	F 600	instructed to report concerns about air temperatures to the Administrator, Director of Nursing, Maintenance Director, or Supervisor dependent on their shift. Element Three □ Systemic Change " A weekend Manager on Duty schedule was implemented, and a list of responsibilities provided to each manager that includes proper notification and reporting of any systems issues. Element Four □ Quality Assurance " Unit Manager/designee will update the emergency triage acuity list on each unit with resident changes in condition and to add new admissions. Changes in conditions are discussed at clinical meetings. " The Assistant Director of Nursing (ADON)/ designee will audit the emergency triage acuity lists on each unit weekly for four weeks and then monthly for two months to be sure the lists are updated and reflect each resident□s acuity level. Findings will be reported at the monthly quality assurance performance improvement meeting for action as appropriate. " The Maintenance Director/designee will monitor room and common area temperatures every two hours x 48 hours, then every shift x 14 days and daily thereafter with no stop date. Results are reported to the administrator and emailed daily to the department health until substantial compliance is achieved. Results are also shared at the weekly Quality Assurance Performance Improvement (QAPI) meeting for action as appropriate.	

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F 600	Continued From page 10 kitchen. She stated that the air conditioning only affected the kitchen yesterday and not the resident areas. She stated because they knew the weather was going to be hot today, they purchased fans and water stations for the resident units just as a precaution. The DON also added that a nurse called her today to inform her that the building was warm. The surveyor asked the DON when the sparking issue occurred that required the shut down of the system, and the DON could not speak to an exact date. She could not speak to air conditioning issues within the resident units adding no residents told her it was hot and "no one complained" to her. She stated that they purchased fans yesterday. The surveyor asked why they purchased fans for the residents if it was not hot indoors and if the air conditioning was functioning on the units, and the DON stated that it was because they anticipated the weather to be hot outside today and reiterated that it was just for an added "precaution." The surveyor asked if she had been on the resident units and felt a difference in air temperature, and the DON replied that "I'm tropical, so heat doesn't hit me like the rest." The DON stated that it may have been a bit warm, but since no one complained to her that it was hot in the building, it couldn't have been too hot. She continued to stated that the Director of Maintenance purchased the fans and returned to the facility today to find out more about the status of the air conditioning system. The surveyor asked what floors were affected, and the DON stated that it was only the [redacted] floor far hallway that was affected which was where they put all the fans. The surveyor asked if there were any fans brought to the second floor, and the DON replied that there were "no fans on the	F 600	" The Administrator/designee makes random daily rounds with the maintenance staff to confirm room air temperatures and assure the comfort of residents. Results are discussed with the Director of Nursing daily and in aggregate at the weekly Quality Assurance Performance Improvement (QAPI) meeting for further action as appropriate. " The Director of Nursing/designee will audit 5 random at-risk residents medical records for signs and symptoms of heat related illness daily x 7 days, weekly x 4 and monthly x 2. Findings are discussed at clinical meetings and acted upon as appropriate. Results are shared in aggregate at the weekly Quality Assurance Performance Improvement (QAPI) meeting for further action as needed. " The Assistant Director of Nursing/designee will monitor all code carts to ensure they are adequately stocked, and Automatic External Defibrillator pads are not expired daily x 7 days, weekly x 4 weeks and monthly thereafter. Results will be provided to the Director of Nursing and shared at the weekly QAPI meeting.	

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second floor." The surveyor asked if there were any temperature checks being done on any of the resident units and the DON stated that she didn't know about any room temperature checks being done.

At 5:19 PM, the surveyor toured the [redacted] Floor. Upon entering the unit, the unit felt noticeably warm and humid. At that time, the surveyor interviewed a Licensed Practical Nurse (LPN #1) who was in the hallway and stated that he works the evening shift and that the air conditioner within the facility "broke" and that some of the resident rooms on the second floor do not have functioning air conditioning in their rooms. He stated that while some of the residents do not have air conditioning in their rooms, no residents have complained to him directly about[redacted]. The surveyor asked if room temperature readings were being taken on the floor and the LPN #1 stated that he doesn't know about that. The surveyor asked how long the air conditioning has not been functioning, and the LPN #1 stated, "since the start of this season." The surveyor clarified what the start of the season meant, and he stated since the start of summer. The surveyor observed a fan at the nurses station and a cooler with water.

At 5:22 AM, the surveyor observed Resident #4 in a wheelchair in their room. The resident's roommate was in bed. The surveyor felt that the room was[redacted] The roommate of Resident #4 stated to the surveyor that the room was[redacted]" but reported "[redacted]." Resident #4 stated that it wasn't just warm, [redacted]" The resident added that the air conditioner in the room has not been working.

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The resident stated that everyone knows about it, including the nurse. The surveyor asked what the facility did to address the issue, and the resident stated that the roommate got a small fan, but that he/she got "nothing." Resident #4 stated that [redacted]." The surveyor observed that there was no air coming out of the packaged terminal air conditioner (PTAC) unit in the resident's room, despite the unit indicating that it was "on."

At 5:25 PM, the surveyor brought LPN #1 into the room of Resident #4 and asked about the air conditioning and the LPN #1 stated that the resident's PTAC unit was not functioning in their room. The LPN #1 attempted to adjust the PTAC unit by playing with the switches and attempted to turn it on again, but there was no air coming from the vent. The LPN #1 stated that "it's not working." The LPN #1 confirmed that there was no air conditioner and no fan in the side of the room belonging to Resident #4. The LPN #1 acknowledged that the room was "very warm" but could not speak to the actual temperature of the room.

At 5:27 PM, the surveyor interviewed an unsampled Resident #6 who was observed to be in a wheelchair in their room. There was a small box fan on the floor, and the room felt very warm. The surveyor interviewed the resident who stated that it was "[redacted]." The resident stated that the PTAC unit in the room had been broken since at least Thursday, so his/her granddaughter delivered the fan from home which helped. The surveyor asked if staff knew that the PTAC unit was broken, and the resident replied that "Everyone knows it's hot in these rooms!" The

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surveyor asked about when it would be fixed and the resident replied that no one told them. The resident asked that the surveyor feel the air that was coming from the PTAC unit stating that the air was warm and not cold despite it being on the coldest setting. The surveyor and the resident both felt the vent, confirming the resident's statement. The resident denied that anyone had been checking room temperatures on the floor or in their room. The resident stated that he/she was provided ice.

The surveyor continued to tour the unit and observed that room [redacted] had a portable air conditioner unit in their room.

At 5:33 PM, the surveyor observed Unsampled Resident #8 in their room. The resident stated that their air conditioner PTAC unit in their room had been broken for days and that nobody had been making an effort to fix it. The resident stated that the facility delivered water and ice instead. The surveyor observed a fan positioned toward the resident.

At that time, the surveyor observed the resident's roommate, Unsampled Resident #7 who stated, "[redacted]" and that staff were supposed to deliver ice but that they only bring it if he/she asks for it. The resident elaborated that it was hot "[redacted]". The surveyor observed the roommate's fan blowing toward the closed curtain which was blocking air from circulating into the resident's side of the room. The resident stated that he/she did not get a fan, "but my roommate does." The resident reported that he/she wanted a fan because of how hot it has been in their room.

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The resident reported that the air conditioner in their room has been broken for a few days.

At 5:37 PM, the surveyor observed a facility staff member walking up the hallway carrying a plastic, red dye analog thermometer. The surveyor stopped the staff member and exchanged introductions. The staff member stated that he was the Executive Director (ED) of the facility and had been employed there for only two weeks, he acknowledged that he was the designated Administrator that spoke to the surveyor today by phone. The surveyor asked if he was the Licensed Nursing Home Administrator (LNHA) of the facility, and he stated that he had a LNHA license but not in New Jersey He stated that he was awaiting reciprocity in New Jersey. The surveyor asked him who the LNHA of the building was, and the Executive Director stated that he was "not sure" and that he would have to check. He stated that he was currently taking a temperature on the floor using the [redacted] He held it up for the surveyor while on the back end of the [redacted] floor hallway near room [redacted]. The ED confirmed that the temperature on the thermometer was reading [redacted] degrees Fahrenheit, stating that the analog thermometers are "hard to tell" an exact temperature. The surveyor asked the ED if that was how the facility was checking temperatures on the floor, and he stated he was only using the [redacted]r temporarily, and that he believed that they had an air temperature gun for checking indoor air temperatures. He stated that he would have to go find it.

At 5:41 PM, the surveyor observed the [redacted] LPN (LPN #2) walking down the hallway. The surveyor interviewed the LPN #2 who stated she

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had worked at the facility for [redacted] years. The surveyor asked her about the use of the fans on the unit, and the LPN #2 stated, "I don't get hot" and "it feels pretty cool right now" on the unit. She stated there have been issues on the floor with the air conditioners for a little while now, but that was why there were fans throughout the unit and in resident rooms. The LPN #2 stated that she did not know what the room temperature readings were and had not seen staff take room temperatures. The LPN #2 explained that if anyone takes the temperatures of the room, "They don't show them to me." She stated that the only thing she had to do different was to give residents water and ice, and monitor the residents by checking in on them. She stated that she could ask the residents how they feel, touch their skin to determine if their skin was hot, and if so, she could relocate them to a cooler location.

At 5:48 PM, the ED returned to the [redacted] floor with the room temperature dual laser, infrared thermometer gun. The ED took the temperature in the room belonging to Unsampled Resident #9 who resided near the window. The resident stated to the surveyor and ED that '[redacted]' The resident had no functioning air conditioner in their room and no fan. The ED stated that he will have more fans brought up that were just purchased.

At 5:50 PM, the ED told the surveyor that room temperatures were not to exceed [redacted] degrees Fahrenheit (F) according to the regulation. The ED took the following room temperatures on the [redacted] floor:

1. Room [redacted] degrees F. There was no fan

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or air conditioner in the room
2. Room [redacted] degrees F. There was no fan or air conditioner in the room.
3. Room [redacted] degrees F.
3. Room [redacted] degrees F.
4. Room [redacted] degrees F.

At 5:56 PM, the surveyor and ED returned to the room of Resident #4 where there was no air conditioner or fan and the resident had complained of it being [redacted]" at 5:22 PM. The room temperature reading was [redacted] degrees F. The ED stated that the room felt "too warm." The surveyor asked him what the plan was for this resident and other residents on the floor, and he stated that he would try and bring more fans. He acknowledged that not all residents had fans and air conditioning in their room and that the outdoor temperature reading was currently [redacted] degrees F. He could not speak to when the air conditioner and PTAC units would be fixed for the residents. The surveyor asked how long there had been fans on the [redacted] floor and the ED wasn't sure. The surveyor informed the ED that the DON had stated that there were no fans in use on the [redacted] floor. He stated that there were fans clearly in use on the [redacted] floor and couldn't speak to why the DON would say there were no fans in use on the second floor, except that maybe she didn't know that there was an air conditioner issue on the [redacted] floor.

At 5:59 PM, the surveyor was introduced to the Director of Maintenance (DoM) who stated that he had only been employed by the facility for approximately four months since [redacted] The DoM stated that the "last few days it's been hot in the facility" and that there had been issues with the air conditioning systems. He stated that

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the facility had several bids out since the beginning of [redacted], since there was a leak in one of the systems. He added that there was also an "air handler with a bad condenser for the [redacted] floor." He continued, that in addition to the [redacted] floor, the [redacted] floor had an issue with the air conditioner system causing "sparking" which required the entire air conditioning system on [redacted] to be shut off "or there would be a fire." The DoM stated that they received a bid on July 6th to address the problem, but it was not processed until yesterday on [redacted] and the bid was for [redacted] or so to diagnose the problem. The surveyor requested documented evidence of that diagnostic visit from the company and the findings. He stated that he didn't have a copy of it, but that he would look into finding out if anyone did.

At that time, the surveyor observed that the DoM was holding a clipboard and loose leaf paper with a hand-written heading "[redacted])" and a list of resident rooms written under it. It was not dated. The surveyor asked the DoM about the list, and he stated that he has not HVAC licensed, but that he had been working on changing the malfunctioning PTAC units in the resident rooms and had made a list. He stated that he started this list about two weeks ago when he began replacing the units. The list indicated that there were three rooms that had "new" PTAC units, rooms [redacted] and [redacted]. The DoM confirmed that those rooms he had replaced the PTAC units with new ones and that the other [redacted] rooms had PTAC units that "did not work." He stated that the process of replacing them had been going slow because he was "only one person." The surveyor asked what has been done for these other resident rooms when the PTAC units do not work

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due to the heat, and the DoM stated that they purchased ten portable air conditioner units and put some of them in resident rooms, in addition to the purchase of 30 fans. The surveyor requested a receipt of the purchases. The surveyor asked other than purchasing 30 fans and ten portable air conditioner units, what had been doing regarding the malfunctioned air conditioning and he added that he purchased four to five jugs of water at [redacted] yesterday and 12 bags of ice, but other than that he had not been doing anything else. The DoM stated that the air handlers won't be fixed for a few days but that there was no definitive date because the bid had only been processed yesterday. He stated that he should be checking room temperatures, and indicated he did check a temperature earlier and it read [redacted] degrees F in a resident area. The surveyor asked where and when that was taken, and he could not speak to it. The surveyor asked if he kept any logs of temperature readings while the air conditioning system had been malfunctioning or not working at full capacity and the DoM stated that there were no room temperature logs. He stated that the last time he kept a room temperature log was "about a month ago" and had given it to the former administrator but "he's gone." The DoM confirmed there were no room temperature logs and could not speak to how the facility was monitoring for compliance with temperatures if they were not checking them over a given period of time and recording them. The DoM stated that the resident rooms were generally cooler than the hallways, but the DoM was unable to provide any documented evidence of that being the case.

At 6:07 PM, the surveyor continued to interview the DoM who stated that he does not routinely

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check room temperatures, but that he uses the thermostats on each floor to determine if temperatures needed to be checked on the floors and that he looks at the thermostats "all day everyday." He stated that if the thermostats read above [redacted] degrees F, he would go and take temperatures of the resident rooms. The surveyor and the DoM checked the thermostat reading on the [redacted] floor which is not a resident unit. The thermostat read [redacted] degrees F.

At 6:11 PM, the surveyor and the DoM went to the [redacted] floor thermostat. The thermostat which was serving the front end [redacted] up to the double doors, read a temperature of [redacted] degrees F. The thermostat for back end of [redacted] was reading [redacted] degrees F.

At 6:13 PM, the surveyor observed that there was no ice in the cooler, and the Certified Nursing Aide (CNA #1) stated that she had just passed out ice to the residents and that she would have to replenish what was in the cooler. The DoM and surveyor observed the thermostat that was for the entire [redacted] unit which read [redacted] degrees F.

At 6:16 PM, the DoM stated to the surveyor that he only works [redacted] and that the nursing staff should be taking room temperatures on weekends. He could not speak to how or when they take room temperatures. (This did not correspond with the interviews with LPN #1 and LPN #2 who stated that they were not aware of staff taking room temperatures nor were they involved in the process).

At 6:18 PM, the surveyor and the DoM entered the [redacted] floor through the elevators. Upon exiting

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the elevator, the surveyor felt the floor to be very warm and humid in the hallways. The surveyor observed with the DoM that there was no ice in the ice cooler. The surveyor and the DoM observed the thermostat reading for the front end of [redacted] which indicated a reading of [redacted] degrees F, and the back end of [redacted] thermostat read it was [redacted] degrees F.

At 6:25 PM, the DoM took the surveyor to the [redacted] unit. At that time the DoM reiterated that the thermostat had no reading on the unit because the system had to be shut down due to sparking. He stated that the overload relay and heavy duty relay were both bad which caused the sparking. He stated that they shut the machine down on [redacted] because of the fire risk. He stated that the switch is located in the ceiling and acknowledged that because the switch was off, this was why there was no thermostat reading.

A review of the weather history report for Camden, New Jersey reflected the following high outdoor temperatures since 7/6/23:

7/6/23: 91 degrees F,
7/7/23: 91 degrees F,
7/8/23: 90 degrees F,
7/9/23: 85 degrees F,
7/10/23: 86 degrees F,
7/11/23: 89 degrees F,
7/12/23: 91 degrees F,
7/13/23: 93 degrees F,
7/14/23: 89 degrees F,
7/15/23: 92 degrees F.

At 6:29 PM, upon entering the [redacted] wing, the air on the unit was very hot and heavy causing the surveyor to feel sweaty instantly while walking

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F 600	Continued From page 21 down the hallway. As the surveyor and DoM toured the [redacted] wing, the surveyor noted beads of sweat dripping from the DoM forehead. The DoM acknowledged that it was very hot and uncomfortable on this unit, yet residents were in their rooms and some were in the hallways. Indoor temperature checks began and revealed the following: [redacted] hallway: [redacted] degrees F. Room [redacted] degrees F. Room [redacted] degrees F. There was no fan or air conditioner on in the resident's room and both residents were in bed in their room. The DoM stated that the air conditioner was not turned on and he turned the PTAC air conditioner on. The surveyor attempted to interview the residents in that room but the residents who were both [redacted] to the surveyor. Both residents were [redacted]. At 6:33 PM, the surveyor observed the LPN #3 assigned to [redacted] in the hallway passing out medications to residents. The LPN #3 stated that the temperatures on this floor were "[redacted]" The surveyor asked about the temperatures, and if she had to do anything different in response to the heat situation on the unit, and she stated that she was assigned [redacted] residents this shift and that she just had to pass out medications, do [redacted] of residents and perform basic resident care. She stated that we can encourage hydration and take vital signs and skin turgor if a resident becomes confused, but otherwise there was nothing different that she had to do. The surveyor asked if any residents had to be hospitalized due to a change in condition, and she stated that there were no residents hospitalized.	F 600		

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F 600	Continued From page 22 At 6:35 PM, the DoM took the room temperature of Unsampled Resident #10 which read [redacted] degrees F. The resident was [redacted] in bed in the room by the door had no fan and no air conditioner. The room by the window had an orange fan on the floor positioned between the bed and the window. Any airflow that was being produced by the fan was getting blocked by the bed and not reaching the unsampled Resident #10. The window was slightly open. The surveyor attempted to interview the resident, but the resident appeared [redacted] to be interviewed. At that time, the LPN #3 entered the resident's room and took a set of vital signs. The resident's body temperature was [redacted] F, the heart rate was [redacted] beats per minute, the blood pressure was [redacted] and the pulse oxygenation status was [redacted] on room air. The surveyor did not see the LPN #3 count a respiratory rate and she exited the room with the vital sign machine. At that time, the LPN #3 stated that there was a resident (Resident #1) who had known [redacted] support and resided a few doors down the hall. At approximately 6:38 PM, the surveyor continued to interview residents on [redacted]. The surveyor observed unsampled Resident #11, who was [redacted]. The resident stated that [redacted] !" The resident continued to state, [redacted] " and [redacted] adding that he/she has two fans and that the air conditioner in their room is broken. (This resident's room was not on the DoM list of malfunctioning PTAC units).	F 600		

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The resident continued to state that he/she had [redacted] and because of the heat, he/she had to utilize their [redacted] with an [redacted]. The resident stated that sometimes they were provided ice, but the facility didn't have ice to give out yesterday. The resident stated that he/she didn't think they had ice today either, and added that "I [redacted]!" At that time, the resident called for the LPN #3 to request for ice. The LPN #3 took the resident's cup to get ice, and she returned and stated that "[redacted]" The LPN #3 put the resident's cup back on their bedside table and left the resident's room. The resident stated to the surveyor, [redacted]!" She stated that they may get ice in the morning, but that was it.

At approximately 6:42 PM, the surveyor observed Resident #1 in bed next to the window. The resident was [redacted], appeared [redacted] and the room felt hot. The resident had no fan and no air conditioning in the room. The surveyor interviewed the resident at that time, and the resident stated, [redacted]" and the resident began to [redacted] from his/her [redacted]. At that time the resident stated, [redacted] The surveyor observed [redacted] running [redacted] from the wall, but the resident was not wearing the [redacted] The surveyor asked the resident if he/she utilized [redacted] and the resident responded that he/she would put it back on and wear it. The surveyor observed the resident place the [redacted] and take some [redacted]

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F 600	Continued From page 24 through the [redacted]. The resident confirmed there was no fan or air conditioning in their room, yet Resident #1 was known by LPN #3 to have known [redacted]. The resident stated he/she would call the nurse. At 6:58 PM, the surveyor and the ED took the room temperature of a recreation room on the [redacted] floor which felt cool. There were three ambulatory residents in there but no staff. The ED stated that the "air conditioner works in here." The temperature read [redacted] degrees F. At that time, the ED stated that "heat is subjective to a person" and that residents may be comfortable in this heat and not want to leave their rooms. He stated that as long as the residents health was okay, they have a right to stay in their rooms and if their health deteriorated from the heat, then they would remove them. The surveyor asked the ED why they would wait until a residents health deteriorated before proactively addressing the issue for each resident regarding the room temperatures, and the ED stated that they need to be proactive and not wait, but if residents don't want to move, they don't have to. The surveyor inquired how the facility was keeping the resident's rooms at an acceptable temperature for those that may not want to move or those that cannot verbalize it, and the ED stated that they provide ice, or the staff can provide a cool cloth for their face to cool the body down, offer and provide fans, and some residents received portable air conditioning units. He acknowledged that not all residents have fans despite their malfunctioning air conditioner units in their room and within the unit. He acknowledged that when conducting tour, no residents had a cool cloth on them.	F 600		

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F 600	Continued From page 25 At 6:59 PM, the surveyor and the ED returned to the room of unsampled Resident #10 who was in bed. There was still no air conditioning and the airflow of a floor fan was being blocked by the roommates bed. The room temperature reading indicated [redacted] degrees F. At 7:00 PM, the surveyor and the ED went to the room of Resident #2 who was in bed and awake. The resident's bed was against the wall adjacent to the window and PTAC unit. There was a large [redacted] on the floor adjacent to the resident's bed acting as a [redacted]. The resident's bedside table was at the foot of the bed and a pitcher of warm water was resting on the bedside table out of the resident's reach. The PTAC unit was turned on from when the surveyor observed the DoM turn it on around 6:30 PM. Only a small amount of warm air was flowing from it. There was no fan in the resident's room. The surveyor and the ED both attempted to interview the resident but the resident's words were soft and inaudible. At that time, the ED took the temperature of the resident's room which read [redacted] degrees F. The surveyor asked the ED about the observation of the situation where Resident #2 was unable to be effectively interviewed, had no air conditioning, no fan, was [redacted], and did not have access to water within reach. The ED acknowledged the surveyor's concerns. The surveyor asked about how the facility chose to prioritize the use of fans and portable air conditioner units and why Resident #2 and his/her roommate was not afforded a method to maintain the temperatures in their room when they could not speak up. The ED acknowledged the surveyor's questions and acknowledged that [redacted] degrees was too hot for	F 600		

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the residents, and that they would move them to the recreation room. The ED stated that he didn't know if doctors were called or how often nurses check or should check the vital signs in this situation. He stated that the staff go around asking if the residents are feeling okay or if they are hot.

At that time, the surveyor followed up with the ED about if he found out who the LNHA is of the facility, and the ED stated that he did not have their name yet, but the reason the LNHA was not in the building today was because it was a [redacted] and it was the religious [redacted]

At approximately 7:05 PM, the surveyor entered the DON's office with the ED. The DON was in her office which was adequately air conditioned. The DON provided the surveyor the name of the LNHA on record and stated that she doesn't know where he is, and that she tried calling him, but he didn't answer the phone because it was Saturday and his religious [redacted]. The DON stated that she only started working at the facility again in [redacted], and that the Regional LNHA was the LNHA on record in [redacted]. She stated that the new LNHA started on or around [redacted].

The DON continued to explain again that the DoM informed her only yesterday about the air conditioner issue and the room temperatures. She stated that there was a previous issue with temperatures and the air conditioner system that needed replacement and explained, "I don't know if its been replaced." The DON added that she was aware of a thermostat reading of [redacted] degrees F and a room that was [redacted] degrees F, but that fans and hydration stations were purchased yesterday because they knew it would be very hot

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outside the next day. The DON and ED acknowledged that there were no room temperature logs and that they never instructed anyone to take and log temperatures. They acknowledged that if temperatures were not monitored and logged, there can't be knowledge of and action for the out of range indoor temperatures, especially when outdoor temperatures were [redacted] degrees F. Temperatures of the second and third floors were discussed with the DON and ED and the residents complaining of it being hot, humid and that they were sweating. The DON began stating that the residents were "comfortable" and "not in distress" and didn't want to leave their rooms. She stated that no residents complained to her about the heat. The surveyor asked the DON if she would wait until the residents were in distress before responding to the lack of adequate temperature control in their facility, and the DON could not speak to it, insisting that the residents were comfortable. The DON acknowledged that the interruption in air conditioning service wasn't reported to the NJDOH until today after the NJDOH had reached out to her.

The DON stated that she believed the room temperature requirement was not to exceed [redacted] degrees F. She stated that she she was not aware that the air conditioner system was shut down on [redacted]

At 7:23 PM the surveyor and New Jersey Department of Health (NJDOH) management who conferenced in telephonically informed the DON and the ED that the facility's failure to maintain adequate room temperatures in accordance with regulatory requirements, implement a system to monitor room

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temperatures when the air conditioning systems were known to not be operational or not functioning at full capacity during the heat of the summer months, including today when it was [redacted] degrees F outside, failure to identify high-risk residents to ensure they had adequate temperature control to reduce the risk for a heat related emergency, with limited access to sufficient cooling areas in the facility placed all residents on both floors in an immediate safety risk situation that required the activation of their Emergency Response Plan and the local Office of Emergency Management (OEM).

The ED stated he would find the phone number of the local OEM and notify them.

At 7:46 PM, the surveyor returned the [redacted] unit and interviewed the unsampled Resident #12 who stated, "[redacted]" and "[redacted]." The resident's roommate, unsampled Resident #11 stated that he/she was also [redacted] and that no one has offered them [redacted] for comfort or ice and that he/she only sees staff "[redacted]." Both residents reported that no one has checked their vital signs.

At 7:49 PM, the surveyor returned to the room of Resident #2 who had a room temperature reading of [redacted] degrees F at 7 PM and noted that the resident was still in their room with the PTAC air conditioner unit still blowing out warm air and there was still no fan in the resident's room. The surveyor noted that he/she was still unable to access their water pitcher which was at the foot of the bed as the floor mat was positioned on the floor next to the resident's bed. The water still had the same amount of water in it from 7 PM and when palpated from the outside the pitcher

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was warm. There was no ice in the pitcher. The surveyor asked the resident how he/she was doing, and the resident stated in a [redacted] to the surveyor '[redacted]?" The resident did not have access to the call bell.

At 7:52 PM, the surveyor saw Certified Nursing Aide (CNA #2) walking down the hallway, and she stated that she has been employed at the facility since [redacted] and that she had informed the facility about the indoor room temperatures on [redacted] stating, "It's been hot for a while-weeks!" She stated that she was familiar with Resident #2 stating that many people think that the resident doesn't talk, but she stated that he/she can express his/her needs at times. The surveyor alerted the CNA #2 regarding the resident's request for water and she confirmed that the resident was unable to reach the water and would need assistance with drinking. She stated that she would go and give him/her water.

At 7:56 PM, the surveyor interviewed the LPN #3 again who was assigned to [redacted]. The surveyor requested the LPN #3 to provide a printed copy of the unit census, and the LPN #3 stated that she just started at the facility only a week ago and that she doesn't know how to print the census or the medical records for any resident. The surveyor asked if a resident was transferred to the hospital, how she would print out the records such as the electronic Medication Administration Record (eMAR) to go with the resident, and she stated that she would have to ask someone else to do it. The surveyor asked if she had been trained on Emergency Preparedness at the facility and how to respond, and the LPN #3 replied that she had not been trained. She stated that if there was an

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emergency, she wouldn't know what what to do and because she didn't know how to print documents, she acknowledged it would make it difficult to send residents elsewhere with their electronic medical records.

At 8:07 PM, the ED informed the surveyor he left a voicemail for the local OEM regarding the facility's indoor heat situation.

At 8:16 PM, the surveyor interviewed unsampled Resident #13 who was ambulatory on the unit. The resident stated that he/she got a fan from the facility about a week ago, "because my AC [air conditioner] doesn't keep up." The resident complained that it was "hot as hell in here" and that the PTAC unit will turn on and start off cool, but then after a short period of time it shuts off. The resident stated that the unit would have to keep being reset by pushing a button in the corner of the machine. The resident added that there was an issue with the ice machine also on the unit.

At 8:18 PM, the surveyor interviewed a resident representative who was visiting a resident on [redacted] The representative stated that "It's so hot on this unit" and that the resident he/she was visiting was sweating and that staff don't providing hygiene to the resident because it's too hot on the unit to do the physical work. The representative stated that the resident did not receive hygiene care that day.

The surveyor noted the new outdoor temperature to have dropped to [redacted] degrees Fahrenheit, and began to take additional temperatures on [redacted] which revealed the following:

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F 600	Continued From page 31 Hallway: [redacted] degrees F. Room [redacted] degrees F. Room [redacted] degrees F. Room [redacted] degrees F Room [redacted] degrees F Room [redacted] degrees F At 8:35 PM, two surveyors returned to the room of Resident #1 and took a room temperature which read [redacted] degrees F. The resident still had no fan or functioning air conditioner in their room. The resident stated that he/she was still hot and not feeling well. At that time, two surveyors went to get the RN/Supervisor. The RN/Supervisor brought the machine into the resident's room to take a set of vital signs, but then stepped out stating he had to look for gloves. There were no gloves accessible in or around the resident's room. The RN/Supervisor took approximately three minutes to find a pair of gloves before taking the resident's vital signs. The RN/Supervisor applied the pulse oximeter onto the resident's finger first to determine his/her oxygenation status which read [redacted] while the resident was on [redacted] The heart rate began at [redacted] beats per minute (bpm) for several seconds on the machine, and slowly started to decline to [redacted] bpm then [redacted] bpm, then [redacted] bpm. The RN/Supervisor never accessed a stethoscope to get an apical heart rate when the heart rate was showing signs from the pulse oximetry device that there may be [redacted]. The RN/Supervisor did not take or document the blood pressure reading or take a temperature, and he went to get the resident a [redacted] to aid in [redacted]. Upon the RN/Supervisor's return, he provided the [redacted] to the resident using a [redacted], but did not take an oral temperature and did not stop to count a	F 600		

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respiratory rate prior to applying the [redacted]
The surveyor asked when was he going to take a temperature, and the RN/Supervisor stated that he wasn't going to take an oral temperature but that he would go try and find a digital thermogun thermometer that can be scanned on the forehead.

At approximately 8:45 PM, the ED provided two surveyors the facility's Emergency Preparedness (EP) Manual stored in a red binder. The surveyors asked about the Heat Response Emergency Plan and relocation/evacuation plan. The ED stated that it was in there somewhere, and he would have to look. At that time, without any urgency, he stepped out without showing the surveyors where to find it and without looking for it himself, and the surveyors began sifting through the EP manual. The surveyors were unable to find any information about facilities in which residents could be transferred in the event of an emergency or evacuation.

Inside the red binder was an Emergency Preparedness Planning and Resource Manual revised October 2012 which indicated "Planning Considerations for Utility Outages" which specified very generic information such as identifying all critical operations including air conditioning systems, emergency generators and communication systems; Ensure that key safety and maintenance personnel are thoroughly familiar with all building systems, establish procedures for restoring systems, determine the need for back up systems, establish preventive maintenance schedules for all systems and equipment.

There was an Emergency Procedure for Utility

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F 600	Continued From page 33 Outage revised October 2012 in which a "Code Brown" is announced overhead, and staff should "determine if the loss of a utility is due to an incident occurring at the facility like a rupture, leak, fire, or collision, determine the impact of service disruption and projected duration...contact 911 if there is an emergency situation. Facility management staff report to the Incident Command Post for a briefing and instruction. Activate the Incident Command System to management the incident...Ensure back-up systems (emergency generators...emergency water...) are available and operating as designated in accordance with requirements. Monitor Residents to ensure they are safe and check resident-used medical equipment...see attached Severe Cold and Hot Weather Procedures to prevent...hyperpyrexia during loss of cooling functions. If the outage is long term and threatens resident safety and welfare, initiate Evacuation Procedures....establish and maintain contact with local emergency responders to advise them of the situation and keep them informed of potential needs as the situation worsens. The situation is only deemed "under control" after the outages has been restored and the Incident Commander has declared the situation 'safe' ... " The attached Severe Hot Weather Procedures included: When the facility temperature reaches [redacted] degrees Fahrenheit and remains so for four hours: 1. Move residents to another air-conditioned part of the facility, if available. 2. Encourage residents to take in more fluids and keep the residents hydrated. Force fluids if necessary and record fluid intake. 3. Provide cold wash cloths as needed. 4. Open windows to let cooler outside air in and utilize fans to move air.	F 600		

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5. Monitor body temperatures of the residents and notify attending physicians if necessary. 6. Notify 911 if a resident/staff member appears to be in danger of heat-related stress. 7. Evacuate residents if necessary. 8. Monitor environmental thermometers. 9. Notify Medical Director.

The Emergency Operations Plan located within the Evacuation Plan revised 7/10/15 included a response for a Heat Emergency. "The facility is equipped with air condition in all common areas and individual units in each patient room. Temperatures in the facility must be 81 degrees Fahrenheit and below. Should the temperature start to rise above 79 degrees Fahrenheit the following procedures should take place:

Maintenance: 1. Complete facility rounds to ensure: a. Window curtains in resident rooms and offices are drawn to block direct sun. b. all windows and doors are closed. 2. log temperatures at all stations initially and at a minimum of every four (4) hours. a. Report all interior facility temperature readings of 80 degrees Fahrenheit or above to the administrator immediately. 3. Turn off lighting in all corridors, offices and common areas, except where lack of light would cause safety issues. 4. Turn on all available fans. a. inventory quantity and location of all portable and wall mounted fans...procure additional ice, quantity as determined by the Administrator or designee. 6. Rent and set up delivery of portable air conditioning units as directed by the Administrator or designee. 7. Continue on-going facility rounds at a minimum of every two (2) hours. ...

Nursing: 1. Conduct facility rounds. 2. Complete preliminary visual survey of all residents to

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establish a baseline assessment of their conditions. Determine residents at greatest risk utilizing the following guidelines: a. significant weight loss, b. dialysis, c. total dependence on staff for nutrition, d. Residents requiring enteral nutrition, e. any resident that is compromised and/or determined to be at high risk. Note: not all residents with the condition(s) listed are necessarily at-risk. Other physical and lifestyle factors must be considered. 4. Collate listing of residents at greatest risk and implement measures to stabilize and/or reduce the risk. Interventions include, but are not limited to: a. notification of physician of any condition change. b. COPD [Chronic Obstructive Pulmonary Disease] -monitor O2 [oxygen] saturation every four (4) hours or as condition warrants. 5. If the internal temperature of the facility reaches 80 degrees Fahrenheit, obtain temperatures on all residents a minimum of every four (4) hours or as condition warrants. ... 7. Relocate residents to cooler areas of facility if possible, as conditions warrant. 8. Continue visual rounds a minimum of hourly. 9. Complete physical assessment as residents' conditions warrant. 10. Maintain lightweight clothing on all residents 11. Initiate continuation hydration cart 7:00 AM to 10:00 PM...12. Revise staffing as needed, to appropriately implement and maintain action plan.

Social Services: 1. Communicate to residents and family members the facility procedures.

Administrator: 1. Implement, oversee, monitor, and revise the facility procedures as needed. 2. Notify the Medical Director. 3. Notify the Regional Manager and Clinical Services Coordinator. 4. Notify regulatory agencies as required. In the event that the indoor air temperature is 82

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degrees Fahrenheit or higher for a continuous period of four hours or longer the immediate notification of the New Jersey Department of Health is required. 5. Ensure staffing levels are adequate to maintain facility emergency procedures and meet resident needs. 6. Assess the need to evacuate."

There was an Evacuation Plan with a revised date of 7/10/2015 but the evacuation plan did not address specific facility agreements for the transfer of residents.

At 9:45 PM, the surveyors interviewed the ED and the DON who stated that they were not sure what local facilities they had an agreement with to transfer residents to in the event of an emergency. The ED stated that he wanted the surveyors to remember he had only been at the facility for two weeks. The DON was unable to speak to evacuation destinations for the residents in the event of an emergency.

At 9:47 PM, in coordination with the local emergency response team, the surveyor returned to the [redacted] with the ED to screen residents for safety, relocation, and take additional room temperatures.

At 9:54 PM, the surveyor observed that even as outdoor temperatures had reduced to [redacted] degrees F, there were [redacted] residents that had room temperatures that exceeded [redacted] degrees F, and the remaining resident rooms had temperatures that were between [redacted] degrees F. The following was observed:

Room [redacted] The PTAC unit that was running on high that was blowing a minimal amount of cool

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F 600	Continued From page 37 air. The room was [redacted] degrees F. Room [redacted] There was no fan and no air conditioner in the room. The room was [redacted] degrees F. Room [redacted] There was a portable air conditioner unit installed in the room. The room was [redacted] degrees F. Room [redacted]: The PTAC unit was set to run on high with cool air, but the PTAC blowing warm air. The room was [redacted] degrees F. (There was no portable air conditioner in the room). Room [redacted]: The PTAC unit was not functioning in the room. The room was [redacted] degrees F. Room [redacted] The PTAC unit was not functioning in the room. The room was [redacted] degrees F. Room [redacted]: The PTAC unit was set on high and blowing a minimal amount of cool air. The room temperature was [redacted] degrees F. Room [redacted] The PTAC unit was not functioning in the room. There was now a box fan in the window of the resident's room that the resident stated was put there one hour ago. The room temperature was [redacted] degrees F. Room [redacted]: The was no functioning air conditioner in the room. The residents stated that the PTAC unit shuts off every hour and the reset button has to be pressed each time in order for it to blow any cold air. The room was [redacted] degrees. Room [redacted] There was functioning air conditioner in the room. The room was [redacted] degrees F. Room [redacted] The PTAC unit was not functioning and the residents who were both to be observed in bed did not have a fan. The room temperature was [redacted] degrees F. Room [redacted] There was no functioning air conditioner in the room but there were two fans. The room temperature was [redacted] degrees F. Room [redacted]: The PTAC unit was functioning at the time and set on high. The room was [redacted]	F 600		

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F 600	Continued From page 38 degrees F. Room [redacted]: There was no air conditioner or fan. The room was [redacted] degrees F. Room [redacted]: The residents had a portable air conditioner unit installed in their room which was running. The room was [redacted] degrees F by the door and [redacted] degrees by the window. Room [redacted] The residents had a portable air conditioner unit. The room temperature was [redacted] degrees F. A review of the undated "P-TAC (Rooms)" list maintained by the DoM reflected nine resident rooms that did not have a working PTAC unit, including rooms [redacted], [redacted] and [redacted] The list reflected that all the rooms listed on [redacted] that had malfunctioning PTAC units had zero of them fixed or replaced since the list was started (which was two weeks ago according to the DoM), particularly upon the shutdown of the air conditioner system on [redacted] on [redacted] when there was noted to a sparking issue system and subsequent fire risk. Upon observation, there was no alternative means provided such as a portable air conditioner to maintain the room temperature below [redacted] degrees F in those resident rooms with malfunctioning air conditioner units in accordance with the regulatory requirements. In addition there was no portable air conditioner in room [redacted] which was also on the list of malfunctioning P-TAC rooms. During the course of the safety and room temperature checks on [redacted] from 9:54 PM to approximately 10:45 PM, there were no facility staff on the unit making a good faith effort to relocate the residents who were unable to make their own decisions or were dependent on staff for activities of daily living and had no air	F 600		

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conditioning in the room In addition, while conducting the rounds with the ED, the ED stated at approximately 10:20 PM that he had to go wheel a resident down the hallway in a wheelchair and that he would be right back, but the ED never returned to the [redacted] Unit and the surveyor continued the tour checking on the residents and taking temperatures without him.

At 11:10 PM, a new facility representative entered the facility and office of the LNHA and stated that he was "second in command" with the company, and and that he wanted to discuss the facility's plan to address the malfunctioning air conditioning system. He stated that they were trying to get every portable air conditioner unit available to the facility. He stated that they were able to bring six over now from another building, and they are hoping to deliver 10 more total. He added that they would relocate residents to the cooler space if they did not have a portable air conditioner to give them.

At that time the DON provided the name of the Medical Director. She stated that the Medical Director had been called earlier this evening, but that she had not heard back from him yet. She confirmed there has not been a physician in the building yet. The DON stated that she was licensed as a Nurse Practitioner, but acknowledged that she could not perform the medical services as a NP since she was also the DON of the facility.

At 11:41 PM, the surveyors and the local emergency response team discussed with facility administration that as of approximately 10 PM there were [redacted] resident rooms affecting [redacted] residents who resided in those rooms on [redacted]

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that had temperatures exceeding [redacted] degrees F with malfunctioning PTAC units.

At 11:50 PM, the DON stated that the Nurse Practitioner (NP) would be at the facility in about 90 minutes in lieu of the Medical Director to assess residents.

On 7/16/23 at 12:35 AM, the surveyors returned to the 3-North Unit and observed Resident #1 still in his/her room. The resident had no air conditioner and a box fan in the room. The resident stated that he/she was still not [redacted]. The resident still appeared [redacted]. At that time the surveyor got the LPN #4 who stated that he worked [redacted] on [redacted] and [redacted], but states that he is familiar with Resident #1. The LPN #4 confirmed that the room temperature felt warm and he acknowledged that it was because there was no functioning air conditioner in the room and there was only a box fan which was in the window. The LPN #4 stated that Resident #1 may be going on [redacted] services soon due to his/her condition but was not currently on [redacted]. He confirmed that this was the resident's normal condition because of the prospect of [redacted]. At that time, the LPN #4 asked the resident if he/she wanted to go to a cooler location, and the resident indicated that he/she did not want to go, but the resident acknowledged that the room was too warm. The LPN #3 offered to bring the resident to the recreation room with his/her bed, and the resident [redacted] At that time, the LPN #4 stated to the surveyors that he couldn't force the resident to leave. The surveyor asked if anything could be done with the room temperature then, and the LPN stated that he would have to look into that. He acknowledged that due to the

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resident's condition, he didn't know why there was no air conditioner in his/her room, especially if he/she didn't want to leave the room. The resident had no cool cloth or other cooling methods offered to him/her at the time of the encounter.

At approximately 12:50 AM, the surveyor observed two new portable air conditioner units being brought up through the elevator. The staff were walking it down the [redacted] unit, but nobody delivered a portable air conditioning unit to the room of Resident #1 on [redacted] who was expressing that he/she was hot and sweaty and had known multiple [redacted] and [redacted].

At approximately 1:00 AM, the second in command regional administrator stated that they went back up to check the temperatures of the rooms again on [redacted] and found that many of the rooms were now below [redacted] degrees, and that all the residents were offered to leave their rooms to go to the recreation room where it was colder and all but two had refused to leave their rooms.

The surveyor went to [redacted] to verify the report. Unsampled Residents #14 and #15 were in their respective rooms and stated that no one from the facility had come to their rooms and offered them to leave to a cooler location. The residents both stated that they would be fine overnight and don't need to leave their rooms. The surveyor observed that Unsampled Resident #10 now a portable air conditioner unit in their room. Unsampled Resident #16 stated that he/she was asked if they wanted to leave the room to go to the cooler room where his/her roommate was, but

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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 600	Continued From page 42 refused. The surveyor went to Resident #3 who previously had a room temperature of [redacted] degrees F with no fan or air conditioning, and the resident stated that no one from the facility came to their room to ask if he/she wanted to go to a cooler location, and that the resident stated that he/she would consider moving to a cooler location because the room was still hot. The resident stated he/she would notify the nurse. On tour, a majority of the residents were in bed with their eyes closed and appeared to be asleep in their rooms. The rooms felt less humid due to the reduced outdoor temperatures. At 1:12 AM, the surveyors conducted an emergency code "crash" cart check on the [redacted] floor with the LPN #4 to determine adequate, easily accessible supplies in the event of an emergency or other heat related event. The LPN #4 and DON were unable to locate the [redacted] initially, despite the LPN #4 stating that he signs off the accountability sheet for the code cart. After looking all over the mobile code cart, the surveyors found it on the top shelf of the cart. At that time, the LPN #4 walked away from the surveyors and the DON acknowledged that this was the [redacted] and that LPN #4 should have known where it was because he signs off on it. At that time, the surveyors continued to review the 11-7 (night shift) Daily Nursing Crash Cart Check List and compared the checklist with what was actually in the emergency code cart. The surveyor observed that the items within the code cart were in disarray with [redacted] was located in several of the drawers with other products stored on top of each other making it	F 600		

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difficult to easily identify supplies. The surveyors observed there was supposed to be [redacted] gels, but there was only one in the code cart. The DON stated that there were [redacted] in the medication carts, and the DON went to the medication cart to pull one out to show the surveyors. The surveyor asked why nurses were signing off that there were two present including on [redacted] but there was only one in the drawer, and the DON stated that they had them accessible in the medication carts, even if it wasn't on the code cart. She acknowledged that the code cart should be stocked with all the items on the list for easy access in the event of an emergency. The surveyor also observed that there supposed to be two [redacted]) in the code cart, but there were none. The surveyors also observed that there were two house-stock doses of [redacted] hat were expired in [redacted], and one [redacted] prescription with a resident's name on it. The DON acknowledged that a medication assigned to an individual resident should not be in the code cart.

The surveyor observed that the 11-7 Daily Nursing Crash Cart Check List had a box to mark down the "[redacted]." However it did not specify what was being verified such as the location of the [redacted], its functioning, and [redacted] expiration check.

At that time, the surveyor checked the functioning of the [redacted] that would need to be used in the event a resident needed [redacted]. The [redacted] turned on and was functioning during the test. However, the [redacted] were noted to have an expiration date of

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[redacted] which was over a month ago. The DON stated that someone from the facility would look into that issue. She confirmed that the 11-7 Daily Nursing Crash Cart Check List did not have accountability for the the expiration of the pads and functioning of the machine. The DON was unable to provide any evidence of a separate [redacted] accountability record.

At 1:24 AM, the surveyor observed LPN #5 in the hallway of the [redacted] Unit. The LPN #5 stated that this was her [redacted] at the facility as she was an [redacted] nurse. She confirmed she was assigned to the [redacted] unit for the night shift. She acknowledged that the unit was on the warm side and that she was aware that not all the air conditioners worked on the unit. She stated that she was waiting on maintenance to fix the issue. The surveyor asked if she was informed to do anything different for the residents in particular related to the malfunctioning air conditioning on the units, and the LPN #5 stated she was not told to do anything different except offer the residents water and ice. The surveyor asked if she had to do more frequent rounding, monitoring or vital signs, and the LPN #5 stated that she did not have to do that. The surveyor asked about more frequent assessments on the residents, and the LPN #5 stated "no" because maintenance was trying to correct the problem.

At that time at approximately 1:28 AM, the surveyor observed the Nurse Practitioner enter the [redacted] floor and walked over to the nurses station to meet with the DON. After meeting with the DON, the NP stated to the surveyor that she was going to start doing assessments on the residents due to the malfunctioning air conditioning system and the heat in the building.

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At that time, the NP stated that she was going to start her assessments on the [redacted] unit. The surveyor stopped the NP and asked about how she prioritized her decision to start on the [redacted] unit when the [redacted] unit was known to have the more serious temperatures by the heat, and the NP turned around and acknowledged the surveyor's question. She stated she would start on the [redacted] unit instead. The surveyor discussed Resident #1 and she stated that she would start her assessment with Resident #1.

At 1:31 AM, the surveyor observed Resident #1 in the hallway in a wheelchair positioned in an alcove. The resident's bed was in the hallway also. The surveyor observed LPN #5 take some vital signs using a machine on the resident who was not utilizing [redacted] at the time. The resident's pulse oxygenation status was [redacted] on room air, and the heart rate using the pulse oxygenation device was reading a pulse of [redacted] bpm. The resident's blood pressure read [redacted]. The NP stated that she wanted to take a manual blood pressure reading. The NP took a manual reading and stated that it was [redacted] She also stated that she had listened to the resident's apical pulse and it was [redacted], and he/she was experiencing a change in their normal behavior as he/she appeared more [redacted]. She stated that she wants to send the resident to the emergency room for evaluation. The surveyor observed that this was how the resident had been presenting since the first observation earlier in the day.

At 1:38 AM, the surveyor interviewed the NP who stated that she had worked at the facility for [redacted] and was familiar with Resident #1. She

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stated that the resident's heart rate when she listened to it was [redacted] and the blood pressure was [redacted]. She stated that the resident was just not [redacted]. The surveyor asked the NP how she was assessing the residents related to a heat event, and she stated that mostly she would be looking for a change in cognition or behavior. She stated that the skin may feel warm too. The surveyor pressed the NP asking if there was anything else she would be assessing the resident's for, and she stated a change in [redacted]. The surveyor asked if staff were supposed to be monitoring the residents over any frequency due to the room temperatures not maintaining safe, comfortable levels, and the NP stated that residents should be assessed [redacted]. The NP then resumed her assessments of the other residents on [redacted]

At 1:45 AM, the surveyor interviewed the second in command Regional Administrator who stated that the facility had already delivered five portable air conditioning units and they were still bringing them in. He stated that he wasn't sure if the families or next of kins had been notified about the malfunctioning air conditioning units. The surveyor asked for any invoices for purchases made related to cooling the facility prior to the survey and the surveyor requested the visit summary of the HVAC company on [redacted], again. The surveyor was told that they had reached out the HVAC company but did not have it. The surveyor asked about the sister facilities or other facilities that have an agreement for evacuation and the surveyor was told that there was one

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sister facility that had 10 vacant beds available, but that was it. The facility still had not provided the EP related to the evacuation plan with the transfer agreements of other facilities.

Approximately 1:50 AM, the local Office of Emergency Management (OEM) officer called for medical transportation for Resident #1 to be transferred to the Emergency Room.

At 2:00 AM, the surveyors found an updated EP manual updated in January 2023 which had the facility agreements for evacuation that the surveyors had been asking for and looking for that the DON, ED and second in command regional administrator were unable to provide or speak to or provide before and during the course of the activation of their Emergency Plan due to the heat.

At approximately 2:30 AM, the surveyors and local responders met with the DON, ED, and second in command regional administrator regarding the surveyors concerns regarding the facility neglect to identify high-risk residents during their heat emergency and develop an individualized plan to prevent a heat-related adverse event when their air conditioning system and individual PTAC units were known to be shut down or not working at full capacity, implement adequate and sustaining cooling measures to reduce the risk for serious harm, initiate room temperature checks when air temperature on resident units were excessively humid and residents were visibly perspiring and complaining of feeling "hot," and appropriately activate their emergency response plan upon identification of their air conditioning malfunction in 89-degree outdoor temperatures with no immediate plan to

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correct the HVAC malfunction. They were notified of Resident #1 had known [redacted] had no air conditioner or fan and the room temperature exceeded [redacted] degrees and had to be hospitalized due to a change in condition that nursing staff did not act upon even when brought to the attention by the surveyors. The surveyors informed the facility that this was an immediate jeopardy situation that required a written removal plan to address the serious situation, including the code cart discrepancies. The facility could not speak to lack of knowledge and response to the Emergency Plan and the implementation of the Heat Emergency plan. The facility's negligence to ensure room temperatures did not exceed 81 degrees with knowledge of their malfunctioning HVAC system on [redacted] and failure to implement measures to identify at risk residents, assess, monitor, and maintain the resident room temperatures on two of their two units ([redacted] floors) from [redacted] until survey intervention placed all residents at risk for serious [redacted] from avoidable [redacted] illness when resident room temperature readings were recorded as high as [redacted] degrees Fahrenheit on the [redacted] floor.

Symptoms of heat exhaustion include headache, nausea, dizziness, irritability, muscle cramps, sweating, thirst, elevated body temperature which can quickly lead to heat stroke when the body temperature can rise to 106 degrees F within 10-15 minutes of prolonged heat exposure, leading to serious health consequences including hospitalization and death.

On 7/16/23 at 6:29 AM, the DON provided a written removal plan addressing the plan to

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F 600	Continued From page 49 remove the immediacy. On 7/16/23 at 12:30 PM, the survey team returned to the facility and observed outside the building a rented generator and HVAC rental trucks. The surveyor entered the building through the main entrance on the [redacted] floor. At 12:47 PM, the surveyor was introduced to the Regional Licensed Nursing Home Administrator (R/LNHA) who stated that he was licensed as an administrator in New Jersey. He stated that while he is not the LNHA on record, he provided the name of the LNHA on record and stated that he is out of the country in [redacted] and that he wouldn't be in today and wouldn't be available for an interview. The surveyor asked why the DON and ED did not know that the LNHA was out of the country in [redacted] when asked, and the R/LNHA could not speak to why they would not have disclosed that to the surveyor. The R/LNHA stated that he wanted to provide an update on what has been done in the facility regarding the air conditioning situation. He stated that they contracted with an HVAC rental company and every resident room in the building was given their own portable air conditioning unit for their room and the room temperatures have been good and "residents are totally comfortable." He stated that they also installed six, five-ton air conditioner units for the hallways that are 60,000 BTU's, two per floor. He stated that they also rented a high power generator to offload the power necessary to supply the air conditioning units. The surveyor requested any invoices of items purchased related to the heat emergency fans including fans, air conditioners, as well as the HVAC visit from the invoice dated [redacted] The Regional LNHA stated that he may not have	F 600		

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F 600	Continued From page 50 a copy of the HVAC visit from that invoice until tomorrow. From approximately 1:00 PM to 2:00 PM, the surveyor toured the [redacted] floor and took room temperatures and conducted resident safety checks. The surveyor verified all resident rooms had the portable air conditioning units and room temperatures were within regulatory requirements. The surveyor reviewed the medical records for Resident #1 who was sent to the hospital on [redacted] at approximately 2 AM. A review of the Admission Record (an admission summary) reflected that the resident was admitted to [redacted]. The resident also had a diagnosis of [redacted]) with an onset date of [redacted]. The Admission Record revealed that the resident was a [redacted]" status, indicating that [redacted] efforts should be performed in the event of a [redacted] A review of the resident's individualized care plan initiated on [redacted] 3 included that the resident had [redacted] due to being an [redacted]. One of the goals included that the resident will display [redacted] daily with an [outdated] target date [redacted]. Interventions included give	F 600		

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[redacted] as ordered. Monitor/document any side effects and effectiveness; Monitor for signs and symptoms of [redacted]; and to utilize the [redacted]

In addition, there was a care plan initiated on [redacted] that the resident has a [redacted]. The goal had an outdated target date of [redacted] that the resident's comfort will be maintained through the review date. An intervention included to consult with physician and social services to have [redacted] care for resident in the facility.

The care plan reflected that the resident required an extensive physical assist of one staff for bed mobility.

A review of the active physician Order Summary Report for [redacted] reflected a physician order for a [redacted] evaluation and treat dated [redacted] and a physician order dated [redacted] for [redacted] administer [redacted] as needed for [redacted]. The Order Summary Report also reflected that the resident was on medication for [redacted]. There was no physician order for [redacted]. In addition the electronic Medication Administration Record (eMAR) for [redacted] did not reflect the same active physician orders found in the Order Summary Report for [redacted].

A review of the Progress Notes for [redacted]

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reflected a physician progress note dated [redacted] at 23:31 (11:31 PM) that the resident was recently readmitted to the facility following an [redacted] and was treated with [redacted]. It further reflected that the resident has [redacted].

There were no electronic Progress Notes (ePN) from the nurse from [redacted] until [redacted] at 2:03 AM which reflected that the resident was sent to the hospital via 911 for [redacted]. The vital signs recorded indicated BP [redacted], HR[redacted] BPM, SP02 (pulse oxygenation status) [redacted] on room air, temperature[redacted] degrees F. The note indicted that the physician was notified and the POA was contacted. There was no respiratory rate recorded on the progress note or documented evidence of the auscultation of [redacted] when the resident had complained of "[redacted]" and received a [redacted] treatment. The nurse documented the resident had [redacted] breaths per minute in the [redacted] Summary on [redacted] at 1:43 AM.

A review of the ePNs for [redacted], the eMAR for [redacted], and the vital signs summary report reflected that the resident had not had any vital signs taken and documented since [redacted] at 15:43 PM (3:43 PM) until surveyor intervention on [redacted] despite knowledge of the resident's [redacted], recent [redacted] being [redacted] on the [redacted]

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[redacted] and in the resident's individual room as indicated on the facility's undated "P-TAC (Rooms)" list for malfunctioning P-TAC units. (Resident #1 had no air conditioner or fan in the room on [redacted] and the room temperature exceeded [redacted] degrees F).

On 7/16/23 at 2:00 PM, the facility provided the surveyors the list of residents identified by the facility to be at [redacted] in accordance with their written Removal Plan. The facility indicated that there were [redacted] residents out of a total of [redacted] residents on their census that were at [redacted] for an [redacted] This indicates a total of [redacted] of their resident population identified to be at high risk for an adverse outcome if not provided adequate room temperatures.

The surveyor reviewed the invoice dated [redacted] that was transmitted through an email for an amount of [redacted] with the HVAC company. The invoice did not specify what the amount was covering or what service it provided.

At 2:47 PM, the Regional LNHA stated that the individual listed on the HVAC invoice dated [redacted] was the "purchaser" of the building.

At 3:56 PM, the surveyor reviewed the emergency transportation contracts in the EP manual which reflected a contract with an ambulance company signed and dated [redacted] with a letterhead of the ambulance company. There was an additional copy of an Emergency Evacuation Plan contract not on an ambulance company letterhead that indicated that the ambulance company "to the best of its ability given the emergency evacuation circumstances

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agrees to prioritize at least two transport vehicles to an emergency evacuation...for the emergency transport of residents requiring ambulance to designated relocation facilities" with a typed signature dated [redacted] but there was no phone number, title, length of contract, or other information related to the ambulance company. At that time, the surveyor discussed the ambulance service contract with the [redacted] Coordinator who called the ambulance service for information, and he informed the surveyor that the facility did not have an active contract with the ambulance company as referenced on the contract(s) in the EP manual.

At 5:02 PM, the surveyor interviewed the Regional LNHA who stated that he was licensed in the state of New Jersey and the LNHA on record went to [redacted] and believed his last day was [redacted] but could not speak to how long he would be out of the country. The surveyor asked why the ED or the DON did not know that the LNHA on record was out of the country when asked them yesterday who and where he was, and that both responded it was due to the religious [redacted]. The Regional LNHA couldn't speak to it. He stated that the DON should also inform him if the LNHA is out for the day. The Regional LNHA stated that he was not sure if the LNHA clocks into the facility. The Regional LNHA stated that the Medical Director should be notified by whoever identified the HVAC issue. He stated that he wasn't sure why the Medical Director never came to the facility yesterday during the heat emergency.

He stated that on [redacted] when the HVAC contractor was contacted regarding their air

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conditioning system which was working at 50%. He stated that they "prepaid everything and fixed most of it." He stated that they ordered the parts and monitored it. The Regional LNHA did not provide evidence of payment to the contractor regarding services rendered at the time of the invoice dated [redacted]. He stated that on Friday [redacted] they called and asked for more parts and that the facility was currently awaiting the parts. He stated that on [redacted] at 2 PM the facility had purchased additional portable air conditioning units. The surveyor requested receipts for those purchases. The surveyor asked what the process was for communicating maintenance issues at the facility, such as the use of a maintenance log, and the Regional LNHA stated that he couldn't speak to the process regarding maintenance logs but he could find out the information and get back to the surveyor.

At 6:06 PM, the surveyor interviewed the DoM again in the presence of the Regional LNHA who stated that he could speak to the maintenance log process. He stated that the logs are what he knows has to be fixed daily, but there are three ways in which he received information about what needed action. He stated that the Maintenance daily work log, word of mouth or the receptionist will tell him what needs to be done such as with the PTAC units in the resident rooms. If contractors are needed to do the work than he would be responsible to call a contractor. He stated that he was not a licensed HVAC professional. He stated that if anyone came to the facility to fix something he can write it in the log. The DoM stated that on [redacted] they instituted ice and some portable air conditioner units on the second and [redacted] floors at that time. The DoM stated that he is "only one person" and wasn't

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able to address all the individual issues with each PTAC unit in the rooms. The Regional LNHA stated that the LNHA, DON and Assistant DON should know how to report an interruption in air conditioning to the New Jersey Department of Health (NJDOH).

A review of the Maintenance Daily Work Log provided at 6:30 PM by the Regional Director of Building Operations indicated that on [redacted] resident rooms received a "New Port [portable] A.C. [Air Conditioner]" unit including room [redacted], and [redacted].

However, on 7/15/23 at 9:54 PM, the surveyor had observed room [redacted] only had a PTAC unit that was blowing warm air and the room temperature was [redacted] degrees F. The resident did not have a portable air conditioner in his/her room. Room [redacted] was also on undated "P-TAC (Rooms)" audit list indicating that the PTAC unit in the room was not functioning at capacity.

Further the Maintenance Daily Work Log indicated that on [redacted] there were five resident rooms that got a "New A.C.," rooms [redacted] and [redacted]. However, there were no invoices provided that indicated the resident received new air conditioning in these rooms. (On 7/15/23 at 5:52 PM, the surveyor observed that resident room [redacted] had a room temperature of [redacted] degrees F).

The Maintenance Daily Work Log for [redacted] reflected that room [redacted] had a "Replaced P-TAC," and on [redacted] room [redacted] received a "new A.C. in the room" due to a "bad valve on A.C." The DoM recorded that he tried to change the valve and there was a big leak that resulted.

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F 600	Continued From page 57 At 7:00 PM, the surveyor interviewed the Regional Director of Building Operations who stated that on [redacted] that they started the PTAC audit and repaired 3 of the PTAC units and the others were reset. The surveyor asked for a copy of the audit. At 7:05 PM, the Regional LNHA stated that there was no procedure/accountability for the [redacted] to check the function of the equipment and pads and no documented process for the oversight of the equipment. At 7:10 PM, the surveyor asked the DON for copies of facilities policies, and the DON stated that all the policies are electronic and that she does not have access to the electronic policies. The surveyor asked why she does not have access to the policies if she has been at the facility since [redacted], and she stated that she has access to the policies only through a hard copy of the policy book and she would have to flip through the book to find the individual policies that the surveyor was looking for. At 7:38 PM, the Regional LNHA returned to inform the surveyor that he found out how long the LNHA on record was going to be out of the country and that he would be gone from [redacted] through [redacted] He could not speak to why none of the administration knew this information. At 7:50 PM, the surveyors requested to meet with the facility administration, and the Regional LNHA brought in himself and the Regional Director of Building Operations. The ED and DON were not brought in and the surveyor asked why. The Regional LNHA stated that the ED was not	F 600		

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coming in today, but he stated that he would get the DON. At that time, the surveyor asked the DON about Resident #1 and she stated that the resident was hospitalized for [redacted]. She stated that he was on [redacted] services but had frequent hospitalizations. She stated that the resident had a history of [redacted] She stated that the resident was not always compliant with the use of [redacted] and was frequently sent to the hospital and would come off of [redacted] each time the resident was sent to the hospital. The surveyor asked if the resident was admitted to the hospital each time, and the DON replied yes, stating that the resident was o[redacted] and at [redacted] for re-hospitalization. The surveyor asked why the resident was not provided air conditioning if the resident's health was so fragile when the PTAC system in the room was known to be nonfunctioning and the unit HVAC system had been shut down to prevent a fire. The DON could not speak to it. There was no documented evidence that the resident was offered and declined a portable air conditioner unit or asked to move to a different room and declined. The DON stated that she did not report the interruption in service to the NJDOH because she didn't know there was an interruption in service. She stated that she had twenty-four hours to report it, and stated that because she became aware of the issue on [redacted] she reported it to the NJDOH on [redacted]. The surveyor further informed the facility of the [redacted] being outdated on the [redacted] floor on [redacted], but were verified to be replaced with new, [redacted] on [redacted] after surveyor inquiry.

On 7/19/23 at 10:39 AM, the surveyor toured the two floors of the building with the Regional

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Director of Building Operations to conduct resident safety rounds and test the room temperatures. The surveyor also observed the PTAC units in the resident rooms. The surveyor asked the Regional Director of Building Operations how the facility tests to determine if the PTAC units are functioning at capacity and he replied that despite he works in Building Operations, he could not answer this question.

The surveyor reviewed the undated "P-TAC (Rooms)" audit again which indicated that there were three resident rooms that received "New" PTAC units, rooms [redacted], and [redacted].

At 11:05 AM, the surveyor and the Regional Director of Building Operations observed the "New" PTAC unit in room [redacted] The surveyor observed the resident sitting in their room. The resident stated to the surveyor that the PTAC unit did not work because of a leak and that he/she had to keep pressing the reset button "a lot" clarifying it was sometimes every hour in order to make it work. The resident stated that it has been doing that for the last four months. The resident stated that there was no consistent air conditioning until the portable air conditioner was delivered into the room over the weekend. The resident kept thanking the surveyor for having the facility provide functioning air conditioning to their rooms. The room temperature with the portable air conditioning was reading [redacted] degrees F and [redacted] degrees F. The surveyor took a photo of the PTAC unit.

At 11:15 AM, the surveyor and the Regional Director of Building Operations observed the "New" PTAC unit in room [redacted]. The surveyor observed that the PTAC unit dial had an unknown

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brown substance stained along the line of the buttons. The plastic cover for the button for the "Hi Cool" was missing, exposing the metal. There was a portable air conditioner in the room. and the room temperature was [redacted] degrees F. The surveyor took a photo of the PTAC unit.

At 11:18 AM, the surveyor and the Regional Director of Building Operations observed the "New" PTAC unit in room [redacted] The PTAC was set on "Hi Cool" but the PTAC unit was not operating. There was no air being released from the unit. There was a portable air conditioner in the room and the room temperature was [redacted] degrees F. The surveyor took a photo of the PTAC unit.

At 11:27 AM, the surveyor interviewed the Regional Maintenance Director and the Regional LNHA in the presence of a second surveyor. The Regional Maintenance Director stated that he provides maintenance support to the building and is not employed by a company but the facilities in which he works. He stated that he does not need to "clock in" to the facilities when he arrives on site. and that the facility recently lost one of their maintenance employees and it has been hard to find a replacement. The Regional Maintenance was not sure how long ago the facility had lost the maintenance employee or how long the DoM had been working independently. The Regional Maintenance Director stated that he found out about the air conditioner issue on [redacted] when the DoM called him and that he stopped in on [redacted] at 2 PM, and that there was a switch issue that needed a part and he called the company that provided the invoice on [redacted] but that they don't make visits on the weekend so they called the company that provided all the

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portable air conditioning rentals, and the earliest they could arrive was [redacted] The surveyor asked why the DoM never disclosed this on [redacted] and none of the administrative staff informed the team on [redacted] about the plan for the air conditioning rentals, and the Regional Maintenance Director stated because the company wasn't called until after the [redacted]. He stated that the last time he was in this facility was about a month ago for an issue with an elevator. He stated that he was aware of only one unit not functioning but if the whole building was compromised, he stated that they would request the HVAC to be here within six hours especially if the outdoor temperatures are elevated.

At that time, the Regional LNHA stated to the surveyors that if the temperature climbs over 78 degrees F in the room, it would be important to implement measures for cooling to prevent it from going above 81 degrees F, as [redacted] degrees F "is not safe." The surveyor asked when the Emergency Plan should be implemented, and he stated that couldn't speak specifically when it would be implemented. He stated however that they would try to exhaust all options first like accessing contractors and if they could not get portable air conditioner units or move the residents within an hour , then they will contact the local [redacted] He stated that he found out about the air conditioning system not functioning on [redacted], and they knew it was going to be a [redacted]." The Regional LNHA clarified that it would be very hot "outside" on [redacted] He confirmed that the air conditioning systems were not working at full capacity.

The surveyor asked how the facility tests to know

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if the air conditioning system was working at full capacity or not, and the Regional Maintenance Director stated that it could be felt in the air, room temperatures could be taken to determine if the air conditioning is functioning, he could check the return and test the return and compare the difference.

At 12:10 PM, the surveyor asked why residents reported that they have to keep resetting the PTAC units, and why when the Regional Director of Building Operations and the surveyor tested out the functioning of the PTAC units in many of the rooms, the reset button, which was often out of reach of the unit, had to be pressed to turn it on, and the Regional Maintenance Director stated that the Certified Nursing Aides might turn it off, residents, or other staff turn the dial to off and the reset button has to be pressed again. He stated that the PTAC units shut down on their own sometimes so it does not burn out the compressor, which is why, in turn, the reset button has to be pressed. The Regional LNHA stated that residents and staff should not have to keep pressing the reset button on the PTAC units, and acknowledged not all residents have the physical or cognitive ability to independently do so. He stated that the facility ordered new overload switches.

The surveyor reviewed the emails that corresponded with the invoice dated [redacted] from the HVAC company. An email dated [redacted] at 8:07 AM from the HVAC service coordinator indicated that once they receive the payment of [redacted], they will schedule a technician to troubleshoot the issues with the three air handler units that were mentioned, and if they were not able to repair them while onsite, another

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employee will send a proposal for the required parts and repairs necessary. The Service Coordinator asked what any insight for what the issues are with the air handler units.

The facility's purchaser submitted a follow up email on [redacted] at 8:27 AM which indicated that they needed a tech out there today or as soon as possible as this facility was "a nursing home and the temps outside are hitting [redacted]"

An email written on 7/12/23 at 12:08 PM from theHVAC company reflected that they were able to inspect two of the water source heat pumps and that they would be sending a proposal for an overload switch for one of the units, and recommended a leak search on the water source heat pump that was "downstairs." The email indicated that an additional proposals would be sent for the two repairs.

The facility's purchaser responded on [redacted] at 3:51 PM asking if there was a quote to repair the unit because it had been almost a week already. The HVAC company responded that they were waiting on pricing and availability from the supplier before sending the proposal.

A review of the HVAC contractor's Service Report dated [redacted] provided by the facility on [redacted] at 12:30 PM, included that on [redacted] there were three air handler units that were not cooling below [redacted] degrees and temps were set around [redacted] It also reflected that the system in the downstairs water source heat pump "has a leak" and the "last unit has a faulty overload protector for the compressor." The Service Report did not indicate what was done to correct the problems identified.

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F 600	Continued From page 64 A review of the Maintenance Daily Work Log for [redacted] indicated "Met with A.C. People, repaired air handler, other units working returning with relays." There was no evidence from the contractor's Service Report that the air handlers were repaired and the emails indicated that the contractor only inspected the water source heat pumps. There were no additional invoice documents or receipts provided to the surveyor that were dated prior to the survey start date of [redacted] to indicate an effort to fix or rectify the malfunctioning HVAC issue. There were no receipts of fans or portable air conditioners purchased provided to the survey team dated prior to the survey. On 7/19/23 at approximately 1:00 PM, the facility administration was notified that the immediacy was lifted on [redacted] through observation, interview, and review of facility documents. A review of an in-service record revealed In-Service Education Provided by the Regional Administrator to Nursing Home Administrator and Director of Nursing and all departments on [redacted] which included the definition of neglect "the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress." A review of the facility's Prohibition of Resident Abuse & Neglect dated [redacted] included under types of abuse, "Neglect: The failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."	F 600		

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F 600	Continued From page 65 Prevention included to "Identify, correct, and intervene in situations in which abuse, neglect, mistreatment, and misappropriation of resident's property are more likely to occur...This includes an analysis of: a. features of the physical environment that may make abuse, neglect, mistreatment ...more likely to occur; b. the staffing on each shift to meet the needs of the residents; c. The training and knowledge of the staff regarding resdient care needs; d. All staff will be trained to immediately report an observed/suspected incident." A review of the Emergency Cart policy effective 11/22/22 included, "The Emergency Cart lock will be checked each 11-7 shift by the nurse to ensure the lock is intact and supplies are in place... The [redacted] is present and battery intact and functioning,...any item misisng will be replaced during the nurse's tour of duty." NJAC 8:39-4.1(a)5,12; 27.1(a)	F 600		
F 658 SS=J	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: COMPLAINT# 165731 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to identify a	F 658	F658 Element One-Corrective Actions " Resident #1 was assessed by Nurse Practitioner on [redacted] and was sent to the Emergency Room (ER) and	7/21/23

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F 658	Continued From page 66 [redacted] resident (Resident #1) who was complaining of [redacted] and [redacted] well and respond in a manner that adheres to professional standards of nursing practice to assess, identify, respond, and call the physician at the time when the resident was verbalizing a change in condition caused from environmental heat. There was no air conditioning in the resident's room, no fan, and the resident's room temperature exceeded [redacted] degrees Fahrenheit. Two LPN's and one RN who each saw Resident #1 stated that this was the resident's baseline. A night shift LPN stated that the resident might be admitted to [redacted] but was not on [redacted] service. The Nurse Practitioner arrived at 1:30 AM and assessed the resident and stated that this was not the resident's [redacted] and the resident had [redacted] and [redacted]. The resident was sent to the hospital during the early morning hours of [redacted] Interview with the night shift agency LPN stated that she was aware of the heat situation in the facility but that she didn't need to do anything different for the residents, no additional monitoring, no additional vital signs. She stated that nobody told her anything extra that she needed to do. Symptoms of heat exhaustion include headache, nausea, dizziness, irritability, muscle cramps, sweating, thirst, elevated body temperature which can quickly lead to heat stroke when the body temperature can rise to 106 degrees F within	F 658	subsequently admitted with a diagnosis of [redacted]. Resident #1 had been placed on [redacted] services on [redacted]. " Roommate of Resident #1 was assessed, offered a room change, or temporary placement in a temperate environment but the resident declined a room change and was provided with a portable air conditioner unit on [redacted] " All Residents were assessed by the medical director for signs or symptoms of [redacted]s on [redacted] with no issues found. " Additional rounds and vital signs monitoring were implemented on [redacted] to evaluate residents for signs or symptoms of [redacted] " Additional Hydration carts were purchased on July 14, 2023 and hydration stations were placed on each unit. " Residents were provided with extra ice throughout the day as needed starting on July 14, 2023. " Residents were notified of the heat emergency and to notify staff if they need assistance or if their room temperature is not to their liking. Resident rooms with nonfunctioning PTAC units were provided with portable air conditioner units and residents instructed in use. Staff monitor resident rooms during hourly rounds and adjust the portable air conditioner unit temperatures for residents unable to do so to assure their comfort. " Both physicians and Responsible Party Representatives were notified of the heat emergency and that they would be	

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F 658	Continued From page 67 10-15 minutes of prolonged heat exposure, causing serious adverse health consequences, hospitalization and death. This resulted in an immediate jeopardy situation for Resident #1 who was known by the nurse to have known [redacted] The resident had no fan and no air conditioner in the room and room temperature readings were in excess of [redacted] degrees. The Resident complained to the surveyor, "[redacted]" Resident was [redacted] and wiped the [redacted] from the [redacted] The facility's failure to ensure room temperatures did not exceed [redacted] degrees with knowledge of the HVAC system not functioning on [redacted] but failed to implement measures to assess and maintain the resident's room temperature and failed to follow professional standards of practice when the resident complained of [redacted] and [redacted] act in an manner to prevent worsening of the condition by calling physician, intervening to address the lack of cooling in the room or offering to transporting the resident to another area of the building until surveyor inquiry. The immediate jeopardy began on [redacted] The facility was notified of the immediate situation on [redacted] An acceptable written Removal Plan was received on [redacted]. The surveyors verified the Removal Plan on [redacted]. The immediacy was lifted on [redacted] This deficient practice was identified for 1 of 1 residents reviewed for hospitalization on [redacted] (Resident #1).	F 658	notified of any resident changes in condition. " All resident rooms, and common areas were immediately re-evaluated for elevated temperatures and portable air conditioning units placed throughout the facility as appropriate on [redacted] " Temperature logs are being utilized to monitor and track room temperatures. " Items missing or expired in the code carts were immediately replaced and staff educated on code cart audit process. New code carts were purchased and restocked to ensure adequate supplies are in the cart. A daily code cart checklist was implemented, and nursing staff re-educated about proper completion. " The [redacted] were replaced, and the [redacted] units checked to ensure proper function. Checking the [redacted] and functioning was added to the code cart checklist. " Nursing staff were re-educated on monitoring of code cart and [redacted] and functioning process/policy. " The Heat Emergency Response Plan was activated [redacted]. The facility Emergency Preparedness Plan was reviewed and revised by the new facility Licensed Nursing Home Administrator (LNHA) with assistance of the Licensed Nursing Home Administrator and Director of Nursing consultants and staff received re-education. New binders were placed on resident care units and throughout the facility where appropriate for easy access. Element Two-Identification of at Risk Residents	

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F 658	Continued From page 68 The evidence was as follows: 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 and 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 regimens 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." On 7/15/23 at 5:02 PM, the surveyor arrived at the facility for an unannounced visit to investigate the issue regarding the malfunctioning air conditioning system at the facility. The surveyor noted that the local outdoor temperature at that time was [redacted] degrees Fahrenheit and humid. The surveyor entered through the main lobby and noted a heavy duty floor fan blowing air across the floor with a long extension cord. The surveyor observed a Security Guard (SG #2) at	F 658	" All residents without adequate temperature control have the potential to be affected by these practices. Element Three-Systemic Change " The Director of Nursing (DON) and Nurse Practitioner (NP) identified residents with [redacted] illness. The high risk acuity list was revised and updated by the interdisciplinary team with the assistance of the Director of Nursing consultant and Unit Managers and placed on each unit for easy access by staff in case of an emergency. The list is updated based on resident changes in condition and with new admissions. " The Medical Director assessed the remaining residents on July 17, 2023 with no additional changes in condition noted for any resident. All residents were assessed for signs and symptoms of heat related illness and a list of diagnoses was determined to identify at risk residents. " The high risk acuity list was reviewed by the Assistant Director of Nursing and DON consultant and Unit Managers and updated based on Resident acuity and posted at each nursing unit for easy reference and nursing staff re-educated about use. The list is updated with any changes in resident conditions and when there is a new admission. " The Licensed Nursing Home Administrator (LNHA) was educated on heat related emergencies, identifying at	

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F 658	Continued From page 69 the front desk and the surveyor asked the SG #2 about the fan on the floor and he stated that he didn't know why it was there. He acknowledged that it was not there for a housekeeping reason. The surveyor asked if the facility had any issue with maintaining air temperatures in the building, and the SG #2 stated that he didn't know anything as he just started his shift and was filling in for someone else. At 5:07 PM, the surveyor interviewed the Registered Nurse/Supervisor (RN/S) who stated that he started the shift at 3 PM and that he took over for another nurse supervisor. At that time, the RN/S didn't want to answer any of the surveyor's questions and called the Director of Nursing (DON). At 5:09 PM, the surveyor conducted a phone interview with the DON. The DON stated that the air conditioning in the building was not functioning due to a "sparking" issue, and it had to be shut down, but that the facility had implemented hydration stations and ice in response. She stated that she "did not know the mechanics of the issue but the Regional Maintenance was on-site working on the issue." She stated that he should be on the roof right now looking at the issue. She stated they had been working on resolving it since yesterday ([redacted]), because there was no air conditioning in the kitchen. She stated that the air conditioning only affected the kitchen yesterday and not the resident areas. She stated because they knew the weather was going to be hot today, they purchased fans and water stations for the resident units just as a precaution. The DON also added that a nurse called her today to inform her that the building was warm.	F 658	risk residents, maintaining appropriate temperatures in facility, reporting interruption of services to the Department of Health, and activation of Emergency Response Plan. " An experienced permanent New Jersey Licensed Nursing Home Administrator replaced the temporary LNHA and executive director effective [redacted]. " Both a DON and a Licensed Nursing Home Administrator consultant were retained as per the Directed Plan of Correction providing 40 hours onsite consulting. " The maintenance director was re-educated and instructed to maintain temperature logs of facility temperatures as required per the Directed Plan of Correction and then after substantial compliance. " Nursing Staff were re-educated on recognizing and assessing for signs and symptoms of heat related illness and reporting to supervisor/designee any air temperature abnormalities and transferring residents to appropriate temperate areas. " Families were updated as were facility physicians. All residents affected by increased temperatures were offered room changes or temporary placement in cool common areas. " All rooms had portable, or wall air conditioners placed, and temperatures continue to be monitored with no abnormal readings as of July 16, 2023. " Repairs to the main cooling system were completed and secondary PTAC	

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F 658	Continued From page 70 The surveyor asked the DON when the sparking issue occurred that required the shut down of the system, and the DON could not speak to an exact date. She could not speak to air conditioning issues within the resident units adding no residents told her it was hot and "no one complained" to her. She stated that they purchased fans yesterday. The surveyor asked why they purchased fans for the residents if it was not hot indoors and if the air conditioning was functioning on the units, and the DON stated that it was because they anticipated the weather to be hot outside today and reiterated that it was just for an added "precaution." The surveyor asked if she had been on the resident units and felt a difference in air temperature, and the DON replied that "I'm tropical, so heat doesn't hit me like the rest." The DON stated that it may have been a bit warm, but since no one complained to her that it was hot in the building, it couldn't have been too hot. She continued to state that the Director of Maintenance purchased the fans and returned to the facility today to find out more about the status of the air conditioning system. The surveyor asked what floors were affected, and the DON stated that it was only the [redacted] floor far hallway that was affected, which was where they put all the fans. The surveyor asked if there were any fans brought to the [redacted] floor, and the DON replied that there were "no fans on the [redacted] floor." The surveyor asked if there were any temperature checks being done on any of the resident units and the DON stated that she didn't know about any room temperature checks being done. A review of the facility's Emergency Procedure for Utility Outage revised October 2012 included the	F 658	units continue to be replaced as they are delivered with portable air conditioner units in every room in the interim allowing residents to control their room temperature. Element 4-Quality Assurance " The Maintenance Director/designee will monitor room and common area temperatures every two hours x 48 hours, then every shift x 14 days and daily thereafter with no stop date. Results are reported to the administrator and emailed daily to the department health until substantial compliance is achieved. Results are also shared at the weekly Quality Assurance Performance Improvement (QAPI) meeting for action as appropriate. " The Administrator/designee makes random daily rounds with the maintenance staff to confirm room air temperatures and assure the comfort of residents. Results are discussed with the Director of Nursing daily and in aggregate at the weekly Quality Assurance Performance Improvement (QAPI) meeting for further action as appropriate. " The Director of Nursing/designee will audit 5 random at-risk residents medical records for signs and symptoms of heat related illness daily x 7 days, weekly x 4 and monthly x 2. Findings are discussed at clinical meetings and acted upon as appropriate. Results are shared in aggregate at the weekly Quality Assurance Performance Improvement (QAPI) meeting for further action as needed. " The Assistant Director of	

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F 658	Continued From page 71 following: Monitor Residents to ensure they are safe and check resident-used medical equipment...see attached Severe Cold and Hot Weather Procedures to prevent... [redacted] functions. If the outage is long term and threatens resident safety and welfare, initiate Evacuation Procedures....establish and maintain contact with local emergency responders to advise them of the situation and keep them informed of potential needs as the situation worsens. The situation is only deemed "under control" after the outages has been restored and the Incident Commander has declared the situation "safe" ... The attached Severe Hot Weather Procedures included: When the facility temperature reaches [redacted] degrees Fahrenheit and remains so for four hours: 1. Move residents to another air-conditioned part of the facility, if available. 2. Encourage residents to take in more fluids and keep the residents hydrated. Force fluids if necessary and record fluid intake. 3. Provide cold wash cloths as needed. 4. Open windows to let cooler outside air in and utilize fans to move air. 5. Monitor body temperatures of the residents and notify attending physicians if necessary. 6. Notify 911 if a resident/staff member appears to be in danger of heat-related stress. 7. Evacuate residents if necessary. 8. Monitor environmental thermometers. 9. Notify Medical Director. The Emergency Operations Plan located within the Evacuation Plan revised 7/10/15 included response for a Heat Emergency. "The facility is equipped with air condition in all common areas and individual units in each patient room. Temperatures in the facility must be 81 degrees Fahrenheit and below. Should the temperature	F 658	Nursing/designee will monitor all code carts to ensure they are adequately stocked, and Automatic External Defibrillator pads are not expired daily x 7 days, weekly x 4 weeks and monthly thereafter. Results will be provided to the Director of Nursing and shared at the weekly QAPI meeting.	

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F 658	Continued From page 72 start to rise above [redacted] degrees Fahrenheit the following procedures should take place: ...Nursing: 1. Conduct facility rounds. 2. Complete preliminary visual survey of all residents to establish a baseline assessment of their conditions. Determine residents at greatest risk utilizing the following guidelines: a. significant weight loss, b. dialysis, c. total dependence on staff for nutrition, d. Residents requiring enteral nutrition, e. any resident that is compromised and/or determined to be at high risk. Note: not all residents with the condition(s) listed are necessarily at-risk. Other physical and lifestyle factors must be considered. 4. Collate listing of residents at greatest risk and implement measures to stabilize and/or reduce the risk. Interventions include but are not limited to: a. notification of physician of any condition change. b. COPD [Chronic Obstructive Pulmonary Disease] -monitor O2 [oxygen] saturation every four (4) hours or as condition warrants. 5. If the internal temperature of the facility reaches 80 degrees Fahrenheit, obtain temperatures on all residents a minimum of every four (4) hours or as condition warrants. ... 7. Relocate residents to cooler areas of facility, if possible, as conditions warrant. 8. Continue visual rounds a minimum of hourly. 9. Complete physical assessment as residents' conditions warrant. 10. Maintain lightweight clothing on all residents 11. Initiate continuation hydration cart 7:00 AM to 10:00 PM...12. Revise staffing as needed, to appropriately implement and maintain action plan. At 5:50 PM, the Executive Director (ED) who had been working at the facility for only two weeks, told the surveyor that room temperatures were not to exceed [redacted] degrees Fahrenheit (F)	F 658		

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according to the regulation.

At 5:59 PM, the surveyor was introduced to the Director of Maintenance (DoM) who stated that he had only been employed by the facility for approximately [redacted] months since [redacted]. The DoM stated that the "last few days it's been hot in the facility" and that there had been issues with the air conditioning systems. He stated that the facility had several bids out since the beginning of [redacted], since there was a leak in one of the systems. He added that there was also an "air handler with a bad condenser for the [redacted] floor." He continued, that in addition to the [redacted] floor, the [redacted] floor had an issue with the air conditioner system causing "sparking" which required the entire air conditioning system on 3-North to be shut off "or there would be a fire." The DoM stated that they received a bid on [redacted] to address the problem, but it was not processed until yesterday on [redacted], and the bid was for [redacted] or so to diagnose the problem. The surveyor requested documented evidence of that diagnostic visit from the company and the findings. He stated that he didn't have a copy of it, but that he would look into finding out if anyone did.

At that time, the surveyor observed that the DoM was holding a clipboard and loose leaf paper with a hand-written heading "P-TAC (Rooms)" and a list of resident rooms written under it. It was not dated. The surveyor asked the DoM about the list, and he stated that he has not HVAC licensed, but that he had been working on changing the malfunctioning PTAC units in the resident rooms and had made a list. He stated that he started this list about two weeks ago when he began replacing the units. The list indicated that there

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were three rooms that had "new" PTAC units, rooms [redacted], and [redacted]. The DoM confirmed that those rooms he had replaced the PTAC units with new ones and that the other [redacted] rooms had PTAC units that "did not work." He stated that the process of replacing them had been going slow because he was "only one person." The surveyor asked what has been done for these other resident rooms when the PTAC units do not work due to the heat, and the DoM stated that they purchased ten portable air conditioner units and put some of them in resident rooms, in addition to the purchase of 30 fans. The surveyor requested a receipt of the purchases. The surveyor asked other than purchasing 30 fans and ten portable air conditioner units, what had been doing regarding the malfunctioned air conditioning and he added that he purchased four to five jugs of water at [redacted] yesterday and 12 bags of ice, but other than that he had not been doing anything else. The DoM stated that the air handlers won't be fixed for a few days but that there was no definitive date because the bid had only been processed yesterday. He stated that he should be checking room temperatures, and indicated he did check a temperature earlier and it reac[redacted] degrees F in a resident area. The surveyor asked where and when that was taken, and he could not speak to it. The surveyor asked if he kept any logs of temperature readings while the air conditioning system had been malfunctioning or not working at full capacity and the DoM stated that there were no room temperature logs. He stated that the last time he kept a room temperature log was "about a month ago" and had given it to the former administrator but "he's gone." The DoM confirmed there were no room temperature logs and could not speak to how the facility was monitoring for compliance

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with temperatures if they were not checking them over a given period of time and recording them. The DoM stated that the resident rooms were generally cooler than the hallways, but the DoM was unable to provide any documented evidence of that being the case.

At 6:07 PM, the surveyor continued to interview the DoM who stated that he does not routinely check room temperatures but that he uses the thermostats on each floor to determine if temperatures needed to be checked on the floors and that he looks at the thermostats "all day everyday." He stated that if the thermostats read above [redacted] degrees F, he would go and take temperatures of the resident rooms.

At 6:18 PM, the surveyor and the DoM entered the [redacted] Floor through the elevators. Upon exiting the elevator, the surveyor felt the floor to be very warm in the hallways. The surveyor observed with the DoM that there was no ice in the ice cooler. The surveyor and the DoM observed the thermostat reading for the front end of [redacted] which indicated a reading of [redacted] degrees F, and the back end of [redacted] thermostat read it was [redacted] degrees F.

At 6:25 PM, the DoM took the surveyor to the [redacted] unit. At that time the DoM reiterated that the thermostat for this unit had no reading, because the system had to be shut down due to sparking. He stated that the overload relay and heavy duty relay were both bad which caused the sparking and they shut the machine down on [redacted] because of the fire risk. He stated that the switch is located in the ceiling and acknowledged that because the switch was off, this was why there was no thermostat reading.

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A review of the weather history report for Camden, New Jersey reflected the following outdoor temperatures since 7/6/23:

7/6/23: 91 degrees F,
7/7/23: 91 degrees F,
7/8/23: 90 degrees F,
7/9/23: 85 degrees F,
7/10/23: 86 degrees F,
7/11/23: 89 degrees F,
7/12/23: 91 degrees F,
7/13/23: 93 degrees F,
7/14/23: 89 degrees F,
7/15/23: 92 degrees F.

At 6:29 PM, upon entering the [redacted] wing the surveyor felt that the air on the unit was very hot and heavy causing the surveyor to feel sweaty instantly. As the surveyor and DoM toured the [redacted] wing, the surveyor noted beads of sweat dripping from the DoM's forehead. The DoM acknowledged that it was very hot and uncomfortable on this unit.

The DoM took the indoor temperature of the [redacted] hallway which read [redacted] degrees F.

The DoM with the surveyor began taking room temperatures on the [redacted] Unit which included the following temperatures:
Room [redacted] degrees F.
Room [redacted] degrees F. There was no fan or air conditioner on in the residents' room and both residents were in bed. The DoM stated that the air conditioner was not turned on and he turned the PTAC air conditioner on. The surveyor attempted to interview the residents in that room but the residents who were both awake did not

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verbally respond to the surveyor. Both residents were visibly perspiring.

At 6:33 PM, the surveyor observed the Licensed Practical Nurse (LPN #3) assigned to [redacted] in the hallway passing out medications to residents. The LPN #3 stated that the temperatures on this floor were "[redacted]." The surveyor asked about the temperatures and if she had to do anything different in response to the heat situation on the unit, and she stated that she was assigned [redacted] residents this shift and that she just had to pass out medications, do [redacted] of residents and perform basic resident care. She stated that we can encourage hydration and take vital signs and skin turgor if a resident becomes confused, but otherwise there was nothing different that she had to do. The surveyor asked if any residents had to be hospitalized and she stated that there were none.

At 6:35 PM, the DoM took the room temperature of Unsampled Resident #10 which read [redacted] degrees F. The resident was [redacted] in bed in the room by the door had no fan and no air conditioner. The room by the window had an orange fan on the floor positioned between the bed and the window. Any airflow that was being produced by the fan was getting blocked by the bed and not reaching the unsampled Resident #10. The window was slightly open. The surveyor attempted to interview the resident, but the resident appeared [redacted] and refused to be interviewed.

At that time, the LPN #3 entered the resident's room and took a set of vital signs. The resident's body temperature was [redacted] F, the heart rate was [redacted] beats per minute, the blood pressure was

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F 658	Continued From page 78 [redacted] and the pulse oxygenation status was [redacted] on room air. The surveyor did not see the LPN #3 stop and count a respiratory rate and she exited the room with the vital sign machine. Upon exiting the room, the LPN #3 stated that there was a resident (Resident #1) who had known [redacted] and utilized [redacted] for [redacted] and resided a few doors down the hall. At approximately 6:38 PM, the surveyor continued to interview residents on [redacted] The surveyor observed unsampled Resident #11, who was [redacted]. The resident stated that "[redacted] " The resident continued to state, [redacted] adding that he/she has two fans and that the air conditioner in their room is broken. The resident continued to state that he/she had asthma and because of the heat, he/she had to utilize their [redacted] with an [redacted] " [redacted] The resident stated that sometimes they were provided ice, but the facility didn't have ice to give out yesterday. The resident stated that he/she didn't think they had ice today either, and added that [redacted] At that time, the resident called for the LPN #3 to request for ice. The LPN #3 took the resident's cup to get ice, and she returned and stated that "We don't have anymore ice...I will have to go and get more somewhere else in a little bit." The LPN #3 put the resident's cup back on their side table left the resident's room. The resident stated to the surveyor, "[redacted] The resident stated that they may get ice in the morning, but that was it.	F 658		

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At approximately 6:40 PM, the surveyor observed Resident #1 in bed next to the window. The resident was [redacted] and the room felt hot. The resident had no fan and no air conditioning in the room. The surveyor interviewed the resident at that time, and the resident stated, "[redacted]" and the resident began to wipe sweat from his/her forehead. At that time the resident stated, [redacted] d" and indicated that he/she was having a [redacted]. The surveyor observed [redacted] running at [redacted] from the wall, but the resident was not wearing the [redacted]. The surveyor asked the resident if he/she utilized [redacted] and the resident responded that he/she would put it back on and wear it. The surveyor observed the resident place the [redacted] back onto their [redacted] and take some [redacted]. The resident confirmed there was no fan or air conditioning in their room. The resident stated that he/she would get the nurse.

At 6:58 PM, the surveyor and the ED took the room temperature of a recreation room on the [redacted] floor which felt cool. There were three ambulatory residents in there but no staff. The ED stated that the "air conditioner works in here." The temperature read [redacted] degrees F. At that time, the ED stated that "heat is subjective to a person" and that residents may be comfortable in this heat and not want to leave their rooms. He stated that as long as the residents health was okay, they have a right to stay in their rooms and if their health deteriorated from the heat, then they would remove them. The surveyor asked the ED why they would wait until a resident's health deteriorated before proactively addressing the issue for each resident regarding the room

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temperatures, and the ED stated that they need to be proactive and not wait, but if residents don't want to move, they don't have to. The surveyor inquired how the facility was keeping the residents' rooms at an acceptable temperature for those that may not want to move or those that cannot verbalize it, and the ED stated that they provide ice, or the staff can provide a cool cloth for their face to cool the body down, offer and provide fans, and some residents received portable air conditioning units. He acknowledged that not all residents have fans or air conditioner units despite their malfunctioning PTAC units in their room and the central air conditioning system within the unit. He acknowledged that when conducting tour, no residents had a cool cloth on them.

At 6:59 PM, the surveyor and the ED returned to the room of unsampled Resident #10 who was in bed. There was still no air conditioning and the airflow of a floor fan was being blocked by the roommates bed. The room temperature reading read [redacted] degrees F.

At 7:00 PM, the surveyor interviewed the ED. The surveyor asked about how the facility chose to prioritize the use of fans and portable air conditioner units when the air conditioning had malfunctioned in the facility. The ED acknowledged the surveyor's questions and acknowledged that [redacted] degrees was too hot for any residents and that they would move them to the recreation room. The ED stated that he didn't know if doctors were called or how often nurses check or should check the vital signs in this situation. He stated that the staff do go around asking if the residents are feeling okay or if they are hot.

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F 658	Continued From page 81 At that time, the surveyor followed up with the ED about if he found out who the Licensed Nursing Home Administrator (LNHA) is at the facility, since the ED was not licensed in New Jersey, and the ED stated that he did not have their name yet, but the reason the LNHA was not in the building today was because it was a [redacted] for their [redacted]. At approximately 7:05 PM, the surveyor entered the DON's office with the ED. The DON was in her office which was adequately air conditioned. The DON provided the surveyor the name of the LNHA on record and stated that she doesn't know where he is, and that she tried calling him but he didn't answer the phone because it was [redacted] and his [redacted]. The DON stated that she only started working at the facility again in [redacted], and that the Regional LNHA was the LNHA on record in [redacted]. She stated that the new LNHA started on or around [redacted] The DON continued to explain again that the DoM informed her only yesterday about the air conditioner issue and the room temperatures. She stated that there was a previous issue with temperatures and the air conditioner system that needed replacement and explained, "I don't know if its been replaced." The DON added that she was aware of a thermostat reading of [redacted] degrees F and a room that was [redacted] degrees F, but that fans and hydration stations were purchased yesterday because they knew it would be very hot outside the next day. The DON and ED acknowledged that there were no room temperature logs and that they never instructed anyone to take log temperatures. They acknowledged that if temperatures were not	F 658		

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monitored and logged, how can the facility have knowledge of and act upon the temperatures, especially when outdoor temperatures were 89 degrees F. Temperatures of the second and third floors were discussed with the DON and ED and the residents complaining of it being hot, humid and that they were sweating. The DON began stating that the residents were "comfortable" and "not in distress" and didn't want to leave their rooms. She stated that no residents complained to her about the heat. The surveyor asked the DON if she would wait until the residents were in distress before responding to the lack of adequate temperature control in their facility, and the DON could not speak to it, insisting that the resident's were comfortable. The DON acknowledged that the interruption in air conditioning service wasn't reported to the NJDOH until today after the NJDOH had reached out to her.

The DON stated that she believed the room temperature requirement was not to exceed [redacted] degrees F. She stated that she she was not aware that the air conditioner system was shut down on [redacted]

At 7:23 PM, the surveyor and the New Jersey Department of Health (NJDOH) management who conferenced in telephonically, informed the DON and the ED that the facility's failure to maintain adequate room temperatures in accordance with regulatory requirements, implement a system to monitor room temperatures when the air conditioning systems were known to not be operational or not functioning at full capacity during the heat of the summer months, including today when it was [redacted] degrees F outside, failure to identify high-risk

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residents to ensure they had adequate temperature control to reduce the risk for a heat related emergency, with limited access to sufficient cooling areas in the facility placed all residents on both floors in an immediate safety risk situation that required the activation of their Emergency Response Plan and the local Office of Emergency Management (OEM).

The ED stated he would find the phone number of the local OEM and notify them.

At 7:46 PM, the surveyor returned to the [redacted] unit and interviewed the unsampled Resident #12 who stated, [redacted] " The resident's roommate, unsampled Resident #11 stated that he/she was also sweating and that no one has offered them cool cloths for comfort or ice and that he/she only sees staff "every few hours." Both residents reported that no one has checked their vital signs today.

At 7:52 PM, the surveyor saw Certified Nursing Aide (CNA #2) walking down the hallway, and she stated that she has been employed at the facility since [redacted] and informed the facility about the indoor room temperatures on [redacted] stating, "It's been hot for a while-weeks!"

At 7:56 PM, the surveyor interviewed the LPN #3 again who was assigned to [redacted]. The surveyor requested the LPN #3 to provide a printed copy of the unit census, and the LPN #3 stated that she just started at the facility only a week ago and that she doesn't know how to print the census or the medical records for any resident. The surveyor asked if a resident was transferred to the hospital, how she would print

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out the records such as the Medication Administration Record (MAR) to go with the resident, and she stated that she would have to ask someone else to do it. The surveyor asked if she had been trained on Emergency Preparedness at the facility and how to respond, and the LPN #3 replied that she had not been trained. She stated that if there was an emergency, she wouldn't know what what to do and because she didn't know how to print documents, she acknowledged it would make it difficult to send residents elsewhere with their electronic medical records.

At 8:07 PM, the ED informed the surveyor he left a voicemail for the local OEM regarding the facility's indoor heat situation.

At 8:18 PM, the surveyor noted the new outdoor temperature to be [redacted] degrees Fahrenheit, and began to take additional temperatures on [redacted], which revealed the following:

Hallway: [redacted] degrees F.
Room [redacted] degrees F.
Room [redacted] degrees F.
Room [redacted] degrees F
Room [redacted] degrees F
Room [redacted] degrees F

At 8:35 PM, two surveyors returned to the room of Resident #1 and took a room temperature which read [redacted] degrees F. The resident still had no fan or functioning air conditioner in their room. The resident stated that he/she was still hot and not feeling well. At that time, two surveyors went to get the RN/Supervisor. The RN/Supervisor brought the machine into the resident's room to take a set of vital signs, but then stepped out

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F 658	Continued From page 85 stating he had to look for gloves. There were no gloves accessible in or around the resident's room. The RN/Supervisor took approximately three minutes to find a pair of gloves before taking the resident's vital signs. The RN/Supervisor applied the pulse oximeter onto the resident's finger first to determine his/her oxygenation status which read [redacted] while the resident was on [redacted]. The heart rate began at [redacted] beats per minute (bpm) for several seconds on the machine, and slowly started to decline to [redacted] bpm then [redacted] bpm, then [redacted] bpm. The RN/Supervisor never accessed a stethoscope to get an apical heart rate when the heart rate was showing signs from the pulse oximetry device that there may be [redacted] The RN/Supervisor did not take or document the blood pressure reading or take a temperature, and he went to get the resident a [redacted] to [redacted]. Upon the RN/Supervisor's return, he provided the nebulizer to the resident using a mask, but did not take an oral temperature and did not stop to count a respiratory rate prior to applying the [redacted]r. The surveyor asked when was he going to take a temperature, and the RN/Supervisor stated that he wasn't going to take an oral temperature but that he would go try and find a [redacted] that can be scanned on the forehead. At 9:47 PM, the surveyor returned to the [redacted] with the ED to screen residents for safety and relocation and take additional room temperatures. At 9:54 PM, the surveyor observed that even as outdoor temperatures had reduced to [redacted] degrees F, there were [redacted] residents that had room	F 658		

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F 658	Continued From page 86 temperatures that exceeded [redacted] degrees F. The surveyor took room temperatures again that included the room of Resident #1. The PTAC unit was not functioning in the room. There was now a box fan in the window and a broken window screen. Resident #1 stated it was put there one hour ago. The room temperature was [redacted] degrees F. The resident stated that the [redacted] provided some relief. During the course of the safety and room temperature checks on [redacted] from 9:54 PM to approximately 10:45 PM, there were no facility staff on the unit making a good faith effort to relocate the residents who were unable to make their own decisions or were dependent on staff for activities of daily living and had no air conditioning in the room. In addition while conducting the rounds with the ED, the ED stated at approximately 10:20 PM, that he had to go wheel a resident down the hallway in a wheelchair and that he would be right back, but the ED never returned to the [redacted] Unit and the surveyor continued the tour checking on the residents and taking temperatures without him. At 11:10 PM, a new facility representative entered the facility and office of the LNHA and stated that he was "Second in command" with the company, and that he wanted to discuss the facility's plan to address the malfunctioning air conditioning system. He stated that they were trying to get every portable air conditioner unit available to the facility. He stated that they were able to bring six over now from another building, and they are hoping to deliver ten more total. He added that they would relocate residents to the cooler space if they did not have a portable air conditioner to give them.	F 658		

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At that time, the DON provided the name of the Medical Director. She stated that the Medical Director had been called earlier this evening, but that she had not heard back from him yet. She confirmed there has not been a physician in the building. The DON stated that she was licensed as a Nurse Practitioner but acknowledged that she could not perform the medical services as a NP since she was also the DON of the facility.

At 11:41 PM, the surveyors discussed with facility administration that, as of approximately 10 PM, there were [redacted] resident rooms affecting [redacted] residents who resided in those rooms on [redacted] that had temperatures exceeding [redacted] degrees F with malfunctioning PTAC units.

At 11:50 PM, the DON stated that the Nurse Practitioner (NP) would be at the facility in 90 minutes in lieu of the Medical Director to assess residents.

On 7/16/23 at 12:35 AM, the surveyors returned to the [redacted] Unit and observed Resident #1 still in his/her room. The resident had no air conditioner and a box fan in the room. The resident stated that he/she was [redacted] The resident appeared [redacted]. At that time the surveyor got the LPN #4 who stated that he worked [redacted] and [redacted], but states that he is familiar with Resident #1. The LPN #4 confirmed that the room temperature felt warm, and he acknowledged that it was because there was no functioning air conditioner in the room and only a box fan which was in the window. The LPN #4 stated that Resident #1 may be going on [redacted] services soon due to his/her condition but was

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not currently on [redacted]. He confirmed that this was the resident's normal condition because of the prospect of [redacted]. At that time, the LPN #4 asked the resident if he/she wanted to go to a cooler location, and the resident indicated that he/she did not want to go, but the resident acknowledged that the room was too warm. The LPN #3 offered to bring the resident to the recreation room with his/her bed, and the resident declined. At that time, the LPN #4 stated to the surveyors that he couldn't force the resident to leave. The surveyor asked if anything could be done with the room temperature then, and the LPN stated that he would have to look into that. He acknowledged that due to the resident's condition, he didn't know why there was no air conditioner in his/her room, especially if he/she didn't want to leave the room. The resident had no cool cloth or other cooling methods offered to him/her at the time of the encounter.

At approximately 12:50 AM, the surveyor observed two new portable air conditioner units being brought up through the elevator. The staff were walking it down the [redacted] unit, but nobody delivered a portable air conditioning unit to the room of Resident #1 on [redacted] who was expressing that he/she was hot and sweaty and had known [redacted] and [redacted].

At 1:12 AM, the surveyors conducted an emergency code "crash" cart check on the third floor with the LPN #4 to determine adequate, easily accessible supplies in the event of an emergency or other heat related event. The LPN #4 and DON were unable to locate the suction machine, despite the LPN #4 stating that he signs

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F 658	Continued From page 89 off the accountability sheet for the code cart. After looking all over the mobile code cart, the surveyors found it on the top shelf of the cart. At that time, the LPN #4 walked away from the surveyors and the DON acknowledged that this was the [redacted]. At that time, the surveyors continued to review the 11-7 Daily Nursing Crash Cart Check List and compared the checklist with what was actually in the emergency code cart. The surveyor observed that the items within the code cart were in disarray with [redacted] located in several of the drawers with other products stored on top of each other making it difficult to easily identify supplies. The surveyors observed there was supposed to be [redacted] but there was only one in the code cart. The DON stated that there were [redacted] in the medication carts, and the DON went to the medication cart to pull one out to show the surveyors. The surveyor asked why nurses were signing off that there were two present including on [redacted] but there was only one in the drawer, and the DON stated that they had them accessible in the medication carts, even if it wasn't on the code cart. She acknowledged that the code cart should be stocked with all the items on the list. The surveyor also observed that there supposed to be [redacted]) in the code cart, but there were none. The surveyors also observed that there were two house-stock doses of [redacted]) that were expired in [redacted], and one [redacted] prescription with a resident's name on it. The DON acknowledged that a medication assigned to an individual resident should not be in the code cart. The surveyor observed that the 11-7 [night shift]	F 658		

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Daily Nursing Crash Cart Check List for [redacted] had a box to mark down the "[redacted]]." However it did not specify what was being verified such as the location of the AED, its functioning, and [redacted] expiration check. The nurse had inaccurately signed off that the code cart check was done on [redacted] and all items listed on the sheet including [redacted] and [redacted] were present and available in the code cart.

At that time, the surveyor checked the functioning of the [redacted] device that would need to be used in the event a resident needed [redacted]. The [redacted] turned on and was functioning during the test. However, the [redacted] were noted to have an expiration date of [redacted] which was over a month ago. The DON stated that someone from the facility would look into that issue. She confirmed that the 11-7 Daily Nursing Crash Cart Check List did not have accountability for the the expiration of the pads and functioning of the machine. The DON was unable to provide any evidence of a separate [redacted] accountability record. She acknowledged that the nurse signed the check list on [redacted] for the '[redacted]."

At 1:24 AM, the surveyor observed LPN #5 in the hallway of the [redacted] Unit. The LPN #5 stated that this was her [redacted] at the facility as she was an agency nurse. She confirmed she was assigned to the [redacted] unit for the night shift. She acknowledged that the unit was on the warm side and that she was aware that not all the air conditioners worked on the unit. She stated that she was waiting on maintenance to fix the issue. The surveyor asked if she was informed to do anything different for the residents in particular

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related to the malfunctioning air conditioning on the units, and the LPN #5 stated she was not told to do anything different except offer the residents water and ice. The surveyor asked if she had to do more frequent rounding, monitoring or vital signs, and the LPN #5 stated that she did not. The surveyor asked about more frequent assessments on the residents, and the LPN #5 stated "no" because maintenance was trying to correct the problem.

At that time at approximately 1:28 AM, the surveyor observed the Nurse Practitioner enter the [redacted] floor and walked over to the nurses station to meet with the DON. After meeting with the DON, the NP stated to the surveyor that she was going to start doing assessments on the residents due to the malfunctioning air conditioning system and the heat in the building. At that time, the NP stated that she was going to start her assessments on the [redacted] unit. The surveyor stopped the NP and asked about how she prioritized her decision to start on the 3 West unit when the [redacted] unit was known to be the most affected by the heat, and the NP turned around and acknowledged the surveyor's question. She stated she would start on the [redacted] unit instead. The surveyor discussed Resident #1 and she stated that she would start her assessment with Resident #1.

At 1:31 AM, the surveyor observed Resident #1 in the hallway in a wheelchair positioned in an alcove. The resident's bed was in the hallway also. The surveyor observed LPN #5 take some vital signs using a machine on the resident who was not [redacted] at the time. The resident's pulse oxygenation status was [redacted] on room air, and the heart rate using the pulse

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F 658	Continued From page 92 oxygenation device was reading a pulse of [redacted] bpm. The resident's blood pressure read [redacted]. The NP stated that she wanted to take a manual blood pressure reading. The NP took a manual reading and stated that it was [redacted] She also stated that she had listened to the resident's apical pulse and it was very irregular, and he/she was experiencing a change in their normal behavior as he/she appeared more [redacted] and was usually [redacted] and [redacted]. She stated that she wants to send the resident to the emergency room for evaluation. The surveyor observed that this was how the resident had been presenting since the first obervation earlier in the day. At 1:38 AM, the surveyor interviewed the NP who stated that she had worked at the facility for three years and was familiar with Resident #1. She stated that the resident's heart rate when she listened to it was [redacted] She stated that the resident was just not acting themselves. The surveyor asked the NP was she was assessing in the residents related to a [redacted] event, and she stated that mostly she would be looking for a change in [redacted] She stated that the skin may feel warm too. The surveyor pressed the NP asking if there was anything else she would be assessing the resident's for, and she stated a change in vital signs, skin turgor that was not elastic, increased thirst sensations, dry skin, and that under the eyes there may be paleness. The surveyor asked if staff were supposed to be monitoring the residents over any frequency due to the room temperatures not maintaining safe, comfortable levels, and the NP stated that residents should be checked every four to six hours. The NP then resumed her assessments	F 658		

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F 658	Continued From page 93 of the other residents on [redacted]. The surveyor reviewed the medical records for Resident #1 who was sent to the hospital on [redacted] around 2 AM. A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included [redacted]) with an onset date of [redacted]. The Admission Record revealed that the resident was a [redacted] status, indicating that [redacted] efforts should be performed in the event of a [redacted] emergency. A review of the resident's individualized care plan initiated on [redacted] included that the resident had [redacted] due to being an [redacted]. One of the goals included that the resident will display [redacted] with an [outdated] target date of [redacted] Interventions included give [redacted] as ordered. Monitor/document any side effects and effectiveness; Monitor for signs and symptoms of acute respiratory insufficiency; [redacted]; and to utilize the [redacted]	F 658		

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In addition, there was a care plan initiated on [redacted] that the resident has a [redacted] related to [redacted]. The goal had an outdated target date of [redacted] that the resident's comfort will be maintained through the review date. An intervention included to consult with physician and social services to have [redacted] care for resident in the facility.

The care plan reflected that the resident required an extensive physical assist of one staff for bed mobility.

A review of the active physician Order Summary Report for [redacted] reflected a physician order for a [redacted] evaluation and treat dated [redacted] and a physician order dated [redacted] for [redacted], administer [redacted] every four hours as needed for [redacted]. The Order Summary Report also reflected that the resident was on medication for [redacted]. There was no physician order for [redacted]. In addition the electronic Medication Administration Record (eMAR) for [redacted] did not reflect the same active physician orders found in the Order Summary Report for [redacted]

A review of the Progress Notes for [redacted] reflected a physician progress note dated [redacted] at 23:31 (11:31 PM) that the resident was recently readmitted to the facility following an acute hospitalization after presenting with [redacted] and was treated with [redacted] and improved. It further reflected that the resident has "multiple admissions to...hospital for [his/her] [redacted]"

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F 658	Continued From page 95 including recurrent [redacted] requiring [redacted]. There were no electronic Progress Notes (ePN) from the nurse from [redacted] unti[redacted] at 2:03 AM which reflected that the resident was sent to the hospital via 911 for [redacted]. The vital signs recorded indicated BP [redacted], HR [redacted] BPM, SP02 (pulse oxygenation status) [redacted] on room air, temperature [redacted] degrees F. The note indicted that the physician was notified and the POA was contacted. There was no respiratory rate recorded on the progress note or documented evidence of the auscultation of lung sounds when the resident had complained of [redacted] and received a [redacted]. The nurse documented the resident had [redacted] e in the [redacted] Summary on [redacted] at 1:43 AM. A review of the ePNs for [redacted], the eMAR for [redacted], and the vital signs summary report reflected that the resident had not had any vital signs taken and documented since [redacted] at 15:43 PM (3:43 PM) until surveyor intervention on [redacted], despite knowledge of the resident's [redacted], recent hospitalizations, and air conditioner being malfunctioning on the unit [redacted] and in the resident's individual room as indicated on the facility's undated "P-TAC (Rooms)" list for malfunctioning P-TAC units. (Resident #1 had no air conditioner or fan in the room on [redacted] and the room temperature exceeded [redacted] degrees F). A review of the undated "P-TAC (Rooms)" list maintained by the DoM reflected nine resident	F 658		

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rooms that did not have a working PTAC unit, including the room belonging to Resident #1. The list reflected that all the rooms listed on [redacted] that had malfunctioning PTAC units had zero of them fixed or replaced since the list was started (which was two weeks ago according to the DoM), particularly upon the shutdown of the air conditioner system on [redacted] on [redacted] when there was noted to a sparking issue system and subsequent fire risk.

Upon observation, there was no alternative means provided such as a portable air conditioner to maintain the room temperature below [redacted] degrees F in the room for Resident #1 who had a malfunctioning PTAC unit and a known [redacted] that put him/her at high risk for adverse events from a [redacted] emergency, in accordance with professional standards of practice to avoid harm.

On 7/16/23 at 2:00 PM, the facility provided the surveyors the list of residents identified by the facility to be at high-risk for adverse outcome related to heat. The facility indicated that there were [redacted] residents out of a total of [redacted] residents on their census that were at [redacted] an adverse outcome. This indicates a total of [redacted] of their resident population identified to be at high risk for an adverse outcome if not provided adequate room temperatures.

Approximately 1:50 AM, the local Office of Emergency Management (OEM) officer called for medical transportation for Resident #1 to be transferred to the Emergency Room.

At approximately 2:30 AM, the surveyors and local responders met with the DON, ED, and

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second in command regional administrator regarding the surveyors concerns to develop an individualized plan to prevent a heat-related adverse event when their air conditioning system and individual PTAC units were known to be shut down or not working at full capacity, implement adequate and sustaining cooling measures to reduce the risk for serious harm, initiate room temperature checks when air temperature on resident units were excessively humid and residents were visibly perspiring and complaining of feeling [redacted]" and appropriately activate their emergency response plan upon identification of their air conditioning malfunction in [redacted] degree outdoor temperatures with no immediate plan to correct the HVAC malfunction. They were notified of Resident #1 had known [redacted] and [redacted] for [redacted] had no air conditioner or fan and the room temperature exceeded 86 degrees and had to be hospitalized due to a change in condition that nursing staff did not act upon even when brought to the attention by the surveyors.

At 7:50 PM, the surveyors requested to meet with the facility administration, and the Regional LNHA brought in himself and the Regional Director of Building Operations. The ED and DON were not brought in, and the surveyor asked why. The Regional LNHA stated that the ED was not coming in today, but he stated that he would get the DON. At that time, the surveyor asked the DON about Resident #1 and she stated that the resident was hospitalized for [redacted]. She stated that he was on [redacted] services but had frequent hospitalizations. She stated that the resident had a [redacted], [redacted]. She stated that the resident was not always compliant with the use of

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supplemental [redacted] and was frequently sent to the hospital and would come off [redacted] each time the resident was sent to the hospital. The surveyor asked if the resident was admitted to the hospital each time, and the DON replied yes, stating that the resident was [redacted]. The surveyor asked why the resident was not provided air conditioning if the resident's health was [redacted] when the PTAC system in the room was known to be nonfunctioning and the unit HVAC system had been shut down to prevent a fire. The DON could not speak to it. There was no documented evidence that the resident was offered and declined a portable air conditioner unit or asked to move to a different room and declined. The surveyor further informed the facility of the [redacted] being outdated on the [redacted] floor on [redacted] but were verified to be replaced with new, non-expired [redacted] on [redacted] after surveyor inquiry. The surveyor also discussed the discrepancies in what was signed off in the 11-7 Daily Nursing Crash Cart Check List on [redacted] and what was available in the emergency code cart that day in the event of an emergency, particularly during their heat emergency. The facility was notified that their failure to identify their high-risk resident (Resident #1) who was complaining of [redacted] and respond in a manner that adheres to professional standards of nursing practice to assess, identify, respond, and call the physician at the time when the resident was verbalizing a change in condition during a time there was no air conditioning in the resident's room, no fan, and the resident's room temperature exceeded [redacted] degrees Fahrenheit.

Two LPN's and one RN who each saw Resident #1 stated that this was the resident's baseline. A

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F 658	Continued From page 99 night shift LPN stated that the resident might be admitted to [redacted] but was not on hospice service. The Nurse Practitioner arrived around 1:30 AM on [redacted] and assessed the resident and stated that this was not the resident's normal behavior or baseline and he/she had an [redacted] There were no vital signs taken or recorded for Resident #1 on [redacted] and [redacted] until surveyor intervention. The resident was sent to the hospital during the early morning hours of [redacted] Interview with the night shift agency LPN stated that she was aware of the heat situation in the facility but that she didn't need to do anything different for the residents despite the Heat Emergency Plan requiring otherwise. This resulted in an immediate jeopardy situation for Resident #1 who was known by the nurses to have known [redacted] for [redacted] and failed to implement measures to assess and maintain the resident's room temperature and failed to follow professional standards of practice when the resident complained of [redacted], and failed to act in an manner to prevent worsening of the condition by promptly calling physician, intervening to address the lack cooling in the room or offering to transporting the resident to another area of the building until surveyor inquiry. No additional information was provided to the surveyors. The facility administration was formally provided an immediate jeopardy template at 8:23 PM on [redacted] and a written Removal Plan was	F 658		

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requested.

On 7/17/23 at 1:27 AM, the facility provided an acceptable written removal plan.

On 7/19/23 from 9:00 AM to 3:08 PM, the surveyors made observations, interviews, conducted a review of records and pertinent facility documents. The survey team was able to verify the implementation of the written Removal Plan, and the immediacy was confirmed as lifted on [redacted]. No additional documentation was provided prior to surveyor inquiry that indicated that the physician had been notified regarading the heat situation and the resident's verbalizations of not feeling well when the room temperature exceeded [redacted] degrees F, and evidence of vital signs during the heat emergency to ensure the resident had no air contitioning in their room, in accordance with professional standards of practice and Emergency Preparedness procedures.

A review of the facility's job description for a Licensed Practical Nurse included "Receives full and detailed report from the outgoing nurses to ensure proper communication and necessary follow-up of resident's guest's care...Recognizes and responds competently to changes in resident's condition and documents appropriately...Interacts and partners with all multidisiplinary service teams, internal and external, to assure continuum of care...Maintains a safe environment for residents/guests and reports unsafe situation for resolution...Notifies responsible party of changes in patient's condition." The job description did not include job duties related to emergency preparedness and response.

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F 658	Continued From page 101 A review of the facility's job description for a Registered Nurse included, "Receives full and detailed report from the outgoing nurses to ensure proper communication and necessary follow-up of resident's guest's care...Recognizes and responds competently to changes in resident's condition and documents appropriately...Interacts and partners with all multidisiplinary service teams, internal and external, to assure continuum of care...Maintains a safe environment for residents/guests and reports unsafe situation for resolution...Notifies responsible party of changes in patient's condition... Refers to Nursing/Administration/IV/Emergency Management Policy and Procedures (Public Folders, Hard Copy manual) to assure standard of care...accurate and timely completion of Nursing Assessment and data collection upon admission... A review of the facility's job description for the Director of Nursing did not include duties related to Emergency Preparedness and response.	F 658		
F 761 SS=F	NJAC 8:39-11.2(b) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		7/21/23

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F 761	Continued From page 102 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: COMPLAINT # 165731 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to implement proper temperature controls for a medication storage room located on the [redacted] floor of the facility while the facility experienced a malfunction in the Heating Ventilation Air Conditioning unit since [redacted]. On 7/16/2023 at 3:13 PM during a tour of the facility, the surveyor observed the [redacted] floor medication storage room. The room was noticeably warm upon entering it. At this time, the Regional Maintenance Director used an Infrared Thermometer to capture the ambient room temperature yielding a result of [redacted] degrees Fahrenheit (F).	F 761	F 761 Element One □ Corrective Actions " All drugs and biologicals were immediately removed from the third floor medication room to a locked storage area with an acceptable air temperature on [redacted]. All [redacted] medications and [redacted] were discarded as per the pharmacy direction and reordered. " Repair of the exhaust vent in the medication storage room is being completed once the ordered part is received. In the interim all drugs and biologicals are now in the [redacted] floor medication room that maintains a proper temperature range per recommendations of the Pharmacist and manufacturer. Element Two - Identification of at risk Residents	

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F 761	Continued From page 103 On the same date and time inside the medication room, the surveyor observed [redacted] medications that were warm to the touch. The surveyor counted [redacted] medications (medications [redacted] in the resident). The labels on the antibiotic intravenous meditations revealed that the medications must be stored at room temperature, specifically between [redacted] and [redacted] degrees Fahrenheit. The surveyor also observed two boxes of an [redacted] milligrams/[redacted], assigned to [redacted] individual residents. Written on each box were instructions to, "Store at [redacted] [degrees] to [redacted] [degrees] F." At 3:05 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who confirmed that the [redacted] were for residents that had [redacted] She acknowledged the room temperature and stated that she would call the pharmacy to get replacements. At approximately 3:15 PM, the surveyor interviewed the DON who acknowledged that the medication room was not considered room temperature if it was reading [redacted] degrees F. She was not able to speak to what room temperature was, but that she would have the medications removed and stored in a cooler location. On the same date at 3:54 PM during a telephonic interview with the surveyor, a Pharmacist for the facility's pharmacy that provided the [redacted] medications recommended that if the medications were in that temperature [redacted]	F 761	" All Residents on the [redacted] floor have the potential to be affected by this practice. Element Three □ Systemic Change " The Director of Nursing and Director of Maintenance checked all medication storage areas to ensure drugs and biologicals were properly stored in locations that complied with the pharmacist and manufacturer room air temperature recommendations. " Licensed nursing staff received re-education regarding monitoring and reporting air temperatures outside the desired range in medication rooms to ensure all drugs and biologicals are properly stored. Element Four □ Quality Assurance " Daily air temperatures are recorded in all medication rooms as assigned and reported to the New Jersey Department of Health per the directed plan of correction. All have been within acceptable range since July 16, 2023. " The Maintenance Director/designee will monitor common area temperatures, including medication storage rooms, every two hours x 48 hours, then every shift x 14 days and daily thereafter with no stop date. Results are reported to the administrator and emailed daily to the department health until substantial compliance is achieved. Results are also shared at the weekly Quality Assurance Performance Improvement (QAPI) meeting for action as appropriate. " The Administrator/designee makes random daily rounds with the maintenance staff to confirm air temperatures are	

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F 761	Continued From page 104 degrees Fahrenheit) for approximately ten days, not to use them. The facility's air conditioning malfunction was identified on [redacted]. A review of the facility's undated Storage of Medications policy included that nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner. The policy was nonspecific about acceptable temperatures for medication storage.	F 761	acceptable where drugs and biologicals are stored. Results are discussed with the Director of Nursing daily and in aggregate at the weekly Quality Assurance Performance Improvement (QAPI) meeting for further action as appropriate.	
F 835 SS=L	§ 8:39-29.4 (h) Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Refer to F600 and F658 COMPLAINT#:NJ00165731 Based on observation, interview, record review and review of other pertinent facility documentation on 7/15/2023, 7/16/2023 and 7/19/2023, it was determined that the facility's Administration failed to initiate their Emergency Heat Plan (EHP) effectively and efficiently to ensure all residents received the care and services needed to maintain their quality of life when indoor temperatures exceeded [redacted] degrees	F 835	F-835 Element One – Corrective Actions · The facility Heat Emergency Response Plan was activated on [redacted] · The air conditioning main system unit was repaired as of [redacted] with all common areas and resident rooms having acceptable temperatures. · The secondary PTAC units are being replaced as they are received, and	7/21/23

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F 835	Continued From page 105 Fahrenheit (F). The air conditioning systems on 2 of 2 resident floors were identified by facility staff as no longer functioning at full capacity on [redacted] through [redacted]. The facility failed to ensure that the maintenance staff implemented a plan to monitor and document room temperatures for heat elevation during the disruption of service on the 2 residential floors. There was no evidence that the facility notified the New Jersey Department of Health (NJDOH) of the disruption of service of the air conditioning systems until [redacted]. There was no evidence that the facility identified high risk residents with medical conditions that have the likelihood to develop heat related symptoms due to the prolonged exposure to elevated indoor heat temperatures. The Executive Director (ED) covering for the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Maintenance Director and facility staff failed to demostrate knowledge of what their roles and responsibilities and course of actions to perform according to their facility's Emergency Preparedness Plan for heat and the failure to locate it for review. Additionally, the Administration failed to ensure that the job description that defines the duties of the Administrator within the facility was being followed since the current Administrator of record went on a leave of absence that began on [redacted] The LNHA continued to allow [redacted] new admissions to the building since [redacted] with knowledge that the air conditioning was not functioning at capacity and without evidence of the HVAC system and PTAC units being restored. This deficient practice created an Immediate	F 835	portable air conditioner units and fans remain in any rooms where PTAC units on order have not been received. All room air temperatures have been acceptable since [redacted]. · Hydration stations, extra ice, and additional fans were placed on each unit on [redacted] and continue to be available daily during extreme heat waves. · Resident #1 was assessed by Nurse Practitioner and was sent to the Emergency Room for evaluation and subsequently admitted with a diagnosis of atrial fibrillation unrelated to the heat on July 16, 2023. This individual no longer resides at the facility. · The interruption of service was reported to the Department of Health on July 15, 2023. · The Executive Director was re-educated on heat related emergencies, identifying at risk residents, maintaining appropriate temperatures in facility, reporting interruption of services to the Department of Health, and activation of Emergency Preparedness Plan on July 17, 2023. · The maintenance director was re-educated on maintaining temperature logs of facility temperatures. · Residents are provided with extra ice in their rooms as appropriate. Element Two – Identification of at Risk	

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F 835	Continued From page 106 Jeopardy (IJ) situation for the facility's failure to follow and to ensure staff were knowledgeable and prepared to initiate and execute the written duties outlined in their heat emergency plan that placed all residents at risk for serious harm, injury and death during prolonged indoor heat exposure. The surveyors identified an IJ situation for F 835 Administration at a scope and severity (s/s) of L. The IJ began on [redacted] and the facility was notified on [redacted]. The IJ was removed on [redacted]. The facility provided an acceptable removal plan on [redacted] and was verified with an on-site visit [redacted]. The non-compliance for F835 remained on [redacted] for no actual harm with the potential for more than minimal harm that is not immediate jeopardy. As evidenced by the following: During a telephone interview on [redacted] at 1:06 p.m., when the surveyor asked the Designated Administrator (DA) about a NJDOH hotline call, he stated he had only been working at the facility for two weeks and he acknowledged that the facility's air conditioning system was not functioning, he was unsure of the exact date and time it started not working and that some parts of the facility had air conditioning but other resident areas were limited. The surveyor then inquired about the current temperature readings in the facility. The DA was not sure of any exact numbers or temperature ranges and could not provide information on the condition of residents affected by the heat because he was not currently in the facility. However, the DA indicated that the Emergency Plan was being followed.	F 835	Residents · All residents without adequate temperature control in their environment have the potential to be affected by these practices. Element Three – Systemic Change: · The permanent New Jersey Licensed Nursing Home Administrator of record started employment at the facility on July 17, 2023 replacing both the Executive Director and the temporary New Jersey Licensed Nursing Home Administrator of record. The permanent New Jersey Licensed Nursing Home Administrator was oriented by the Regional Licensed Nursing Home Administrator and the consultant Licensed Nursing Home Administrator. · The Nursing Home Administrator and consultant administrator meet each morning and at the end of each day to discuss events of the day and actions taken including the emergency operation plan. · The maintenance director was re-educated on maintaining temperature logs of facility temperatures on [redacted] · Logs are submitted to the Department of Health daily as required by the directed plan of correction. · Nursing Staff were re-educated on	

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F 835	Continued From page 107 On 7/15/2023, at 5:02 p.m. and 7:30 p.m. an on-site visit by surveyors was conducted to the facility based on the lack of clear and concise information communicated over the phone from facility staff about the condition of the residents who are being effected by the air conditioning units that were not fully functioning on the [redacted] and [redacted] floors. On 7/15/2023 at 5:19 p.m. the Surveyor toured the [redacted] Floor and found the air warm and humid. The surveyor interviewed LPN#1 if room temperature readings were being taken and the he replied that he didn't know about that. The surveyor continued to observe residents on the [redacted] floor. At 5:22 p.m., the surveyor knocked and walked into room of Resident #4, who was in a wheelchair and whose roommate was in bed. The surveyor noted room was warm and humid. The roommate stated it was "warm" but Resident #4 stated "[redacted] The resident added that the air conditioner in the room has not been working. The resident stated that everyone knows about it, including the nurse. The surveyor asked what the facility did to address the issue, and the resident stated that the roommate got a small fan, but that he/she got "nothing." Resident #4 stated that "if you want something you must ask for it. No one came around offering fans." The surveyor observed that there was no air coming out of the PTAC unit, despite the unit indicating that it was "on." The surveyor interviewed LPN #1 at 5:25 p.m.	F 835	recognizing and assessing for signs and symptoms of heat related illness and reporting to supervisor/designee any air temperature abnormalities and transferring residents to cooler areas on July 16, 2023. · The Emergency Preparedness Plan was reviewed and revised with assistance of the consultant Administrator, and binders were placed on each unit, and front lobby desk, nursing office and Administrators' office. Staff were re-educated on the location and content of the Emergency Preparedness Plan binder and their role responsibilities. · All residents were reassessed on July 17, 2023, and findings documented by facility Medical Director/Nurse Practitioner as required with no indication of heat related illness noted for any resident. · All resident rooms, and common areas were assessed for elevated temperatures and results documented and sent to NJ Department of Health (DOH) daily as required by the Directed Plan of Correction (DPOC). · A temperature log is utilized to monitor and track room and common space air temperatures. · All residents were assessed by nurse practitioner for signs and symptoms of heat related illness and an acuity list designating high risk residents was generated and placed on each nursing	

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F 835	Continued From page 108 about Resident #4 and the roommate lack of air conditioning in the room. LPN #1 said that the residents' PTAC unit was not functioning in their room. The LPN #1 went to the room and attempted to adjust the PTAC unit playing with the switches and there was no air coming from the vent. The LPN #1 stated that [redacted]." The surveyor observed that there was no air coming out of the PTAC unit, despite the unit indicating that it was "on." LPN #1 could not provide information regarding how high the temperature was in the room. At 5:33 p.m. the surveyor continue to observe residents' rooms on the [redacted] floor for non-functioning PTAC units, fans in place and if hydration needs were being met. The surveyor observed at 5:37 p.m., while still on the second floor, a facility staff member walking up the hallway carrying a plastic, red dye analog thermometer. This was the Executive Director (ED) of the facility who had communicated earlier by phone with the surveyor about the situation at the facility. The surveyor asked if he was the Licensed Nursing Home Administrator (LNHA) of the facility, and he stated that he had a LNHA license but not in New Jersey and was waiting for reciprocity to work in this state. The surveyor asked the ED who was the LNHA for the facility. The ED indicated he was "not sure" and that he would have to check. The ED stated that he was the "designated administrator" and that he was currently taking temperatures on the floor using the red dye analog thermometer. He held it up for the surveyor while on the back end of the [redacted] floor hallway near room [redacted]. The ED confirmed that the temperature on the thermometer was	F 835	unit to be used in an emergency as appropriate. · Residents unable to effectively communicate their feelings of comfort, unable to ambulate, with a BIMS<12 or unable to shift/roll independently were placed in a higher acuity level and assessed more frequently for signs or symptoms of possible heat related illness or discomfort was reviewed and updated by the DON consultant and the interdisciplinary team and staff re-educated. · Families were notified of the air conditioner repair issue and updated as were facility MD's. · Residents were updated verbally and at scheduled Resident Council Meetings of the repairs to the air conditioning units. · Residents affected by increased temperatures were offered temporary room changes or temporary placement in cool common areas, those that refused to move were provided with portable air conditioning units. · Facility purchased in room portable air conditioners and placed in each resident room on July 16, 2023. · Facility rented six 5-ton portable air conditioner rentals and placed 2 on each floor in hallways/common areas on July 16, 2023.	

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F 835	Continued From page 109 reading [redacted] degrees Fahrenheit, stating that the analog thermometers are "hard to tell" an exact temperature. The surveyor asked the ED if that was how the facility was checking temperatures on the floors. The ED explained that he was only using the thermometer temporarily, and that he believed that they had an air temperature gun for checking temperatures and was going to look for it. The surveyor continued the [redacted] floor tour with the ED at 5:50 p.m., who now had the room temperature dual laser infrared thermometer gun which revealed the following room temperatures: 1. Room [redacted] degrees F. There was no fan or air conditioner in the room 2. Room [redacted] degrees F. There was no fan or air conditioner in the room. 3. Room [redacted] degrees F. 3. Room [redacted] degrees F. The surveyor and the ED took the room temperature at 5:56 p.m. of Resident #4 and roommate and it was [redacted] degrees F. This room contained no fan or functioning air conditioner. At the time, ED stated that the room felt "too warm." The surveyor wanted to know what was the plan for this resident and other residents on the floor. The ED replied that he would try and bring more fans. He did acknowledged that not all residents had fans and air conditioning in their room. The ED could not provide a timeline as to when the air conditioner systems and PTAC units would be fixed for the residents. The surveyor informed the ED that the DON had revealed that there were no fans in use on the [redacted] floor. He stated that there were fans clearly in use on the [redacted] floor and couldn't speak to why the DON would say	F 835	· Temperatures are monitored and documented every shift per the requirements in the directed plan of correction (DPOC). · The facility engaged the services of a 40 hour a week LNHA to oversee and assist the Administrator as required in the Directed Plan of Correction. Weekly reports are sent to the department of health as required in the as required in the Directed Plan of Correction. · The facility engaged the services of a 40 hour a week Director of Nursing consultant to oversee corrective actions and assist the Director of Nursing as required in the Directed Plan of Correction. · A weekend manager on duty schedule was implemented with a checklist including confirming air temperatures. · A root cause analysis of the system breakdown was completed, and weekly Quality Assurance Performance Improvement (QAPI) meetings initiated to continue until substantial compliance and then monthly thereafter. Element Four – Quality Assurance · The Maintenance Director/designee will monitor room and common area temperatures every two hours x 48 hours, then every shift x 14 days and daily thereafter with no stop date. Results are reported to the administrator and emailed	

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F 835	Continued From page 110 there were no fans in use on the [redacted] floor, except that maybe she didn't know that there was an air conditioner issue on the [redacted] floor. At 5:59 PM, the surveyor was introduced to the Director of Maintenance (DoM) who stated that he had only been employed by the facility for approximately four months, since [redacted]. The DoM stated that the "last few days it's been hot in the facility" and that there had been issues with the air conditioning systems. He stated that the facility had several bids out since the beginning of [redacted] since there was a leak in one of the systems. He added that there was also an "air handler with a bad condenser for the [redacted] floor." He continued that in addition to the [redacted] floor,that the third floor had an issue with the air conditioner system causing "sparking" which required the entire air conditioning system on [redacted] to be shut off, "or there would be a fire." The DoM stated that they received a bid on July 6th to address the problem, but it was not processed until yesterday [redacted], and the bid was for [redacted] to diagnose the problem. The surveyor requested documented evidence of that diagnostic visit from the company and the findings. The surveyor asked the DoM if he kept any logs of temperature readings while the air conditioning system had been malfunctioning or not working at full capacity. The DoM revealed that there were no room temperature logs. He stated that the last time he kept a room temperature log was "about a month ago" and had given it to the former administrator but "he's gone." The DoM confirmed there were no room temperature logs and could not provide information on how the facility was monitoring for compliance with	F 835	daily to the department health until substantial compliance is achieved. Results are also shared at the weekly Quality Assurance Performance Improvement (QAPI) meeting for action as appropriate. · The Administrator/designee makes random daily rounds with the maintenance staff to confirm room air temperatures and assure the comfort of residents. Results are discussed with the Director of Nursing daily and in aggregate at the weekly Quality Assurance Performance Improvement (QAPI) meeting for further action as appropriate. · The Director of Nursing/designee will audit 5 random at-risk residents medical records for signs and symptoms of heat related illness daily x 7 days, weekly x 4 and monthly x 2. Findings are discussed at clinical meetings and acted upon as appropriate. Results are shared in aggregate at the weekly Quality Assurance Performance Improvement (QAPI) meeting for further action as needed.	

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temperatures, since they were not checking them over a given period of time and recording them.

At 6:16 PM, the DoM stated to the surveyor that he only works [redacted] and that the nursing staff should be taking room temperatures on weekends. He was not aware of how the nursing staff take room temperatures. It should be noted at this time that this did not correspond with the aforementioned interviews with LPN #1 and LPN #2 who stated that they were not aware of staff taking room temperatures indicating that they were not involved in the process.

At 6:25 PM, the DoM and the surveyor went to the [redacted] unit. The DoM replied that the thermostat had no reading on this unit because the system had to be shut down due to sparking on [redacted]
At 6:33 PM, the surveyor observed the LPN #3 assigned to [redacted] in the hallway passing out medications to residents. The LPN #3 stated that the temperatures on this floor were "[redacted]"
The surveyor asked about the temperatures and if she had to do anything different in response to the heat situation on the unit, and she stated that she was assigned [redacted] residents this shift and that she just had to pass out medications, do [redacted] of residents and perform basic resident care. She stated that we can encourage hydration and take vital signs and skin turgor if a resident becomes confused, but otherwise there was nothing different that she had to do. The surveyor asked if any residents had to be hospitalized and she stated that there were none.

The [redacted] wing at 6:29 p.m. the air on the unit

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was very hot and heavy. The DoM took a temperature reading of [redacted] hallway and it was 88 degrees F.

At approximately 6:42 PM, the surveyor observed Resident #1 in bed next to the window. The resident was [redacted] and the room air was hot. The resident had no fan and no air conditioning in the room and this was confirmed by the resident. The surveyor interviewed the resident at that time, and the resident stated, "[redacted] and the resident began to wipe sweat from his/her [redacted]. At that time the resident stated, "I [redacted]. The surveyor observed [redacted] from the wall, but the resident was not wearing the [redacted]. The surveyor asked the resident if he/she utilized oxygen and the resident responded that he/she would put it back on and wear it. The surveyor observed the resident place the [redacted] and take some [redacted]. At 8:35 PM, the surveyor returned to the room of Resident #1 and took a room temperature which read [redacted] degrees F. The resident still had no fan or functioning air conditioner in their room. The resident stated that he/she was still [redacted] well. At approximately 1:28 a.m. on [redacted] the surveyor observed the Nurse Practitioner enter the [redacted] floor and walked over to the nurses station to meet with the DON. The Nurse Practitioner performed and assessment on Resident #1 and approximately at 1:50 AM, the local Office of Emergency Management (OEM) officer called for medical transportation for the resident to be transferred to the acute care hospital Emergency Room.

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The surveyor asked the ED at 6:58 p.m., why the facility was not being proactive and applying preventive measures to prevent the deterioration of the residents' health due to the current conditions existing in the facility. The ED replied that they need to be proactive and not wait, but if residents don't want to move, they don't have to. The surveyor inquired how the facility was keeping the resident's rooms at an acceptable temperature for residents that did not want to move and residents who could not verbalized their needs. The ED told the surveyor staff can provide the following: ice;a cool cloth for their face; provide fans and received portable air conditioning units. He did acknowledge that not all residents have fans and or portable air conditioning units despite malfunctioning air conditioner units in their rooms. The surveyor and ED observed any residents had a cool cloth on them.

At 7:00 PM, the surveyor and the ED went to the room of Resident #2 who was in bed and awake. The resident's bed was against the wall adjacent to the window and PTAC unit. There was a large [redacted] on the floor adjacent to the resident's bed acting as a [redacted] mat. The resident's bedside table was at the foot of the bed and a pitcher of warm water was resting on the bedside table out of the resident's reach. The PTAC unit was turned on but a small amount of warm air was flowing from it. There was no fan in the resident's room and the room temperature read[redacted] degrees F. The ED stated that he didn't know if doctors were called or how often nurses check or should check the vital signs in this situation. He stated that the staff does go

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	315205	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE	TWO COOPER PLAZA CAMDEN, NJ 08103

(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 835	Continued From page 114 around asking if the residents are feeling okay or if they are hot. At approximately 7:05 PM, the surveyor entered the DON's office with the ED. The DON provided the surveyor the name of the current LNHA on record and noted that the new LNHA started on or around [redacted]. The DON explained again that the DoM informed her only yesterday about the air conditioner issue and the room temperatures. The DON and ED acknowledged that there were no room temperature logs and that they never instructed anyone to take document temperatures. They acknowledged that if temperatures were not monitored and logged, how can the facility have knowledge on how to respond. The DON stated that she believed the room temperature requirement was not to exceed [redacted] degrees F and that she was not aware that the air conditioner system was shut down on [redacted]. At 7:23 PM the surveyor and New Jersey Department of Health (NJDOH) management who conference in telephonically informed the DON and the ED that the facility's failure to maintain adequate room temperatures in accordance with regulatory requirements, implement a system to monitor room temperatures when the air conditioning systems were known to not be operational or not functioning at full capacity during the heat of the summer months, including on this date when it was [redacted] degrees F outside, failure to identify high-risk residents to ensure they had adequate temperature control to reduce the risk for a heat related emergency, with limited access to sufficient cooling areas in the facility placed all	F 835		

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F 835	Continued From page 115	F 835		

residents on both floors in an immediate safety risk situation that required the activation of their Emergency Response Plan and the local Office of Emergency Management (OEM).

At approximately 8:45 PM, the ED provided two surveyors the facility's Emergency Preparedness (EP) Manual stored in a red binder. The surveyors asked about the Heat Response Emergency Plan and relocation/evacuation plan. The ED stated that it was in there somewhere, and he would have to look. At that time, without any urgency, he stepped out without showing the surveyors where to find it, and the surveyors began sifting through the EP manual. The surveyors were unable to find any information about facilities to which residents could be transferred in the event of an emergency or evacuation.

Inside the red binder was an Emergency Preparedness Planning and Resource Manual revised October 2012 which indicated "Planning Considerations for Utility Outages" which specified very generic information such as to identify all critical operations including air conditioning systems, emergency generators and communication systems; Ensure that key safety and maintenance personnel are thoroughly familiar with all building systems, establish procedures for restoring systems, determine the need for back up systems, establish preventive maintenance schedules for all systems and equipment.

The attached Severe Hot Weather Procedures included: When the facility temperature reaches 85 degrees Fahrenheit and remains so for four hours: 1. Move residents to another

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F 835	Continued From page 116	F 835		

air-conditioned part of the facility, if available. 2. Encourage residents to take in more fluids and keep the residents hydrated. Force fluids if necessary and record fluid intake. 3. Provide cold wash cloths as needed. 4. Open windows to let cooler outside air in and utilize fans to move air. 5. Monitor body temperatures of the residents and notify attending physicians if necessary. 6. Notify 911 if a resident/staff member appears to be in danger of heat-related stress. 7. Evacuate residents if necessary. 8. Monitor environmental thermometers. 9. Notify Medical Director.

The Emergency Operations Plan located within the Evacuation Plan revised 7/10/15 included response for a Heat Emergency. "The facility is equipped with air condition in all common areas and individual units in each patient room. Temperatures in the facility must be 81 degrees Fahrenheit and below. Should the temperature start to rise above 79 degrees Fahrenheit the following procedures should take place:

Maintenance: 1. Complete facility rounds to ensure: a. Window curtains in resident rooms and offices are drawn to block direct sun. b. all windows and doors are closed. 2. log temperatures at all stations initially and at a minimum of every four (4) hours. a. Report all interior facility temperature readings of 80 degrees Fahrenheit or above to the administrator immediately. 3. Turn off lighting in all corridors, offices and common areas, except where lack of light would cause safety issues. 4. Turn on all available fans. a. inventory quantity and location of all portable and wall mounted fans...procure additional ice, quantity as determined by the Administrator or designee. 6. Rent and set up delivery of portable air conditioning units as

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F 835	Continued From page 117 directed by the Administrator or designee. 7. Continue on-going facility rounds at a minimum of every two (2) hours. ... Nursing: 1. Conduct facility rounds. 2. Complete preliminary visual survey of all residents to establish a baseline assessment of their conditions. Determine residents at greatest risk utilizing the following guidelines: a. significant weight loss, b. dialysis, c. total dependence on staff for nutrition, d. Residents requiring enteral nutrition, e. any resident that is compromised and/or determined to be at high risk. Note: not all residents with the condition(s) listed are necessarily at-risk. Other physical and lifestyle factors must be considered. 4. Collate listing of residents at greatest risk and implement measures to stabilize and/or reduce the risk. Interventions include, but are not limited to: a. notification of physician of any condition change. b. COPD [Chronic Obstructive Pulmonary Disease] -monitor O2 [oxygen] saturation every four (4) hours or as condition warrants. 5. If the internal temperature of the facility reaches 80 degrees Fahrenheit, obtain temperatures on all residents a minimum of every four (4) hours or as condition warrants. ... 7. Relocate residents to cooler areas of facility if possible, as conditions warrant. 8. Continue visual rounds a minimum of hourly. 9. Complete physical assessment as residents' conditions warrant. 10. Maintain lightweight clothing on all residents 11. Initiate continuation hydration cart 7:00 AM to 10:00 PM...12. Revise staffing as needed, to appropriately implement and maintain action plan. Social Services: 1. Communicate to residents and family members the facility procedures.	F 835		

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Administrator: 1. Implement, oversee, monitor, and revise the facility procedures as needed. 2. Notify the Medical Director. 3. Notify the Regional Manager and Clinical Services Coordinator. 4. Notify regulatory agencies as required. In the event that the indoor air temperature is 82 degrees Fahrenheit or higher for a continuous period of four hours or longer the immediate notification of the New Jersey Department of Health is required. 5. Ensure staffing levels are adequate to maintain facility emergency procedures and meet resident needs. 6. Assess the need to evacuate."

There was an Evacuation Plan with a revised date of 7/10/2015 but the evacuation plan did not address specific facility agreements for transfer of residents.

At 9:45 PM, the surveyors interviewed the ED and the DON who stated that they were not sure what local facilities they had an agreement with to transfer residents to in the event of an emergency. The ED stated that he wanted the surveyors to remember he had only been at the facility for two weeks. The DON was unable to speak to evacuation destinations for the residents in the event of an emergency.

At 11:10 PM, a new facility representative entered the facility and office of the LNHA and stated that he was "Second in command" with the company, and and that he wanted to discuss the facility's plan to address the malfunctioning air conditioning system. He stated that they were trying to get every portable air conditioner unit available to the facility. He stated that they were able to bring six over now from another building, and they are hoping to deliver 10 more total. He

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F 835	Continued From page 119 added that they would relocate residents to the cooler space if they did not have a portable air conditioner to give them. At 11:41 PM, the surveyors discussed with facility administration that as of approximately10 PM, there were [redacted] resident rooms affecting [redacted] residents who resided in those rooms on [redacted] that had temperatures exceeding [redacted] degrees F with malfunctioning PTAC units. At approximately 1:00 AM on 7/16/2023, the second in command regional administrator stated that they went back up to check the temperatures of the rooms again on [redacted]h and found that many of the rooms were now below [redacted] degrees, and that all the residents were offered the opportunity to leave their rooms to go to the recreation room where it was colder and all but two had refused to leave their rooms. The surveyor went to [redacted] to verify the report. Unsampled Residents #14 and #15 were in their respective rooms and stated that no one from the facility had come to their rooms and offered them to leave to a cooler location. The residents both stated that they would be fine overnight and don't need to leave their rooms. The surveyor observed that Unsampled Resident #10 now a portable air conditioner unit in their room. Unsampled Resident #16 stated that he/she was asked if they wanted to leave the room to go to the cooler room where his/her roommate was, but refused. The surveyor went to Unsampled Resident #17 who previously had a room temperature of [redacted] degrees F with no fan or air conditioning, stated that no one from the facility came to their room to ask if he/she wanted to go to a cooler location, and that the resident stated	F 835		

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F 835	Continued From page 120 that he/she would consider moving to a cooler location because the room was still hot. The resident stated he/she would notify the nurse. On tour, a majority of the residents were asleep in their rooms and the rooms were less humid due to the reduced outdoor temperatures At 2:00 AM, on 7/16/2023, the surveyors found the updated EP manual updated in January 2023 in the Administrator's office located on the table. This manual contained the facility agreements for evacuation that the surveyors had been requesting since arriving on 7/15/2023 from the ED, DON and facility staff that were present in the building. They were unable to provide or acknowledge the responsibilities and protocols before and during that should be performed according to the facility's Emergency Plan for heat. On 7/16/2023 at 2:30 a.m., the surveyors initiated another temperature reading check of rooms on the [redacted] in the presence of a member of the corporate maintenance staff. The unit hallway contained a large fan circulating the warm air. The temperature checks noted in the aforementioned rooms revealed the rooms were below[redacted] degrees F. On 7/16/2023 at 12:47 PM, the surveyor was introduced to the Regional Licensed Nursing Home Administrator (R/LNHA) who stated that he was licensed as an administrator in New Jersey. He stated that he is not the LNHA on record and provided the name of the LNHA on record who was out of the country. The surveyor asked why the DON and ED did not know that the LNHA was out of the country. The R/LNHA didn't know why.	F 835		

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F 835	Continued From page 121	F 835		

The R/LNHA stated that he wanted to provide an update on what has been done in the facility regarding the air conditioning situation. He stated that they contracted with an HVAC rental company and every resident room in the building was given their own portable air conditioning unit for their room and the room temperatures have been good and "residents are totally comfortable." He stated that they also installed six, five-ton air conditioner units for the hallways that are 60,000 BTU's, two per floor. He stated that they also rented a high power generator to offload the power necessary to supply the air conditioning units. From approximately 1:00 PM to 2:00 PM, the surveyor toured the [redacted] floor and took room temperatures and conducted resident safety checks. The surveyor verified all resident rooms had the portable air conditioning units and room temperatures were within regulatory requirements.

At 6:06 PM, the surveyor interviewed the Regional LNHA who stated that the LNHA, DON and Assistant DON should know how to report an interruption in air conditioning to the New Jersey Department of Health (NJDOH).

A review of the Admission/Discharge To/From Report dated [redacted] reflected that the LNHA continued to allow [redacted] new admissions to the facility since [redacted] when the air conditioner system was known to not be operating at capacity and without an expected correction date.

On 7/19/2023, at 9:00 a.m. the surveyors conducted an on-site revisit for the removal plan implementation for the other 2 citations for Nursing and the Administration. At 10:39 AM, the surveyor toured the [redacted] floors of the building with

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F 835	Continued From page 122	F 835		

the Regional Director of Building Operations to conduct resident safety rounds and test the room temperatures. At 11:27 AM, the surveyor interviewed the Regional Maintenance Director and the Regional LNHA in the presence of a second surveyor. At that time, the Regional LNHA stated to the surveyors that if the temperature climbs over [redacted] degrees F in the room, it would be important to implement measures for cooling to prevent it from going above [redacted] degrees F, as [redacted] degrees F "is not safe." The surveyor asked when the Emergency Plan should be implemented, and he stated that couldn't speak specifically when it would be implemented. He stated however that they would try to exhaust all options first like accessing contractors and if they could not get portable air conditioner units or move the residents within an hour, then they will contact the local OEM. He stated that he found out about the air conditioning system not functioning on [redacted], and they knew it was going to be a '[redacted]." The Regional LNHA clarified that it would be very hot "outside" on Saturday. He confirmed that the air conditioning systems were not working at full capacity.

A review of the Administrator's job description revealed that the position summary indicated that the "Administering, directing and coordinating all operations of the facility in accordance with Federal and State and local regulations." Under PERFORMANCE #9. " Plans and organizes preparation for facility disasters, emergencies and severe weather conditions." and #14. "Meets with Department Heads individually weekly to ensure proper departmental operation and advises concerning issues."

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F 835	Continued From page 123 NJAC 8.39-9.2(a), 19.4(a)(d)(e)(f)(g)(n)	F 835		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060412	A. Building B. Wing	8/28/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE	TWO COOPER PLAZA CAMDEN, NJ 08103

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 S0765 Reg. # 8:39-9.2(a) LSC	Correction Completed 07/21/2023	ID Prefix S0870 Reg. # 8:39-9.4(e)(1) LSC	Correction Completed 07/20/2023	ID Prefix S1090 Reg. # 8:39-13.1(c) LSC	Correction Completed 07/20/2023
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
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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 7/19/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315205 Y1	A. Building B. Wing Y2	8/28/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE	TWO COOPER PLAZA CAMDEN, NJ 08103

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 F0600	Correction	ID Prefix F0658	Correction	ID Prefix F0761	Correction
Reg. # 483.12(a)(1)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed
LSC	07/21/2023	LSC	07/21/2023	LSC	07/21/2023
ID Prefix F0835	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.70	Completed	Reg. #	Completed	Reg. #	Completed
LSC	07/21/2023	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
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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	
7/19/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO