STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315269	A. BUILDING _____ B. WING _____	C 11/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE POINT	**THREE DAVID BRAINERD DRIVE MONROE TOWNSHIP, NJ 08831**

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E 000	Initial Comments Survey: 11/20/23 This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Survey Date: 11/20/23 Census: 100 Sample: 21+15 = 36 Complaint #: NJ 161843 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.	F 610		12/29/23

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

Electronically Signed | 12/08/2023

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F 610	Continued From page 1 §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of pertinent documents it was determined that the facility failed to conduct a thorough investigation for an Ex.Order 26.4(b)(1) for Resident #87. This Deficient practice was identified for 1 of 5 residents reviewed for accidents and was evidenced by the following: On 11/13/23 at 9:30 AM, the surveyor observed Resident #87 sitting at the table in the common area of the [redacted] unit. The resident was observed with a bandage covering to the [redacted] and [redacted] in the surrounding area. On 11/13/23 at 11:18 AM, the surveyor reviewed the Electronic Medical Record (EMR) and reviewed a Physician note dated [redacted]. The note revealed that Resident #87 [redacted] and sustained a [redacted] to the [redacted] and a [redacted] to the [redacted]. On 11/14/23 at 11:46 AM, the surveyor interviewed Licensed Practical Nurse #1 (LPN)	F 610	1. Resident #87 incident report was revisited by DON. The investigation was conducted as soon as the DON reviewed the report, staff were interviewed, and written statements were obtained. The DON interviewed the daughter of resident #87 who repeated that her mother "[redacted]" that was at site of [redacted] and that her mother [redacted] at [redacted]. The administrator and MD were notified of the findings. An order for an X-ray to the affected site was given by the physician and carried out by the unity manager. The result showed no [redacted] to the affected site. Resident #87's daughter was notified. The incident report was completed with the root cause noted regarding the incident. In addition, the care plan of resident #87 was updated to include the incident, along with the interventions. 2. All residents with an incident	

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F 610	Continued From page 2 about Resident #87's Ex.Order 26.4(b)(1). The LPN #1 stated that the resident went home with the family on EX Order 26.4B1 and came back to the facility with a [redacted] above the EX Order 26.4B1. The LPN #1 stated the nurse that was working on EX Order 26.4B1 reported that the resident returned on Monday and the area around the EX Order 26.4B1 was EX Order 26.4B1 On 11/14/23 at 11:49 AM, the surveyor interviewed the Registered Nurse (RN) about Resident #87's Ex.Order 26.4(b)(1). The RN stated that the resident went home on EX Order 26.4B1 with [family]. The RN stated the [family] stated that the resident had EX Order 26.4B1 that was from the incident that occurred on EX Order 26.4B1. The RN stated that on Ex.Order 26.4(b)(1) the EX Order 26.4B1 had EX Order 26.4B1 which and stated that it was not from the incident on EX Order 26.4B1. On 11/14/23 at 12:30 PM, the surveyor interviewed the Director of Nursing (DON) about Resident #87's EX Order 26.4B1. The DON stated the LPN did a risk management report and failed to have a written statement at the time for the incident of the EX Order 26.4B1 that was thought had occurred on EX Order 26.4B1. The DON stated that it is important to have a statement immediately to narrow down what happened to the resident. Furthermore, the DON stated a conclusion needed to be apparent to be able to implement intervention to prevent these types of situations from recurring, and to rule out abuse. The DON stated, "it should not have happened this way". On 11/14/23 at 1:00 PM, the surveyor interviewed Licensed Practical Nurse #2 (LPN) about Resident #87's Ex.Order 26.4(b)(1). The LPN #2 stated that	F 610	occurence in the facility have the potential to be affected by the deficient practice. The incident reports were reviewed by the DON and administrator. It was noted that all other incident reports were investigated and a conclusion regarding the the incident was completed in a timely manner, the physician or designee has been notified, the family members were informed and that the care plan has been updated. 3.To ensure that the deficient practice does not reoccur, an in-service was done by the DON and the nursing supervisors for all licensed nursing staff regarding the completion of incident reports, which includes the investigation and formulation of a conclusion, immediate notification of the administrator and physician, and the updating of the care plan of the resident. The DON/Designee will review incident occurences on weekdays. 4. The DON or designee will audit the incident reports on weekdays and will report the findings in the weekday daily meeting with the department heads and unit managers. The DON will report the findings in QAPI meetings monthly x3 months, then quarterly x2. Then the QAPI committee will determine if it requires to be continued.	

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F 610	Continued From page 3	F 610		

the Resident returned to the facility on Ex.Order 26.4(b)(1) at 6:00 PM and the residents family member showed the LPN the Ex.Order 26.4(b)(above the EX Order 26 EX Order 26.4B1. The resident's family member said that the resident was EX Order 26.4B1 from EX Order 26.4B1 and EX Order 26.4B1 EX Order 26.4B1. LPN #2 had observed a EX Order 26.4 EX Order 26.4B1 and the family member stated that the resident had been EX Order 26.4B1 her/his EX Order2

On 11/15/23 at 8:04 AM, the surveyor observed resident #87 in the common area during breakfast on EX Order 26.4B1 unit. The resident was observed with a EX Order 26.4B1 that surrounded the EX Order 26.4B1 area and a EX Order 26 above the EX Order 26.4B1. The resident reported to the surveyor EX Order 26.4B1 EX Order 26.4B1.

On 11/15/23 at 9:24 AM, the surveyor interviewed the DON and she stated that she was unaware that the resident EX Order. The surveyor inquired about Resident #87's EX Order 26.4 of unknown origin that happened on Ex.Order 26.4(b)(1) to the DON and she stated she did not contain any documentation of interviews with the resident until the surveyors informed the facility of what the resident had stated. The DON stated it is important to start an investigation and do interviews to rule out abuse. The DON stated that the nurse providing care for the resident was aware of the EX Order 26.4B1 and "unfortunately the nurse didn't do what he was supposed to do regarding initiating an investigation."

11/16/23 at 11:22 AM, the DON was interviewed by the survey team and asked if the family was

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F 610	Continued From page 4 contacted regarding an investigation. The DON stated that on [EX Order 26.4B1] was when the UM observed the [EX Order 26.4B1] getting darker and the UM reached out to the family who did not respond until [EX Order 26.4B1]. The DON stated the UM typically would complete an investigation but the DON stated she had to get involved because the UM didn't do it properly and confirmed she did not have a documented statement from the family. On 11/20/23 at 8:30 AM, the surveyor reviewed a facility provided policy on Resident Abuse revised on 6/19/23. Section 4 Identification and Reporting of Possible Incidents, part A: Facility staff members received training and orientation regarding the identification of an abused, neglected, or exploited resident. The following guidelines apply included, but not limited to unexplained bruises, repeated falls, reports by the resident of physical abuse, bruising or laceration of lips from force-feeding. Section 5 Investigation of Any Violation Which is Suspected and/or Substantiated, part A of the facility provided policy reads as followed: The nursing supervisor on duty shall IMMEDIATELY report any alleged violations of this prevention policy to Administrator or designee. Section 6 Reporting, Investigation, Response/Protection to any Violation which is Suspected and/or Substantiated, part D and E revealed:	F 610		

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F 610	Continued From page 5 D. The Administrator and/or a nursing supervisor will conduct a thorough investigation. The investigation will include, but not be limited to, interviewing the alleged perpetrator, all staff, residents, and visitors who are believed to have knowledge of the event. E. A thorough account of the investigation will be documented. All witnesses will sign their individual statements. All notifications will be noted on the Riskwatch report and Narrative Nurses Notes. NJAC 8:39-27.1(a)	F 610		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care	F 692		12/29/23

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F 692	Continued From page 6 provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to: a.) consistently identify, comprehensively assess, implement, and modify interventions for an unplanned Ex.Order 26.4(b)(1) of [redacted] pounds (lbs) which was [redacted] in 6 months from [redacted] through [redacted], then an additional [redacted] lbs which was ([redacted]) in [redacted] days from [redacted] through [redacted], b.) implement weekly weights for 4 weeks after a Ex.Order 26.4(b)(1) occurred; c.) monitor for effectiveness, and ensure coordination of care among the interdisciplinary team for Resident #23 and d.) obtain a re-weight to verify a Ex.Order 26.4(b)(1) [redacted] consistently record and monitor meal consumption, and ensure a recommended nutritional supplement was prescribed and provided to the resident prior to surveyor inquiry for Resident #23 and Resident #63. This deficient practice was identified for 2 of 4 residents reviewed for nutrition which resulted in a Ex.Order 26.4(b)(1) [redacted] for Resident #23 and Resident #63 and was evidenced by the following: Reference: The Academy of Nutrition and Dietitians, "Position of the Academy of Nutrition and Dietitians: Individualized Nutrition Approaches for Older Adults: Long-Term Care, Post-Acute Care, and Other Settings", dated April 2018. Position Statement "It is the position of the Academy of Nutrition and Dietitians that the quality of life and nutritional status of older adults	F 692	1. Resident's #63 and #23 were reweighed by the unit manager and C.N.A. on 11/16/23. It was noted that resident #23 was [redacted] lbs. and resident #63 was [redacted] lbs. The physician was notified of the findings. On 11/22/23, resident #63 was enrolled and accepted to hospice service. Resident #23 was placed on weekly weights and ordered Ensure supplement three times a day by the physician. 2. The DON and the dietician audited the weights of all residents in the facility. Those with weight loss or gain of [redacted] lbs. were reweighed immediately, while those with weights less than [redacted] lbs and [redacted] lbs. weight loss or gain were also reweighed immediately. The dietician made recommendations for supplements for those who needed them. The physician was notified, and orders were made for those who needed the supplements and other interventions, i.e., blood work, weekly weights, etc. Orders for supplements that the nurses carried out were documented in the EMAR of each resident to ensure that the licensed staff documents how much each resident consumes. 3. To ensure that the deficient practice does not reoccur, the DON/designee inserviced the nursing staff in the policy of weighing and reweighing residents. The	

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F 692	Continued From page 7 in long-term care, post-acute care, and other settings can be enhanced by individualized nutrition approaches. The Academy advocates that as part of the interprofessional team, registered Dietitian nutritionist assess, evaluate, and recommend appropriate nutrition interventions according to each individual's medical condition, desires, and rights to make health care choices. Nutrition and dietetic technicians, registered assist registered Dietitian nutritionists in the implementation of individualized nutrition care." On 11/13/23 at 10:29 AM, during the initial tour of the facility, the surveyor observed Resident #23 awake and alert, sitting in a wheelchair in the dining room with the activities department. On 11/13/23 at 12:55 PM, the surveyor observed Resident #23, awake and alert, sitting in the dining room eating lunch consisted of pork, rice, and peas. On 11/14/23 at 09:14 AM, the surveyor observed Resident #23 lying in bed with his/her eyes closed. On that same day at 9:21 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated that the resident was very sleepy that morning and she had fed the resident in bed which consisted of eggs, toast, coffee, and orange juice. The CNA stated that when the resident was up in his/her chair, he/she could feed his/themselves with set up and supervision. On 11/14/23 at 12:43 PM, the surveyor observed Resident #23, awake and alert, sitting in a	F 692	DON/designee inserviced the CNA in completing the ADL documentation for each resident. The DON/designee will audit the physician orders for supplements documented in the resident's EMR. The new dietician has been inserviced by the DON and administrator on facility policy and procedures for weighing and communicating recommendations to the facility nurses. In addition, the weighing scales in the facility will be checked monthly by the Maintenance Director/designee for proper function and calibration. They will be tested by an outside contracted vendor for calibration every quarter. 4. The Unit Managers and the Registered Dietician will report weight discrepancies in the daily morning meeting. The dietician will report the findings in QAPI meetings monthly x3, then quarterly x2. Then the QAPI committee will determine if it requires to be continued, thereafter.	

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wheelchair in the dining area feeding him/herself lunch which consisted of chicken, scalloped potatoes, green beans, and soup.

Review of Resident #23's Face Sheet (Admission Record) revealed the resident was admitted with diagnoses which included but were not limited to: EX Order 26.4B1 [redacted]

Review of the Electronic Medical Record (EMR) revealed a physicians' order (PO) dated Ex.Order 26.4(b)(1) [redacted] 3, for a Ex.Order 26.4(b)(1) [redacted]

A review of Resident #23's Vital Sign Report in the EMR revealed the following dates/weights:

EX Order 26.4B1 [redacted]

There were no further documented follow up weights or re-weights in the EMR.

A review of the Registered Dietitian's (RD) Admission "Nutritional Assessment" dated EX Order 26.4B1 [redacted] at 1:15 PM, reflected that the resident was [redacted]. on admission. It included that the resident's diet was Ex.Order 26.4(b)(1) [redacted] and intake was good and usually consumed greater than 75%. The summary included that Resident #23 was at risk for unintended Ex.Order 26.4(b)(1) [redacted] related

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to history of [redacted] and interventions included to continue weekly weights times 4 then monthly if stable.

A review of the RD Quarterly "Nutritional Progress Note," dated [redacted] at 4:55 PM, revealed that per available weights, Resident #23 had experienced an [redacted] (4.3)% weight [redacted] x [redacted] days and [redacted]. (4.8%) weight [redacted] x [redacted] days. Weight goal at this time was for stabilization. The resident's intake was typically adequate. Will provide additional sandwich with dinner and continue to monitor po intake and encourage as needed. Continue to encourage monthly weights as ordered.

A review of the RD Quarterly "Nutritional Progress Note," dated [redacted] at 5:10 PM, revealed that Resident #23's intake had been fair to adequate. Per weights, the resident had experienced a [redacted] lb.(0.7%) weight [redacted] days, a significant [redacted] lb. (8.8%) weight [redacted] days and a significant [redacted] lbs. (16%) weight [redacted] days. The RD recommended [redacted] at breakfast and a [redacted] with lunch and dinner. Continue with weights as ordered.

A review of the RD "Significant Weight Change Nutritional Progress Note," dated [redacted] reflected a weight history that had been variable. Weights indicated a significant [redacted] lb. (5.3%) weight [redacted] days, a significant [redacted] lb. (13.6%) weight [redacted] days, and a significant [redacted] lb. (17.7%) weight [redacted] days. Recommended a [redacted] three times a day and weekly weights. Encourage weights as needed/accepted. Continue with liberalized diet. No recent labs noted. This assessment was

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F 692	Continued From page 10 completed after surveyor inquiry. A review of the April 2023 through November 2023 Physician Orders (PO), Medication Administration records (MARs) and Treatment Administration Records (TARs) did not reveal any documentation of dietary interventions as recommended by the RD in July 2023, October 2023 and November 2023. A review of the Physicians' notes dated April through October 2023, indicated that Resident #23 had no Ex.Order 26.4(b)(1) and was Ex.Order 26.4(b)(1) . A review of the EMR from April 2023 through November 2023, did not reveal any documentation that the physician, family, or the interdisciplinary team was aware of Resident #23's Ex.Order 26.4(b)(1). A review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated EX Order 26.4B1, reflected a Brief Interview for Mental Status (BIMS) score of EX out of 15 which indicated the resident's EX Order 26.4B1 . It further reflected independent with Ex.Order 26.4(b) with set up assistance, weight of EX Order 26. . and no weight loss or gain Ex.Order 26.4(b)(1) or loss or gain Ex.Order 26.4(b)(1) months. A review of the Quarterly MDS, dated EX Order 26.4B1 reflected a BIMs score of EX C out of 15 which indicated the resident's cognition was EX Order 26.4B1 EX Order 26.4B1 . It further reflected independent with Ex.Order 26.4(b) with set up assistance, no weight measurement was documented, and no weight	F 692		

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F 692	Continued From page 11 loss or gain of Ex.Order 26.4(b)(1) or loss or gain of Ex.Order 26.4(b)(1) months. According to the [redacted] weight in the EMR, Resident #23's weight was documented as [redacted]. Review of the Quarterly MDS, dated [redacted], reflected a BIMS score of [redacted] out of 15 which indicated the resident's EX Order 26.4B1 [redacted]. It further reflected that the resident needed set up or clean up assistance for the task of eating. The MDS revealed a weight of [redacted] lbs. and weight Ex.Order 26.4(b)(1) or more in the last month or a weight Ex.Order 26.4(b)(1) or more in the last 6 months and was not on a prescribed-physician Ex.Order 26.4(b)(1) regimen. A review of the person-centered comprehensive Care Plan revealed a [redacted] care plan created on [redacted], revealed a goal to maintain a weight of approximately [redacted] lbs and interventions included to honor preferences, allow staff to weigh resident and to provide diet as ordered. On [redacted], the RD updated the care plan and changed the goal to maintain a weight of [redacted] lbs. in the next 90 days. The updated intervention included for staff to monitor intake and encourage resident as needed/accepted. The Care Plan was not updated to address Resident # 23's Ex.Order 26.4(b)(1) and did not include the RD's recommended interventions for the sandwich, Ex.Order 26.4(b)(1) cereal, weekly weights etc. On 11/15/23, the surveyor reviewed the "ADL Verification Worksheets," provided by the facility,which revealed that the CNA's failed to	F 692		

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F 692	Continued From page 12 consistently document daily the percentage of meals and snack intake for Resident #23 from April 6, 2023 through November 15, 2023. On 11/14/23 at 1:00 PM, the surveyor reviewed the handwritten "Dietician Recommendations" book from January through November 2023, which revealed a handwritten recommendation dated [EX Order 28.4B1], for Resident #23 to increase the [Ex.Order 26.4(b)(1)]t to three (3) times a day for significant [Ex.Order 26.4(b)(1)] and to start weekly weights. No other recommendations were written by the RD for Resident #23. On 11/14/23 at 1:02 PM, the surveyor interviewed the CNA who stated that upon admission all residents would be weighed weekly x 4 weeks then monthly thereafter. When inquired regarding the process, the CNA stated that all CNAs would obtain the resident's weights, write them on a piece of paper and give to the nurses who would entered the weights in the EMR. If a resident refused their weights, "we would attempted again later, inform the nurse, and the nurse would document the refusal in EMR." On 11/14/23 at 1:08 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that a resident would be weighed the day of admission, weekly x 4 weeks, then monthly. The CNA's and the nurses would assist in obtaining the weights and the nurses would document the weights in the EMR. If the nurses noted any weight loss, the nurse should notify the physician and follow their recommendations. If the RD was consulted, then the RD would give the nurse their recommendations either verbally or written down in the "Dietician Recommendation" log and then	F 692		

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F 692	Continued From page 13 the nurses would call the physician and obtain the order. The LPN further stated that any weight loss more than 2 lbs. weekly or monthly would be considered a significant weight loss. On 11/14/23 at 1:14 PM, the surveyor interviewed the Registered Nurse Unit Manager (RN/UM #1) who stated that upon admission all residents were weighed, then weighed weekly x 4 weeks then monthly thereafter. If a resident had a change in weight, loss or gain, the nurse would reweigh the resident and document the weight in the EMR. If it was a true weight loss or gain, the nurse would then notify the physician and consult the RD then follow their recommendations. The RD would see the residents on admission then quarterly thereafter. The RD would be consulted immediately for any significant weight loss or gain, and an assessment would be completed. A significant weight change would be weight loss or gain of 2 lbs daily or 4-5 lbs monthly. The nurses were supposed to document in the EMR progress notes that the physician was notified of a weight change. The RN/UM #1 stated that the first week of November 2023, she called the physician regarding Resident #23's weight of [redacted] and consulted the RD. The RN/UM#1 confirmed that she did not document in the EMR that the physician or the RD was notified. On 11/15/23 at 11:08 AM, the surveyor interviewed the Director of Nursing (DON) who stated that all residents are weighed on admission, then weekly x 4 weeks then monthly thereafter. The DON added, that the CNAs would obtain the resident's weights and the nurses would document the weights in the EMR. The nurses should document how the resident was	F 692		

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F 692	Continued From page 14	F 692		

weighed whether it was standing, wheelchair, a lift and what type of scale was used. The DON further stated that if a resident had a weight loss or gain weekly or monthly, "I would expect the nurses to reweigh the resident to rule out that nothing was interfering with the discrepancy weight. If it was a true weight change then the nurse would notify the physician who would request a dietary consult." The nurses would then follow the physician and the RD recommendations. There should be a physician's order for any supplements and weekly weights. " I would expect the nurses to notify the physician of any weight change of 3 lbs either weekly or monthly." Any significant weight change should be discussed in the morning meeting and reported to the team. If the RD recommended a sandwich, there would not be an order, dietary recommendations would come directly from the kitchen.

On 11/15/23 at 11:25 AM, the surveyor interviewed the RD who stated that her role included to oversee all nutritional aspects of the residents on admission, quarterly and as needed. All new admissions would be weighed on the day of admission, then weekly x 4 weeks then monthly thereafter. The CNAs would obtain the weights then the nurses would enter the weights into the EMR. If the nurses saw any change in weight, whether a gain or loss, the nurses would reweigh the resident then notify the physician and the RD. If there was a significant weight change, "I would complete an assessment, make recommendations and follow up more frequently such as monthly." The RD further stated "I usually don't notify the doctor or family in my note, but any recommendations would be placed

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F 692	Continued From page 15 in the "Dietician Recommendation" book and the nurses would notify the physician." Any supplements or weekly weight recommendations would require a physician order,but for dietary recommendations such as fortified cereal or an extra sandwich would be sent to dietary and placed on the meal ticket. The surveyor then reviewed Resident #23's weight [Ex.Order] with the RD. The RD confirmed that in [EX Order 26.4B1] quarterly assessment did trigger a significant weight [Ex.Order 26] and that she did not write the recommendations in the "Dietician Recommendations" book. Therefore, the [Ex.Order 26.4(b)(1)] cereal were never carried over. "I think I forgot to put them in the book. " The RD further stated that the RN/UM #1 informed her that the resident had a [Ex.Order 26.4(b)(1)] in weight for "this month" ([EX Order 26.4B1]) and "I completed an assessment yesterday" (on [EX Order 26.4B1], after surveyor inquiry). On 11/15/23 at 11:59 AM, in the presence of the surveyor, the staff obtained and recorded Resident #23's weight at [EX Order] lb. On 11/15/23 at 12:22 PM, the surveyor attempted to contact the attending physician, and was informed by the office that the physician was on vacation. On 11/15/23 at 01:40 PM, the surveyor conducted a telephone interview with the covering physician (MD). The MD stated that if he was aware of a resident's significant weight loss, he would want to identify the causal factor and implement interventions to address the weight loss. The MD further stated that he would	F 692		

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F 692	Continued From page 16 expect the nurses to notify the MD if there was a significant weight Ex.Order 26.4(b)(1) %. When asked if he was notified of Resident #23's significant weight Ex.Order 26 of Ex.Order 26 lbs in the last 6 months. He stated, "I do not recall." On 11/16/23 at 11:17 AM, the surveyor reviewed the documented weights in the EMR with the RN/UM #1. The RN UM #1 confirmed that when there was a discrepancy in Resident #23's weights, the nurses should have reweigh the resident and documented the reweighs in the EMR. The RN/UM#1 confirmed that there were no documented weights for the month of June Ex.Order 26.4 and EX Order 26.4B1 The RN/UM #1 stated that on EX Order 26.4B1 she noticed that the EX Order 26.4B1 of Ex.Order 2 lbs "was off" so she obtained another weight on EX Order 26.4B1 of Ex.Order 26.4 lbs "which was closer to the residents previous weight." The RN/UM #1 stated that she just put the weights in the EMR, but the RD would monitor the weights. The RN/UM#1 also confirmed that the physician, the family, and the DON were not notified of the significant weight change on EX Order 26.4B1. The RN UM #1 stated that she entered the EX Order 26.4B1 weight of Ex.Order 26.4B1 lbs in the EMR. She stated that she had notified the physician and consulted the RD, but did not document in the EMR. The RD did not complete her significant weight change assessment until Ex.Order 26.4(b)(1) (after surveyor inquiry). The RN/UM #1 further stated that the CNAs do not document how the residents were weighed such as standing, wheelchair/or using a lift. The RN/UM #1 further stated "if we reweigh the resident, we don't document the reweigh, we only document the correct weight. This was missed, we all missed this."	F 692		

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F 692	Continued From page 17 On 11/16/23 at 11:53 AM, the surveyor interviewed the LPN who documented the Ex.Order 26.4(b)(1) weight of Ex.Order lbs. The LPN stated that she does not remember if she notified the RN/UM #1 of the weight change. On 11/16/23 at 1:30 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), DON and RD in the presence of the survey team. The surveyor reviewed the past six (6) months weights and the significant weight Ex.Order 26 for Resident #23. The LNHA stated her expectation was that all residents would have maintained their weight. She would have expected if any weight changed, the nurses would notify the physician and the RD, reweigh the resident and document in the EMR. The DON and LNHA confirmed that they were not aware of Resident #23's significant weight Ex.Order 26 until the surveyor's inquiry. The RD confirmed that the residents' weights were not monitored and there was not documentation of a weight Ex.Order 26 trend. The RD stated that the significant Ex.Order 26.4(b)(1) should have been communicated to the DON, LNHA and the physician. If the resident was uncooperative with the procedure, that should have been documented. The DON and LNHA confirmed that supplement recommendations were not entered onto the MAR or TAR for October 2023 and November 2023 nutritional recommendations. There was no documented evidence in the EMR that Resident # 23 was eating the sandwich or consuming the supplement as recommended by the RD. The RD confirmed that she did not follow up with the resident's weights, the recommendations were not implemented and she did not notify the DON and LNHA of the significant Ex.Order 26.4(b)(1) in	F 692		

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F 692	Continued From page 18 October 2023. The DON and LNHA stated that it was a system failure from the whole team. The LNHA and the RD stated, " We missed it." 2. On 11/13/23 at 10:24 AM, during the initial tour of the EX Order 26.4B1 Unit, the surveyor observed Resident #63 lying in bed with his/her eyes closed. The surveyor observed snacks at the bedside. Review of Resident #63's Face Sheet (Admission Record) revealed the resident was admitted with diagnoses which included but were not limited to; EX Order 26.4B1 . Review of the Electronic Medical Record (EMR) revealed the following physician orders (PO): Ex.Order 26.4(b)(1) dated Ex.Order 26.4(b)(1), a Ex.Order 26.4(b)(1) 2 times a day dated Ex.Order 26.4(b)(1), and Ex.Order 26.4(b)(1) 2 times a day dated Ex.Order 26.4(b)(1). Review of the May 2023 through November 2023 MARs and TARs did not reflect the above corresponding physician's orders. A review of Resident #63's Vital Sign Report in the EMR revealed the following dates/weights: EX Order 26.4B1 .	F 692		

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F 692	Continued From page 19 There were no further documented follow up weights or re-weights in the EMR. Review of the Quarterly MDS, dated [redacted], revealed that Resident #63 had a BIMs score of [redacted] which indicated the resident had [redacted] and had a [redacted]. Section K indicated a height of [redacted] inches and a weight of [redacted] lbs and had a [redacted] of [redacted] % or more in the last month or loss of [redacted] % or more in last 6 months. Review of the Nurse Practitioners (NP) note, dated [redacted], revealed that Resident #63 had [redacted], weight of [redacted] lbs. The note further included to restart [redacted] for [redacted]. The NP documented that the family was notified. Review of the Quarterly "Nutritional Progress Note," dated [redacted] at 5:30 PM, reflected that Resident #63 intake was variable. Resident #63's current diet was [redacted] and a [redacted] a day. The assessment further revealed that the resident had a significant [redacted] lb [redacted] weight [redacted] days. No [redacted] issues or recent labs noted. The resident was receiving a supplement and [redacted] ([redacted]) which was reinitiated on [redacted]. Review of Resident #63's Comprehensive Care Plan for [redacted] identified the weight [redacted] and had interventions updated which included the following: "I will consume supplements as ordered and I will follow diet as ordered."	F 692		

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F 692	Continued From page 20 On 11/16/23 at 10:04 AM, the surveyor interviewed the LPN who stated that Resident #63 preferred to stay in bed, needed assistance with meals. On 11/16/23 at 11:35 AM, the surveyor interviewed the LPN who stated monthly weights were completed the first week of each month and if there was a weight loss or gain, the nurse would reweigh the resident. The surveyor reviewed the documented weights in the EMR with the LPN who stated a reweigh should have been done on Ex.Order 26.4(b)(1) for the discrepancy weight of [redacted] lbs. On 11/16/23 at 11:58 AM, the surveyor and the RN/UM #1 reviewed the weights documented in the EMR on EX Order 26.4B1 as [redacted] lbs and stated the resident should have been reweigh and documented the weight in the EMR. The RN/UM #1 stated that she documented the weight as an error and the reweigh of [redacted] lbs on EX Order 26.4B1. On 11/16/23 at 1:30 PM, the surveyor, in the presence of the survey team, interviewed the DON, LNHA and RD. The DON stated that Resident #63 was not reweigh when there was a discrepancy of the weight on Ex.Order 26.4(b)(1). The RD confirmed there was no follow up from September 2023, when a significant weight [redacted] was identified. The DON stated that the RN/UM #1 should have been overseeing all the weights. The DON and LNHA confirmed that the Ex.Order 26.4(b)(1) ordered were not transcribed onto the MAR and TAR. There was no documented evidence that Resident # 63 received the Ex.Order 26.4(b)(1) recommendations from May 2023 through November 2023.	F 692		

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F 692	Continued From page 21 A review of the facility provided, " Specialist Dietitian I" job description, dated 2019, included but was not limited to; responsible for nutrition screening, assessment, diagnosis, intervention , monitoring, evaluation, and plan of care : communicate effectively with the interdisciplinary team, residents, and families; meal rounds, and evaluate and coordinate nutrition formulary per regulatory guidelines. A review of the facility provided, "Resident Weights and Weight Changes" policy, revised 11/07/17,reflected that significant weight changes will be reviewed by the DON/designee and referred to the dietician and physician if indicated. A reweigh must be obtained within 48 hours if a weight change meets the following criteria: 1 month- 5% body weight change or 6 months-10 % body weight change. The DON/designee or dietician will assess the weight change and make a notation in the medical record as to the plan of action for the weight change-diet counseling, physician notification, dietician notification, etc. The Dietician recommendations will be recorded in the medical record or on the designated form. The resident care plan will be adjusted to reflect the dietary recommendations. A review of the facility provided, "Clinical Nutrition Services" policy, revised 01/22, revealed that when recommendations are made which require a physician's order, the Registered Dietician Nutritionist (RDN)will follow up within 7 days to verify a response to the recommendations. The RDN monitors and evaluates the patient's response to care which include any or all of the	F 692		

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F 692	Continued From page 22 following: nutrition assessment, meal rounds and or care plan rounds/meeting. The results of monitoring and evaluation are documented in the patient's medical record by the RDN. NJAC 8:39-17.1 (c); 17.2(d)	F 692		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure the physician: a.) addressed a significant weight [redacted] days, a significant [redacted] days, and a [redacted] days, b.) monitored weekly and monthly resident weights, and c.) implemented [redacted]	F 710	1. Resident's #63 and #23 were reweighed by the unit manager and C.N.A. on [redacted] It was noted that resident #23 was [redacted] lbs. and resident #63 was [redacted] lbs. The physician was notified of the findings. On [redacted], resident #63 was evaluated and accepted to hospice service. Resident #23 was placed on weekly weights and was	12/29/23

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F 710	Continued From page 23 interventions in a timely manner for 1 of 4 residents (Resident #23) reviewed for Ex.Order 26.4(b)(1) The deficient practice was evidenced by the following: Refer F692G On 11/13/23 at 10:29 AM, during the initial tour of the facility, the surveyor observed Resident #23 awake and alert sitting in a wheelchair in the dining room with the activities department. On 11/13/23 at 12:55 PM, the surveyor observed Resident #23, awake and alert, sitting in the dining room eating lunch. On 11/14/23 at 09:14 AM, the surveyor observed Resident #23 lying in bed with his/her eyes closed. At 9:21 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated that the resident was very sleepy that morning and she assisted the resident with the breakfast meal which consisted of eggs, toast, coffee, and orange juice. The CNA stated that when the resident was up in his/her chair ,he/she could feed themselves with set up and supervision. The CNA stated that Resident #23 could get agitated and sometimes would throw the food on the floor. The CNA further stated that she usually cared for the resident and noticed a weight change On 11/14/23 at 12:43 PM, the surveyor observed Resident#23, awake and alert, sitting in a wheelchair in dining area eating lunch which consisted of chicken, scalloped potatoes, green beans, and soup.	F 710	provided with Ensure supplement three times a day by the physician. 2. The DON and the dietician audited the weights of all residents in the facility. Those with weight loss or gain of [redacted] lbs. were reweighed immediately, while those with weights were less than [redacted] lbs. and had [redacted] lbs weight loss or gain were also reweighed immediately. The dietician made recommendations for supplements for those who needed them. The physician was notified of any weight discrepancy and orders were given and carried out for those who needed the supplements and other interventions, i.e., blood work, weekly weights, etc. 3. All residents have the potential to be affected. To ensure that the deficient practice does not reoccur, the DON/designee inserviced the nursing staff, physician and the dietician on the policy of weighing and reweighing residents in the facility and notification of the physician or designee regarding significant weight discrepancy or loss. The physician was instructed to document in the EMR significant changes in resident's weight and interventions. 4. The Unit Managers and dietician will report weight discrepancies and physician notification in the daily morning meeting. The dietician will report the findings on weight loss and the DON will report physician notification in QAPI meetings monthly x3, then quarterly x2. Then the	

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F 710	Continued From page 24 Review of Resident #23's Face Sheet (Admission Record) revealed the resident was admitted with diagnoses which included but were not limited to, EX Order 26.4B1 [redacted] Review of the Electronic Medical Record (EMR) revealed under "other orders" a physicians' order (PO) for a Ex.Order 26.4(b)(1) [redacted] No other dietary recommendations were ordered. A review of Resident #23's Vital Sign Report in the EMR revealed the following dates / weights: EX Order 26.4B1 [redacted] There were no further documented follow up weights or re-weights in the EMR. Review of the RD Quarterly "Nutritional Progress Note" dated Ex.Order 26.4(b)(1) [redacted] at 5:10 PM, revealed that Resident #23 intake has been fair to adequate. Per weights the resident had experienced EX Order [redacted] lb. (0.7%) weight Ex.Order 26.4(b)(1) [redacted] days, a significant Ex.Order 26 [redacted] days and a significant [redacted] lbs. (16%) weight Ex.Order 26.4(b)(1) [redacted] days. The RD recommended Ex.Order 26.4(b)(1) [redacted] at breakfast and a Ex.Order 26.4(b)(1) [redacted] with lunch and dinner. Continue with	F 710	QAPI committee will determine if it requires to be continued, thereafter.	

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F 710	Continued From page 25 weights as ordered. Review of the RD "Significant Weight Change Nutritional Progress Note" dated [redacted], reflected a weight history that had been variable. Weights indicate a significant[redacted] Recommended a[redacted] three times a day and weekly weights. Encourage weights as needed/accepted. Continue with liberalized diet. No recent labs noted. This assessment was completed after surveyor inquiry. A review of the Physicians' notes dated 04/10/23, 04/10/23, 04/14/23, 04/17/23, 04/19/23, 05/01/23, 07/17/23, 09/11/23 and 10/06/23 indicated that Resident #23 had [redacted]. A review of the EMR from April 2023 to November 2023 did not reveal any documentation that the doctor, family, or interdisciplinary team was aware of Resident #23's significant [redacted]. On 11/16/23 at 1:30 PM, the surveyor interviewed the Registered Dietitian (RD) in the presence of the survey team. During this interview, the RD acknowledged that the resident had a significant [redacted] and did not notify the physician On 11/15/23 at 12:22 PM the surveyor attempted to contact the attending physician , but was informed by the office that the physician was on vacation.	F 710		

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F 710	Continued From page 26 On 11/15/23 at 01:40 PM , the surveyor conducted a telephone interview with the covering physician. (MD). The MD stated that if he was aware of a resident's significant weight [redacted], he would want to identify the causal factor for the weight [redacted] and implement interventions to correct the weight [redacted] The MD further stated that he would expect the nurses to notify the MD if there was a significant weight Ex.Order 26.4(b)(1) When asked if he was notified of the Resident #23's significant weight [redacted] of [redacted] lbs. in last 6 months, he stated "I do not recall." On 11/17/23 at 11:50 AM, in the presence of the survey team, the LNHA and the DON acknowledged that weekly weights were not consistently recorded, the resident experienced a significant weight Ex.Order 26.4(b)(1) and [redacted] and there was no documentation of the doctor being notified. The LNHA and the DON stated that the doctor should be monitoring the residents' weights. A review of the facility policy titled, "Resident Weights and Weight Changes" policy, revised 11/07/1, reflected that significant weight changes will be reviewed by the DON/designee and referred to the dietician and physician if indicated. A reweigh must be obtained within 48 hours if a weight change meets the following criteria: 1 month- 5% body weight change or 6 months-10 % body weight change. The DON/designee or dietician will assess the weight change and make a notation in the medical record as to the plan of action for the weight change-diet counseling, physician notification, and dietician notification.	F 710		

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F 710	Continued From page 27 A review of the facility policy titled "Clinical Nutrition Services", revised 01/22, reflected that when recommendations are made that require a physician order, the Registered Dietician Nutritionist(RDN) will follow up within 7 days to verify a physicians response and if no response the RDN will contact the physician to discuss the recommendations made. The (RDN) will communicate all nutrition related problems to other disciplines by was of care plan/ morning meeting (FYI: examples may include but not limited to Interdisciplinary Patient Care Plan, Medical Rounds	F 710		
F 804 SS=D	NJAC 8:39-23.2 (b) Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review it was determined that the facility failed to serve meals at an appetizing temperature for 1 of 1 resident reviewed for food (Resident #148) and on 1 of 4 resident units (Willow). The deficient practice was evidenced by the following: On 11/13/23 at 10:18 AM, during the initial tour, Resident #148 expressed concerns about the	F 804	1. a. Resident #148 is currently on EX Order 26.4B1 services since EX Order 26.4B1 She is unable to verbally tell the administrator about her concerns about her food. The nursing staff were inserviced immediately on making sure that the resident is awake, alert, properly seated and ready to accept/eat her meal. Nursing staff were instructed to offer alternate is	12/29/23

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F 804	Continued From page 28 quality of the meals served and the temperature of the meals served. The breakfast meal sat on the bedside table, untouched, during the interview. On 11/15/23 at 8:04 AM, the surveyor observed residents in the [redacted] unit dining room sitting at tables waiting for the breakfast meal. On 11/15/23 at 8:09 AM, a meal cart was brought to the unit and the first tray was served. On 11/15/23 at 8:52 AM, the 2nd to last tray was removed from the cart and the surveyor removed the last tray to review for the test tray. The meal was Regular consistency meal. At 8:56 the Food Service Director (FSD) and the surveyor proceeded to test the food temperatures. The FSD stated that the hot food should be 140 degrees Farenheight (F) or higher and the cold food should be 41 F or below and in the 30s would be preferred. The meal tray contained: a) 4 ounces oatmeal; surveyor and FSD both had 121 F. b) 2- ½ pieces of cinnamon French Toast; surveyor- 87 F, FSD- 88 F c) ½ Cup Pineapple tidbits; surveyor- 60 F and FSD-61F d) 8 ounces 2% milk; The surveyor observed that the carton felt warm to the touch; surveyor-61 F, FSD 58. The surveyor asked the FSD if that temperature was okay and the FSD stated, "it is not okay by any means, I wouldn't want it".	F 804	resident does not like the main food served. 2. The administrator requested to attend the resident council meeting with the residents to discuss issues of concern with food quality and temperature. The administrator/designee made rounds on the units during mealtimes and spoke with the residents about the food that was served. 3. All residents in the facility have the potential to be affected. To ensure that the deficient practice does not reoccur, the DON/designee will inservice nursing staff to ensure the residents are ready to accept their meals in the dining rooms and/or their rooms, when the food trucks are delivered. The meal trays are passed out immediately upon arrival. Cold items served will be flash chilled by placing cold beverages on ice for 10-15 minutes before placing beverages on trays and into food truck for delivery. Food will be plated in kitchen on warmed dining plates and placed on insulated pellet plates with dome lids. Trays will be placed in closed food truck to keep the proper temperature. The dietician will conduct food temperature checks of last tray served on the unit, three times a week. Nursing staff also instructed to offer meal alternates if the resident does not like the main food served. 4. The dietician will report the findings on food temperature in the morning meetings	

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F 804	Continued From page 29 The Production, Purchasing and Storage Policy, Date issues 5/95 revealed: Hot holding temperatures; Foods should be held hot for service at a temperature of 140 F or higher. Cold holding temperatures: Foods should be held cold for service at a temperature of 41 F or less. NJAC 8:39-17.4 (a)2	F 804	and in QAPI meetings monthly x3, then quarterly x2. Then QAPI committee will determine if it requires to be continued, thereafter.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review it was determined that the facility failed ensure: a) the kitchen environment and equipment was maintained in a clean and	F 812	1. a. The contracted service vendor was called in to address the error message of the dish machine. The issue was resolved. A new temperature log was	12/29/23

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F 812	Continued From page 30 sanitary manner, b) the dish machine was functioning in a manner to ensure proper wash and rinse temperatures were maintained, c) refrigerated resident food storage areas (3 of 4 observed) were maintained in a clean manner and food was appropriately labeled and dated, and d) staff performed appropriate hand hygiene, to limit potential bacteria growth and potential food borne illness. The deficient practice was evidenced by the following: On 11/13/23 at 9:24 AM through 10:07 AM, the surveyor conducted a tour of the kitchen with several staff including the Regional Director of the Food Management Company, Executive Chef, Registered Dietitian (RD) and observed: 1. At 9:26 AM, the dish machine was observed in use and resident meal items, including insulated lids and trays were being washed. The surveyor observed the temperature screen to identify the wash temperatures and the wash temperature blinked 156 degrees Farenheight (F) and then intermittently blinked "P2 error" and continued to flash back and forth. The surveyor asked the RD what the error message meant, and she stated, she was not sure and then instructed the food service worker (FSW) that she wanted to look into it before they continued washing dishes. The surveyor observed that under the temperature gauge, there was a Manufacturer sticker that revealed the "Hot Water Sanitizing Wash Temperature, 150 F" and the "Hot Water Sanitizing Rinse Temperature was 180 F" The surveyor asked the FSW what the blinking error message meant and the FSW stated it "was just an error". The surveyor asked the FSW if temperatures of the machine were taken, and he	F 812	posted and the correct readings were written in place. b. The floor area near the ice machine was cleaned by the dietary staff. The salad spinner was also cleaned by the staff. c. The rolling bins were emptied and then cleaned by the dietary staff. Then, labeled the bins appropriately. d. The plastic bag on the slicer was removed and the base of the slicer was cleaned thoroughly. e. The dry storage room floor and under the racks was cleaned immediately by the dietary staff and Director of Dining. f. The cooks cleaning checklist was replaced by the Director of Dining. g. The pans that were on the rack were washed and cleaned, then air dried to prevent nesting. h. The Aspen refrigerator was cleaned immediately. Outdated and unlabeled foods discarded. The ice packs in the freezer were removed and the Unit Manager was inserviced about not having such items in the refrigerator or freezer. i. The administrator called the Director of dining to the unit to stop the process of washing the dishes in the Evergreen pantry. The Food service staff #1 was inserviced by the IP on hand hygiene. j. The food that was unlabeled or outdated in Sandalwood pantry was discarded and the refrigerator was cleaned by the dietary staff. 2. All residents in the facility have the potential to be affected. The	

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F 812	Continued From page 31 responded "yes" and then he showed the surveyor the temperature logbook which revealed: "Dish machine Temperature Record (High Temperature Machine)" November 2023. The Wash Temperature and Final Rinse Temperature area of the form (see date plate on machine) was blank. The form indicated Wash Temp (temperature), Final Rinse Temp and Checked by for Breakfast, Lunch and Dinner. The November 13, 2023, Breakfast indicated Wash temp 120 F, Final Rinse 155 F and initialed by the FSW. At that time, the surveyor also observed that the Lunch and Dinner Wash and Final Rinse Temperatures were also documented with the same temperatures and initialed by the FSW. The surveyor asked the FSW why all three meals had been pre-filled out and the FSW stated because when sometimes when he comes in to work the temperatures are not always documented. Further review of the Final Rinse Temperatures revealed that there were no documented Final Rinse Temperatures from November 1-13, 2023, that met the posted Manufacturer's final rinse temperature of 180 F. At 9:31 AM, the surveyor asked the RD about what the "P2 error" meant and why the temperatures being pre-filled out for the entire day and the RD stated, "I cannot answer that now". 2. At 9:33 AM, the surveyor continued the tour with another Food Service Management Company Representative (FSMC). The surveyor observed the floor area by the ice machine. The floor area on the side of the ice machine and toward the baseboard and under a metal table was very soiled with various colored debris.	F 812	administrator, Director of Dining and the dietician checked all the other unit refrigerators and pantries to ensure that all were in regulatory compliance. A contractor was hired to clean all the unit refrigerators and the entire main kitchen on the evening of 11/13/23. 3. To ensure that the deficient practice does not reoccur, the Infection Preventionist educated all the facility staff on hand hygiene and will conduct hand hygiene competency with the facility staff, once a week. The Dining Director inserviced kitchen staff on nesting, food sanitation and storage. The Director of Dining/designee conducts daily audits of cooks checklist, temperature logs for the dish machines and the unit refrigerators. The Director of Dining inserviced kitchen staff on nesting, food sanitation and storage. 4. The Director of Dining will report findings in the daily morning meetings with department heads and unit managers. Director of Dining will also report in QAPI meetings monthly x3, then quarterly x2. Then QAPI committee will determine if it requires to be continued, thereafter.	

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F 812	Continued From page 32 There was a large green salad spinner stored on a lower metal shelf which also was observed by the surveyor and the FSMC to be covered with debris on the lid. The surveyor asked the FSMC if the floor area, including the salad spinner was clean and the FSMC stated, "no, not cleaned." 3. At 9:38 AM, the surveyor observed white rolling bins stored under a metal table in the kitchen. The area under the table, on the wall adjacent to the table and the baseboard had visible stains and debris. Both bins had debris on the exterior of the bins, and on the top of the lids. One bin contained an opened bag of sugar that which did not contain a use by date. The adjacent white bin was identified as containing flower was also stored in an open bag with debris in the bin next to the bag. The surveyor asked the FSMC about the items in the bins and if the area and bins were clean. The FSMC stated "this was not really done properly". 4. The large metal meat slicer was wrapped in plastic and identified as clean by the FSMC. The bag was removed, and debris was observed on the base of the slicer. 5. The surveyor observed the dry storage room and there was various debris on the floor and under the food storage racks. At that time, the EC acknowledged the floor was not clean. 6. The surveyor reviewed a "P.M. Cook's Cleaning Checklist" provided by the FSMC for November 23, Sunday 11/12" which revealed "Mop and Sweep" was checked off. The FSMC and RD acknowledged that the floor was not clean. The Checklist also revealed "Make sure	F 812		

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F 812	Continued From page 33 slicer and mixer is cleaned and covered". 7. Per the surveyor request, the FSMC held up pans that were stored on the clean pan rack. The FSMC, in the presence of the EC, held up 1/3rd deep pans, and 3/5 pans were visibly wet and nested, and 4/5 of the 1/6th pans were visibly wet nested. The FSMC stated the pans are supposed to be air dried. The surveyor observed four coffee pots stored upright and asked the EC to show the surveyor 4/4 coffee pots were stored upright and wet inside and they were removed by the EC. At 9:56 AM the surveyor requested the cleaning policy and equipment policy, and dish machine policy. 8. On 11/13/23 at 10:12 AM, the surveyor toured the Aspen Pantry. The surveyor observed that the interior of the refrigerator was soiled with splatters and debris and observed a labeled sandwich snack. The surveyor asked the Registered Nurse Unit Manager (RNUM) to observe and confirmed the refrigerator was not clean. The RNUM then accompanied the surveyor to observe a pantry and small resident area with a refrigerator on the same unit. The refrigerator had dried on splatters on the shelves. Items including what the RNUM identified as a submarine sandwich with a name and was undated, and an undated food item in a brown paper bag. The surveyor asked how long food could stay, the RNUM stated "I think 7 days" and although the item had no date, he returned it to the refrigerator. The other item was also undated which he then also returned to the refrigerator and stated, "it is supposed to be dated". There	F 812		

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F 812	Continued From page 34 were also unlabeled/undated items in plastic bags and the RNUM stated, "I will keep it, because they [residents] ask about it. The surveyor then opened the freezer in the presence of the RNUM and observed two pints of ice cream and a box of individual Italian Ices which were stored with multiple blue ice packs that filled the bottom of the freezer and a black and white cloth ice pack. The surveyor asked about what the ice packs were used for. The RNUM stated, "the cold packs for the body" and when asked if that was okay to store those items with food, the RNUM stated, "I don't see any problem with that, that is where we store it". 9. On 11/13/23 at 10:27 AM, the surveyor conducted a tour of the Evergreen Pantry. There were two Food Service Staff (FSS) cleaning dishes in the pantry using an under mount dish machine. The pantry was visibly soiled with debris throughout the floor and on the equipment and the metal tables appeared soiled. The FSS were washing black insulated resident meal items including lids, cups, and containers. The surveyor observed that the dish machine had 117 F as the wash temperature that was on the display. The surveyor watched FSS #1 remove clean dishes with her bare hands and then begin to place dirty dishes on the rack. At that time, the surveyor asked what the temperature of the dish machine should be. The FSS#1 stated she "doesn't know and normally doesn't do that". At that time, the surveyor then observed the FSS #1 rinse off her hands under running water in a non-hand washing sink, without using soap and then put a pair of gloves on her hands. The surveyor tried the soap dispenser on the hand washing sink on the opposite side of the FSS #1	F 812		

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F 812	Continued From page 35	F 812		

and it was not dispensing soap. The FSS #1 then placed the dirty dishes in the dish machine. The surveyor asked the FSS#1 if there was anything that should be done prior to putting gloves on and she stated, "wash", and the surveyor asked how that would be completed with no soap dispensing. The FSS#1 stated "yes, no soap, I rinsed my hands".

On 11/13/23 at 10:39 AM, the surveyor alerted the Licensed Nursing Home Administrator (LNHA) of the concerns regarding the observations.

10. On 11/13/23 at 10:40 AM, the surveyor toured the Sandalwood Pantry in the presence of the Unit Manager Nurse (UMN). The refrigerator that stored resident items including two snack sandwiches, was soiled with splatters and debris. There were two frozen food unlabeled and undated items in the freezer. The UMN confirmed the surveyor's observations and when asked if the refrigerator was clean, the UMN stated, "no, I agree with you" and then discarded the unlabeled/undated items.

On 11/13/23 at 1:45 PM, the surveyor interviewed the LNHA about the condition of the pantries and who was responsible for maintain the cleanliness. The LNHA stated the kitchen was responsible.

On 11/14/23 at 11:00 AM, the LNHA provided the surveyor with a "Summary of Service" form the dish machine service contractor dated 11/13/23 at 5:13 PM. The Description revealed the P2 error was the rinse display temperature probe and temperature was not displaying and the

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F 812	Continued From page 36 probe was replaced. On 11/15/23 at 9:04 AM, the surveyor interviewed the Food Service Director (FSD) regarding the error code and dish machine service. The FSD stated the temperature sensor was broken and needed to be replaced. The FSD stated the rinse temperature was okay when the technician checked it with an indicator strip. The FSD confirmed he did not have the indicator strips to confirm that the rinse temperature was adequate during the surveyor observations. A review of the Cleaning of Food and Nonfood Contact Surfaces Policy #F013, Date Issues 05/95 revealed: The food-contact surfaces of all cooking equipment shall be kept free of encrusted grease deposits and other accumulated soil, Nonfood contact surfaces of equipment, such as handles on reach in units, sides of sinks ... shall be cleaned as often as necessary to keep the equipment free of accumulation of dust, dirt, food particles and other debris ... Dish machine Temperatures Policy #F019, Date Issued 05/95 revealed: Dish machine wash and rinse water should be maintained at temperatures that meet the guidelines established by the Food and Drug Administration ... Director Confirms the wash and rinse temperatures listed on the manufacture's data plate on the dish machine. Modify the dish machine temperature record as necessary. High temperature Dish machine- record on dish machine temperature record form. Wash and final rinse temperatures during each period of	F 812		

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F 812	Continued From page 37 use. Once a day, run a test strip (160 F strip) through the dish machine to verify the surface temperature of a dish. Attach the used test strip to the Test Strip Results form. The test strip "must" verify that the surface temperature of the plate reached 160F ... The Food Handling Guidelines (HACCP) Policy # B007, Date issues 05/95 revealed that Hands should be scrubbed following appropriate hand washing techniques according to the facility/community policy (e.g., after toilet use, between food preparation tasks, before putting on gloves, etc.). The Area and Equipment Cleaning Policy # F014, Date issues 05/95 revealed: Director: ... assigns daily cleaning responsibilities in each position workflow, Management/Supervisory Personnel: Assigns weekly and special cleaning to be completed each day. The Personal Food Storage Policy, revised: 11/22/16 revealed: Food or beverage brought in from outside sources for storage in the facility pantries, or refrigeration units will be monitored by a designated facility staff for food safety. Food Safety for Your Loved Ones. Food or beverages should be labeled and dated to monitor for food safety.	F 812		
F 865 SS=E	NJAC 8:39-17.2 (g) QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program.	F 865		12/29/23

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F 865	Continued From page 38 Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the	F 865		

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F 865	Continued From page 39 facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services	F 865		

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F 865	Continued From page 40 provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, it was determined that the facility Quality Assurance Performance Improvement (QAPI) Committee failed to a.) improve quality of life and improve quality of care for residents by not having a system in place to identify residents who sustained significant unplanned weight [redacted], and b.) ensure the kitchen and associated areas were maintained in a sanitary manner. This deficient practice occurred for 1 of 2 residents (Resident #23) and during observations conducted on 11/13/23 and 11/15/23 and was evidenced by the following:	F 865	1. A. Resident #23 was reweighed on 11/16/23 with weight noted at [redacted] lbs. The physician was notified of the findings. The physician gave orders for weekly weight to be done and for resident to have Ensure supplement three times a day. The nursing staff were inserviced to make sure that the resident is awake, alert, sitting in an upright position and ready to accept the meal served. The nursing staff were also inserviced in making sure that the resident(s) are offered the alternate to the meal, if the resident does not prefer the main meal.	

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F 865	Continued From page 41 Refer to 692G and 812F On 11/17/23 at 9:25 AM, the surveyor intrviewed the Licensed Nursing Home Administrator (LNHA) regarding the currently active QAPI plans. The LNHA stated the facility was working on reducing falls and psychotropic medications as part of the QAPI program. The surveyor inquired to the LNHA if the identified concerns identified during the survey regarding the significant unplanned weight [redacted] for Resident #23 and the sanitation concerns regarding the Dietary department were identified and part of the QAPI program. The LNHA stated, "that is what the missing piece was, we did not looking at the resident weights." The LNHA further stated that the Dietary department did not have a QAPI in place to monitor the cleanliness of the kitchen. On 11/12/23 at 10:29 AM, the surveyor observed Resident #23 on the initial tour of the facility. The resident was then observed at 12:55 PM the same day sitting in the dining area feeding him/herself pork, rice and peas. On 11/14/23 at 9:21 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) and stated that Resident #23 could feed him/herself with some assistance and supervision. The CNA explained that Resident #23 was sleepy this morning and assisted with feeding. The CNA stated that the resident had [redacted]. A review of Resident # 23's Electronic Medical Record (EMR) revealed the following weights: [redacted]	F 865	B. The kitchen was deep cleaned by an outside vendor in the evening of 11/13/23. C. The dishwasher was repaired immediately to address the "P2 error", the sensor was changed. D. The salad spinner was washed and completely dried before storage. E. The undated sugar in the white rolling bins was discarded. The container and the lid was washed and properly labeled. F. The meat slicer was cleaned by the Dining Director and recovered. G. The dry storage room floor and under the food storage racks was cleaned. H. The pots and pans noted nesting on the clean pan rack were rewashed and placed upside down on the racks to prevent nesting. I. The refrigerators in Aspen, Evergreen, and Sandalwood were immediately cleaned and outdated or unlabeled food items discarded J. The Kitchen worker was immediately inserviced regarding hand hygiene by the Infection Preventionist. 2. All residents can be affected by the deficient practices that were found. The issues identified through the audits done by the dietician, DON and Director of Dining will be discussed the the daily morning meeting with other department heads and Unit Managers. Residents with weight loss/discrepancy will be reweighed immediately or within 48 hours of noting	

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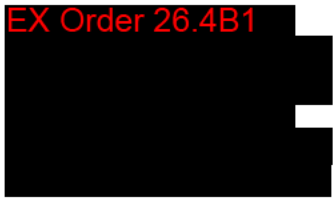
F 865	Continued From page 42 EX Order 26.4B1 [redacted]  A review of the Physicians Orders, Medication Administration Record and Treatment Administration Records for April, July, August, September, October, and November 2023 did not reveal any documentation of dietary interventions as recommended by the RD. It was also indicated that Resident #23 had Ex.Order 26.4(b)(1) [redacted] according to the Physicians' notes dated for 04/10/23, 04/10/23, 04/14/23, 04/17/23, 04/19/23, 05/01/23, 07/17/23, 09/11/23 and 10/06/23. The Electronic Medical Record (EMR) did not have any supporting documentation that Resident #23's Ex.Order 26.4(b)(1) was notified to the doctor, family, or the interdisciplinary team. On 11/15/23 at 11:25 AM, the surveyor interviewed the Registered Dietician (RD) and it was confirmed that Resident #23 did trigger a Ex.Order 26.4(b)(1) in October 2023's quarterly assessment and she did not write the recommendation in the "Dietician Recommendations" book. The RD stated, "I think I forgot to put them in the book." The failure to document in the "Dietician Recommendation" book resulted of Resident #23's not receiving the Ex.Order 26.4(b)(1) [redacted] the resident required. On 11/15/23 at 01:40 PM, the surveyor conducted a telephone interview with the	F 865	the discrepancy. The findings will be documented in the residents medical record and reported to the physician and dietician. The physician and dietician will document interventions in the residents medical record. 3. The Administrator/designee conducted an inservice about QAPI with all staff and met with the Director of Dining and dietician to ensure that both present QAPI reports in the meetings to be held. 4. The dietician and Director of Dining will present the reports on their weekly audits on weight loss, kitchen sanitation, dishwasher sensor function and reading, proper labeling of bins, dry storage room cleanliness, meat slicer cleanliness, nesting of pots and pans, refrigerator cleanliness in all four units and any other areas of concern identified, at QAPI meetings monthly x3, then quarterly x2. Then the QAPI committee committee will determine if it requires to be continued, thereafter.	

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covering Medical Doctor (MD) regarding the interventions that are taken for a resident with Ex.Order 26.4(b)(1). The MD stated that he would expect the nurses to notify him of any resident's significant Ex.Order 26.4(b)(1) The MD stated once aware of the Ex.Order 26.4(b)(1), he would determine if it was Ex.Order 26.4(b)(1) medical reason the resident Ex.Order 26.4(b)(1). The MD was not aware of Resident #23's significant Ex.Order 26.4(b)(1) of Ex.Order 2 lbs. in the last 6 months. The MD stated, "I do not recall."

On 11/16/23 at 1:30 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON) and the Registered Dietician (RD) in the presence of the survey team. The DON and the LNHA both confirmed of not being aware of the significant Ex.Order 26.4(b)(1) that Resident #23 had until the surveyor's inquired. The RD stated the Ex.Order 26.4(b) trend was not documented and monitored of Resident #23, therefore it should have been communicated with the DON, LNHA and the doctor. The DON and LNHA stated that it was a system failure from the whole team. The LNHA and the RD stated, " We missed it."

A review of the facility provided, "Clinical Nutrition Services" policy, revised 01/22, revealed that when recommendations are made which require a physician's order, the Registered Dietician Nutritionist (RDN) will follow up within 7 days to verify a response to the recommendations.

B.) On 11/13/23 at 9:24 AM, the surveyor conducted the initial tour of the kitchen and observed unsanitary conditions that included but were not limited to; the dishwasher was not

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F 865	Continued From page 44 operating at the optimum rinse temperature of 180 degrees Fahrenheit with the machine reading error code "P2 error". The floor area by the ice machine was very soiled and had various colored debris. A large green salad spinner stored on a lower metal shelf had debris on the lid. There were two white rolling storage bins, one containing sugar that had no use by date and the other containing flour with debris in it; both bins had visible debris on the outside and lids. The meat slicer was covered with plastic and was identified as clean by the Food Service Manager Cooperate Representative (FSMC); after the cover was removed the surveyor observed debris at the base of the slicer. In the dry storage room various debris was observed on the floor and under the food storage racks. The area that stored the clean pan rack had various size pans and 4/4 coffee pots in upright position that were wet and nesting. On 11/13/23 at 10:12 AM, the surveyor toured the Aspen unit pantry and observed unsanitary conditions that included but were not limited to; the interior of the refrigerator was visibly soiled with dried on splatters and debris and there were food items that were unlabeled and undated. The surveyor observed the freezer that contained two pints of ice cream, a box of individual Italian ices and multiple ice packs that were used for resident care, all in the same area. The Registered Nurse Unit Manager (RNUM) stated, "the cold packs were for the body" and did not see an issue with storing the resident care ice packs with food items. On 11/13/23 at 10:27 AM, the surveyor conducted a tour of Evergreen unit pantry. The	F 865		

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pantry was visibly soiled with debris on the floor, on the equipment and the metal tables. The Food Service Staff (FSS) #1 was observed removing clean dishes with her bare hands, followed by putting dirty dishes on the rack without performing hand hygiene. The surveyor observed the same FSS #1 rinse her hands under running water in a non-hand washing sink without any soap.

On 11/13/23 at 10:40 AM, the surveyor toured the Sandalwood unit pantry with the Unit Manager Nurse (UMN). The refrigerator that belonged to the residents was visibly spoiled with splatters and debris. The freezer contained two food items that were unlabeled and undated. The UMN confirmed the refrigerator was not clean and discarded the unlabeled and undated items.

On 11/15/23 at 9:04 AM, the surveyor interviewed the Food Service Director (FSD) in reference to the error code of the dishwasher and service. The FSD stated that the temperature sensor was replaced. The FSD stated the technician tested the rinse temperature with the indicator strip and it was okay. The FSD confirmed he did not use a indicator strip to test the rinse temperature during the survey.

On 11/17/23 at 9:25 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) regarding the currently active QAPI plans. The LNHA stated the facility was working on reducing falls and psychotropic medications as part of the QAPI program. The surveyor inquired to the LNHA if the identified concerns identified during the survey regarding the significant unplanned Ex.Order 26.4(b)(1) for Resident

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F 865	Continued From page 46 #23 and the sanitation concerns regarding the Dietary department were identified and part of the QAPI program. The LNHA stated, "that is what the missing piece was and not looking at the resident weights. The LNHA further stated that the Dietary department did not have a QAPI in place to monitor the cleanliness of the kitchen. It was confirmed the facility did not follow the following policy and procedures: #F013 Cleaning of Food and Nonfood Contact Surfaces; #F019 Dish Machine Temperatures; #F014 The Area and Equipment Cleaning; The Personal Food Storage Policy.	F 865		
F 868 SS=D	NJAC 8:39-33.2(b)(c)6 QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI	F 868		12/29/23

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F 868	Continued From page 47 program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have the Medical Director (MD) and the Director of Nursing (DON) present for one of four Quality Assurance and Performance Improvement (QAPI) meeting as evidenced by the following: On 11/17/23 at 9:15 AM, the surveyor reviewed the QAPI policy and procedure and requested the sign-in sheets or the last four quarterly QAPI meetings. On 11/20/23 at 9:00 AM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with four quarterly sign-in sheets for the each quarter of 2023, which revealed: The First Quarter 2023: January 17, 2023, Quarterly QAPI Team Meeting Signature Log.	F 868	1. The Administrator and DON called the medical director and presented the missed QAPI meeting information/topics discussed at the quarterly meeting. 2. The medical director and DON were informed that the next quarterly QAPI meeting will be held on January 16, 2024 and that attendance is mandatory. 3. To ensure that the deficient practice does not reoccur, the department heads and other members/attendees of the QAPI will be informed that it will be scheduled on the 3rd Tuesday of the quarter at 11:00am. A reminder via email will be sent to all the department heads and other participants of the meeting with the request to respond if the person is	

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F 868	Continued From page 48 The sign-in sheet was missing the attendance of the Medical Director (MD) and the Director of Nursing (DON). At that time, the LNHA stated that on January 17, 2023 the MD was on vacation and the DON was not present. The facility provided QAPI plan policy included but was not limited to: The Quality Improvement (QI) Committee consists of the Director of Nursing, the Medical Director, the Administrator, Activity Director, Social Work, Housekeeping Director, Dining Director, Coordinators, Maintenance Supervisor and the Infection Control/Prevention Officer. The QAPI Committee, which includes the Medical Director, meets at least quarterly as is accountable for monitoring the continuous improvement in Quality of Life and Quality of Care. Minutes are recorded and shared with staff verbally. NJAC 8:39-23.1(3)	F 868	going to attend the meeting one week before the date. If the medical director/designee, director of nursing, administrator, and/or IP cannot be available for the meeting day, an alternate date for the QAPI meeting will be scheduled. 4. The administrator will monitor the physician's and DON's attendance at quarterly QAPI meetings and will report at QAPI meetings monthly x3, then quarterly x2. Then QAPI committee will determine if it requires to be continued, thereafter.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		12/29/23

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

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F 880	Continued From page 50 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to: a.) adhere to accepted standards of infection control practices for the proper storage of Ex.Order 26.4(b)(1) after use for 3 of 3 residents reviewed for EX Order 26.4B1 services (Resident #39, #75 and #149). b.) follow the facility infection control policy to limit the potential spread of infection by failing to perform hand hygiene prior to serving and assisting with resident meal tray preparation and during medication pass administration, and c.) ensure individuals providing services under a contractual arrangement were educated on infection control practices. This deficient practice was observed on 2 of the 4 units EX Order 26.4B1) and was evidenced by the following:	F 880	1. a. Resident #149 EX Order 26.4B1 equipment was replaced by the EX Order 26.4B1 replaced the EX Order 26.4B mask and tubing and placed in a clean plastic bag The bedside table was sanitized by the housekeeper. b. Resident #39's EX Order 26.4B1 mask was replaced by the EX Order 26.4B1 with a new one and was placed in a clean plastic bag next to the machine. c. Resident #75 EX Order 26.4B equipment was replaced by the EX Order 26.4B1 and placed in a clean plastic bag. The bedside drawer was emptied and cleaned by the housekeeper. d. The RN who was noted to be deficient in hand hygiene was inserviced by the Infection Preventionist to make sure that handwashing is done for 20 seconds. e The speech therapist student was	

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F 880	Continued From page 51 1. During the initial tour of the facility on 11/13/23 at 9:13 AM, the surveyor observed Resident #149 in bed. The surveyor observed a Ex.Order 26.4(b)(1) ( ) on the bedside table. The EX Order 26.4B1 including the tubing was noted on the floor underneath the bed. The resident was alert and informed the surveyor that he/she used the EX Order 26.4B1 machine at night while sleeping. The surveyor left the room to continue the tour. While in the hallway, the surveyor observed a staff exiting the room. At 10:45 AM, the surveyor returned to the room and observed the mask and the tubing in the same position on the floor. That same day at 10:15 AM, the surveyor observed a Certified Nursing Assistant (CNA) in the room assisted the resident with care. The CNA picked up the tubing and the mask from the floor and placed them on the bedside table. At 12:30 PM, the surveyor escorted the Registered Nurse Unit Manager (RN/UM) to the room where we all observed the EX Order 26.4B1 Mask lying directly on the bedside table. The mask appeared cloudy. Review of Resident #149's medical record revealed that the resident was admitted to the facility with diagnoses which included but were not limited to; EX Order 26.4B1 The Admission Minimum Data Set (MDS), an assessment tool used by the facility to prioritize care, reflected that Resident #149 scored EX Order 26.4 on the Brief Interview for Mental Status (BIMS), indicative of EX Order 26.4B1	F 880	inserviced immediately by the Infection Preventionist regarding infection control practices. 2. Residents with EX Order 26.4B and EX Order 26.4B1 treatments were audited to make sure that equipment is stored properly. Those that were found not in a plastic bag were replaced immediately and then stored properly in a clean plastic bag. The Infection Preventionist did an inservice on hand hygiene and infection control practices, i.e. sitting on the floor then getting up from the floor and sitting on resident bed. 3. To ensure that the deficient practice does not reoccur, the DON/designee inserviced staff on the proper technique and procedure for storing EX Order 26.4B and EX Order 26.4B1 treatment equipment. The DON/designee implemented a competency for respiratory supply/equipment use and storage for the licensed nursing staff. The DON/designee will make daily rounds, specifically, for those residents with EX Order 26.4B and EX Order 26.4B1 machines, masks and tubings to ensure that the masks and tubings are kept in a clean plastic bag. The Infection Preventionist provided inservicing on hand hygiene and proper infection control practice to all nursing staff. 4. The DON or designee will perform a random audit daily on residents with respiratory equipment to make sure that it is properly stored and hand hygiene	

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F 880	Continued From page 52 Review of the November Order Summary Report reflected Resident #149 had a Physician's Order dated Ex.Order 26.4(b)(1), for EX Order 26.4B1 One Time Daily. Notes: Apply Order 26.4 at HS (Hour of Sleep), Setting: EX Order 26.4B1 water). On 11/13/23 at 11:10 AM, the surveyor escorted the RN UM to the room and both observed the EX Order 26.4B1 EX Order 26.4B1 mask was sitting directly on top of the machine. The mask was stained and cloudy. 2. On 11/13/23 at 10:40 AM, the surveyor entered Resident #39's room and observed a EX Order 26.4B1 machine was on the bedside table with a mask connected to the EX Order 26.4B1 set and tubing. Upon inquiry, the resident revealed that he/she used the EX Order 26.4B1 for EX Order 26.4B1 treatment. The nurse would set the treatment and once the treatment was completed, the mask would be placed at the bedside on top of the EX Order 26.4B1 The mask was observed to be cloudy with white materials. Review of the admission record reflected that Resident #39 was admitted to the facility with diagnoses which included but were not limited to; EX Order 26.4B1 Review of the Minimum Data Set (MDS) dated Ex.Order 26.4(b)(1), an assessment summary reflected that Resident #39 scored EX Order 26.4 on the Brief Interview for Mental Status (BIMS) indicative of EX Order 26.4 EX Order 26.4B1 Review of the November Order Summary Report revealed that Resident #39 had a Physician's Order for the administration of EX Order 26.4B1	F 880	properly performed. The findings will be reported by the DON/designee at daily morning meetings and at QAPI meetings monthlyx3, then quarterly x2. Then QAPI committee will determine if it requires to be continued, thereafter.	

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F 880		F 880		

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EX Order 26.4B1 daily starting EX Order 26.4B1

On 11/13/23 at 10:57 AM, the surveyor escorted the RN/UM to the room where we both observed the EX Order 26.4B1 mask sitting directly on the table. The UM stated that the nurses were to place the mask in a bag after the EX Order 26.4B1 treatment had been administered. When inquired regarding the rationale for storing the mask in a bag, the UM stated that for infection control purposes, all respiratory masks should have been placed in a bag after being used.

3. On 11/13/23 at 10:27 AM, the surveyor entered Resident #75's room. The surveyor observed a EX Order 26.4B1 machine on the bedside table. The bedside table drawer was partly open exposing the EX Order 26.4B1 mask and tubing inside the drawer along with other objects. The mask was not protected, and the mask was cloudy.

A record review of Resident #75 admission record, reflected that Resident #75 was admitted to the facility with diagnoses which included but were not limited to; EX Order 26.4B1

Review of the Minimum Data Set (MDS) dated EX Order 26.4B1 reflected that Resident #75 scored [redacted] on the Brief Interview for Mental Status (BIMS), indicative of intact EX Order 26.4B1.

Review of the November Order Summary Report revealed that Resident #75 had the following Physician's Order dated 1 Ex.Order 26.4(b)(1): EX Order 26.4B1

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F 880	Continued From page 54 ([redacted] machine one time daily. Notes: Apply [redacted] at (HS) hour of sleep, (setting: [redacted] auto [redacted] (centimeter) H2O (water). Review of the Treatment Administration Record (TAR) revealed that staff had signed for the application of the [redacted] machine at bedtime. An interview with the Registered Nurse Unit Manager (RN/UM) on 11/13/23 at 10:30 AM, revealed that all respiratory masks were to be kept at the bedside secured in a bag. On 11/13/23 at 11:15 AM, the surveyor escorted the RN/UM to the room where we both observed the [redacted] mask inside the resident's drawer along with other residents toiletries, the mask was not protected. On 11/14/23 at 9:30 AM, the surveyor interviewed the RN UM regarding how he addressed the above issues. The RN UM stated he verbally informed the nurses to place the mask in a bag. He could not provide documentation of any in-services education that was done to address the concerns. On 11/15/23 at 10:34 AM, the surveyor interviewed again the RN UM regarding the [redacted] masks and the [redacted] masks. The RN UM stated that he informed the nurses that after care the masks were to be placed in a bag. The RN UM added that the facility protocol was to place the mask in a bag after use. The RN UM further added that he was not aware if the nurses were educated regarding the storage of respiratory equipment prior to the surveyor's	F 880		

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F 880	Continued From page 55	F 880		

inquiry. The surveyor then inquired regarding Resident #149's mask that was noted on the floor. The RN UM stated that he used alcohol swab to wipe the mask and placed the mask in a bag.

On 11/15/23 at 12:25 AM, the surveyor conducted an interview with the Infection Preventionist Registered Nurse (IP/RN) regarding the storage of the respiratory masks after treatment. The IP/RN stated that he had just started the role and was not involved in the process of educating the staff regarding respiratory equipment. He further added that the Respiratory Therapist oversaw the staff's education regarding storage and changing respiratory equipment. The IP/RN stated that the Respiratory Therapist (RP) was responsible for oxygenation and other respiratory supplies. The IP/RN did not have any in-services education for the staff regarding storage of respiratory equipment.

On 11/16/23 at 9:50 AM, the surveyor conducted an interview with the Respiratory Therapist (RT), who informed the surveyor that she was a contracting agent. She visited the facility for about four hours every day to provide respiratory services to the residents and was not responsible to educate the staff. The RT further added that if she observed some concerns during her visits, she would address them at that time. The surveyor then inquired regarding the maintenance of oxygenation masks, Nebulizer and C-PAP. The RT added that the staff was responsible to secure the mask in a bag. The RT stated also if a mask was found on the floor, it should be discarded. The resident should know

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F 880	Continued From page 56 how to clean the [EX Order 26.4B3] mask and the staff should inquire regarding how the resident maintained the [EX Order 26.4B3] mask at home. . On 11/16/23 at 10:04 AM, during an interview with the DON, she confirmed the RP was not responsible to educate the staff. The DON added, "it is part of the competency, I will provide it." On 11/17/23 at 11:30 AM, a review of the competency package the DON provided,revealed there was no competency for the [EX Order 26.4B3] masks. The [EX Order 26.4B1] competency failed to provide directives to staff regarding the care and storage of the masks. A review of the facility's policy titled, " Skilled Nursing Policies and Procedures Oxygen Therapy", dated 6/01/01 and last revised 1/20/21, indicated the following: Tubing and humidifiers are changed at least weekly. These are to be dated and initialed each time they are changed. Oxygen/concentrator tubing and nasal cannula shall be stored in a clean plastic bag when not in use. (The policy was not being followed). 4. On 11/15/23 at 08:45 AM, the surveyor observed the Registered Nurse (RN) administering medications to a resident. The surveyor observed that the nurse did not perform hand hygiene prior to preparing the medications for the resident. The nurse entered the room, administered medications to the resident, then went to the bathroom to wash her hands. The nurse turned on the faucet, wet her hands, lathered her hands, and completed the entire hand hygiene within 10.42 seconds.	F 880		

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F 880	Continued From page 57 On 11/15/23 at 10:41 AM, the surveyor interviewed the RN regarding the hand hygiene observed during meds pass. The RN stated, " I missed the counting, I am sorry." 5. On 11/13/23 at 11:30 AM, the surveyor observed a facility staff sitting in the middle of the hallway on the carpeted floor. The surveyor observed a resident seated in a wheelchair in the hallway next to the staff. The surveyor also observed a nurse on the medication cart in the same hallway. The surveyor inquired about the staff observed sitting directly on the floor. The nurse replied, "I asked myself the same question". The surveyor continued the tour, while in the hallway, the surveyor observed the same staff that was sitting on the floor was now sitting directly in the room and on the unsampled resident's bed. On 11/13/23 at 12:53 PM, the surveyor remained in the hallway and observed the staff exiting the resident's room. During an interview with the staff, she informed the surveyor that she was a student in training with the speech therapist. When inquired regarding being seated on the floor, while interacting with the resident, she added she did not see any issue regarding being seated on the floor, she wanted to be at the resident's eyes level. The surveyor then asked about infection control practices. The student stated that she had been at the facility since September and had not received any in-service education on infection control. On 11/13/23 at 11:57 PM, the surveyor interviewed the Speech Therapist Director (STD)	F 880		

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F 880	Continued From page 58 and shared the above concerns. The surveyor asked for the employee orientation file for review. The STD informed the surveyor that she did not have a file for the student and the student was verbally educated regarding infection control practices. On 11/16/23 at 10:30 AM, the STD provided a "Self-Study Orientation Packet" dated 10/06/23 which included topics on infection prevention and Bloodborne Diseases. No in-service education was provided after the issue was discussed with the facility. 6. On 11/15/23 at 8:04 AM, the surveyor observed the breakfast meal on the [redacted] unit and observed the following: On 11/15/23 at 8:07 AM, an Activity Staff (AS) was observed cutting an unsampled resident's meal tray, then removed soiled tray items into garbage, and without first performing hand hygiene proceeded to take out another resident's meal tray from the food cart. The AS then, without first performing hand hygiene, proceeded to put a straw in an unsampled resident's beverage and opened the resident's syrup for the French toast. Then, the AS removed the soiled tray items into the garbage and, without first performing hand hygiene proceeded to place Resident #87's meal tray in front of them and began cutting up the resident's food. On 11/15/23 at 8:15 AM, the surveyor observed a Certified Nurse Aide (CNA) place a clothing protector on an unsampled resident, then set up the resident's meal tray, and dumped the tray debris in the garbage. Then, without first performing hand hygiene removed another	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315269	A. BUILDING _____ B. WING _____	C 11/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE POINT	**THREE DAVID BRAINERD DRIVE MONROE TOWNSHIP, NJ 08831**

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F 880	Continued From page 59 unsampled resident's meal tray from the meal cart, opened the resident's nutrition drink and the straw and placed the straw inside the drink. On 11/15/23 at 8:21 AM, the surveyor interviewed the CNA regarding what is the process when you go from one resident's tray to the other, and the CNA stated, "you use wipes". On 11/15/23 at 8:30 AM, the surveyor interviewed the AS regarding if wipes or cleaning hands would be done between setting up the residents. The AS stated," yes, I forgot". On 11/15/23 at 11:13 AM, the surveyor requested and reviewed the facility's policy titled, " Handwashing/Hand Hygiene", dated 3/1/17 and last revised 7/18/18. The policy revealed: Purpose: This facility considers hand hygiene the primary means to prevent the spread of infections. Procedure: 1. All personal shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare -associated infections. 7. Use an an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: before preparing or handling medications. Washing Hands: Vigorously lather hands with soap and water and rub together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) away from the stream of water. (The procedure was not being followed)	F 880		

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	315269	A. BUILDING _____ B. WING _____	C 11/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 60 NJAC 8:39-19.4 (a)1	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061219	A. BUILDING: _____ B. WING _____	C 11/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE POINT	THREE DAVID BRAINERD DRIVE MONROE TOWNSHIP, NJ 08831

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. This was evident in Certified Nursing Assistant (CNA) staffing for 7 of 14-day shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,	S 560	1. The staffing Scheduler/Administrator/DON/designee review direct care to resident ratios for compliance with mandatory staffing requirements daily. The Staffing Scheduler/DON/Administrator and Human resources conduct weekly recruitment meetings to discuss open positions/staffing needs/recruitment efforts, and review resumes. Direct care staff positions are being advertised in various venues such as our Company's Website, Online Recruitment Companies, advertisements for recruitment to local Vocational Tech and	12/29/23

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

Electronically Signed — 12/08/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061219	A. BUILDING: _____ B. WING _____	C 11/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE POINT	THREE DAVID BRAINERD DRIVE MONROE TOWNSHIP, NJ 08831

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S 560	Continued From page 1 codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. A review of the "Nurse Staffing Report" completed by the facility for the 2 weeks from 10/29/2023 to 11/11/2023 for the 11/20/2023 Standard survey revealed that the facility was deficient in CNA staffing for residents on 7 of 14 day shifts as follows: -11/03/23 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs. -11/04/23 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -11/05/23 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -11/06/23 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs. -11/08/23 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -11/09/23 had 12 CNAs for 101 residents	S 560	CNA training schools and social media. Agency contracted individuals are utilized to supplement direct care staff. 2. All residents have the potential to be affected. 3. When a staff to resident ratio inequity is identified, the facility will contact all available staff to come to work for an additional shift, offer incentive pay to those who volunteer to work an additional shift, and/or contact contracted staffing agencies to assist with the mandatory staffing levels. The facility will conduct weekly recruitment meetings to recruit staff and review efforts/status (refer to #1 above) Administrator/DON/HR will review wages/benefits to remain competitive, offer sign-on and referral bonuses to current staff and new hires. Daily staffing levels will be reviewed by the Staffing Scheduler/Administrator/DON/Designee to ensure compliance with the regulation for direct care staff to resident ratio. 4. Results of the daily staffing levels will be reported by the DON/Designee monthly for 3 months to QAPI committee. Any staffing level inequities that are identified will be addressed immediately with the appropriate corrective action. Results of the weekly recruitment meetings will be reported by HR/Designee to the QAPI Committee monthly for 3 months, then quarterly x2. Then QAPI committee will determine if it requires to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061219	A. BUILDING: _____ B. WING _____	C 11/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE POINT	THREE DAVID BRAINERD DRIVE MONROE TOWNSHIP, NJ 08831

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S 560	Continued From page 2 on the day shift, required at least 13 CNAs. -11/10/23 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs. During an interview with the surveyor on 11/16/23 at 10:46 AM, the Staffing Coordinator (SC) stated that she was employed full-time at the facility as a SC for [redacted] Ex.Order 26.4(b)(1). The SC stated that she was in charge of scheduling and maintaining staff in the nursing department. "I do my best to make sure we are fully staffed." The SC was able to state the minimum staffing requirements of Certified Nursing Assistant (CNAs) to resident ratio for nursing homes in New Jersey and revealed that the facility meets those requirements. The SC indicated that facility staff was used first to fill any staffing voids but does use nursing agencies as a last resort to maintain the mandatory ratios. The SC added that the facility administration would provide monetary incentives to the facility staff for overtime. The SC stated that when she was not in the building, especially on the weekends, the nursing supervisors or administration would fill any staffing voids and added that the facility does not use any Temporary Nursing Assistants (TNAs) or hospitality aides. The SC revealed that the facility advertised consistently for CNAs and, together with the Director of Nursing (DON), was involved with the hiring and orientation of CNAs. NJAC 8:39-5.1(a)	S 560	be continued, therafter.	

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
315269 Y1	A. Building B. Wing Y2	1/3/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE POINT	THREE DAVID BRAINERD DRIVE MONROE TOWNSHIP, NJ 08831

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 F0610	Correction	ID Prefix F0710	Correction	ID Prefix F0804	Correction
Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.30(a)(1)(2)	Completed	Reg. # 483.60(d)(1)(2)	Completed
LSC	12/29/2023	LSC	12/29/2023	LSC	12/29/2023
ID Prefix F0812	Correction	ID Prefix F0865	Correction	ID Prefix F0868	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i)	Completed	Reg. # 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)	Completed
LSC	12/29/2023	LSC	12/29/2023	LSC	12/29/2023
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/29/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/20/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061219 Y1	A. Building B. Wing Y2	1/3/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE POINT	THREE DAVID BRAINERD DRIVE MONROE TOWNSHIP, NJ 08831

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 12/29/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 11/20/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315269	A. BUILDING **02** B. WING _____	**11/20/2023**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 11/13/23 and 11/14/23, Village Point was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 NEW Health Care Occupancies. Village Point is a two story (2), Type I Fire Resistant building (new construction), that was built in July 2018. The facility is divided into 6 smoke zones. The exterior 1000 KW diesel generator does 100% of the building. The facility is licensed for 120 beds currently occupied at 100.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.	K 222		12/20/23

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

Electronically Signed | 12/08/2023

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K 222	Continued From page 1 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic	K 222		

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K 222	Continued From page 2 fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/14/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. This deficient practice was identified for 1 set of sliding doors and was evidenced by the following. 1). At 11:15 AM, the surveyor, MD and RPOD observed at the main entrance, that the inner and outer set of sliding doors had a lockset that engaged a hook-type deadbolt. The device on the door could restrict emergency use of the exit. The current evacuation plan indicated that the front doors were designated an exit/egress route. The sliding doors had a sign indicating push to open in an emergency, but with the thumb-latch locks engaged this procedure would not open the doors as stated on the signs. At the time of the observation, the surveyor interviewed the DOF and RPOD who both stated that the 2 locksets (hook type deadbolt) could restrict use of the exits from the egress-side in the event of an emergency. 2). The surveyor observed exit/egress doors that	K 222	1. a. The hook-type deadbolt was removed b. A readily visible sign indicating "push until alarm sounds door can be open in 15 seconds" was placed at the following locations: A-Wing fire door by A224, C-Wing fire door by C201, C-Wing fire door by C211, C-Wing fire door by C214, C-Wing fire door by C114, C-Wing fire door by C111 2. All residents have the potential to be affected by the practice 3. Maintenance Team Members will conduct monthly audits of egress doors to ensure compliance 4. The Maintenance Director/designee, will present the reports on the audits of egress doors in QAPI meetings monthly x3, then quarterly x2, Then the QAPI committee will determine if it requires to be continued, thereafter.	

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K 222	Continued From page 3 had 15-second delayed devices installed, but the doors did not have any signs indicating so. The fire doors were located in the following areas of the facility: EX Order 26.4B1 [redacted] An interview was conducted with the MD and RPOD who both stated the delayed-egress locking systems must have a readily visible sign indicating: "push until alarm sounds door can be open in 15-seconds" The Administrator and Regional staff were notified of the findings at the Life Safety Code Exit Conference on 11/14/23. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section - 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. NFPA 101:2012 Edition, Section - 7.2.1.6.1.1(3)C	K 222		
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 NEW Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/13/23	K 293	1. The bulbs in the exit sign in the	12/29/23

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K 293	Continued From page 4 and 11/14/23 in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to provide illuminated exit signs to clearly identify the exit access route.This is deficient practice was evidenced for 1 of 18 exit sign observations, by the following: On 11/13/23 at 1:22 PM, the surveyor, RPOD and MD observed in the A-wing corridor leading to the exit access of the aspen patio, that the exit sign was observed to not be illuminated due to bulbs blown in the fixture. An interview was conducted with the MD and RPOD during the observation, where they confirmed the above finding. The Administrator and Corporate staff were informed of the finding at the Life Safety Code exit conference on 11/14/23.	K 293	A-Wing corridor leading to the exit access of the Aspen patio will be replaced. 2. All residents have the potential to be affected by the deficient practice. 3. Maintenance Team Members will conduct monthly random audits of exit signs to ensure compliance. 4. The Maintenance Director/designee, will present the reports on the audits of exit signs at QAPI meetings monthly x3, then quarterly x2. Then the QAPI committee will determine if it requires to be continued, thereafter.	
K 311 SS=E	NJAC 8:39 -31.1 (c) Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 NEW Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 2 hours connecting four or more stories. (1 hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.6.7. 18.3.1 through 18.3.1.5	K 311		12/22/23

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	315269	A. BUILDING **02** B. WING _____	**11/20/2023**

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K 311	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/14/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure that vertical openings between floors were enclosed with 1-hour fire-rated construction as evidenced by the following: At 1:08 PM, the surveyor, MD, and RPOD observed that the A-1 fire door, had gaps between the door and frame and was not positive latching into its frame. An interview was conducted with the MD and RPOD, who both stated the above finding during the observation. This Administrator and Regional staff were informed of the finding at the Life Safety Code exit conference on 11/14/23. NJAC 8:39-31.2(e)	K 311	1. The A-1 fire door was adjusted to eliminate gaps between the door and the frame and positive latching is achieved. 2. All residents have the potential to be affected. 3. Maintenance Team Members will conduct monthly audits of fire doors to ensure compliance with no gap and positive latching. 4. The Maintenance Director/designee, will present the reports on the audits of fire doors at QAPI meetings monthly x3, then quarterly x2. Then the QAPI committee will determine if it requires to be continued, thereafter.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 New Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a 3/4-hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4. Describe the floor and zone locations of	K 321		2/29/24

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K 321	Continued From page 6 hazardous areas that are deficient in REMARKS. 18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 and less than 100 square feet) g. Combustible Storage Rooms/Spaces (over 100 square feet) h. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/14/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, labeled and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practice was identified in one 2 of 8 hazardous storage areas in the facility and was evidenced by the following: At 11:38 AM, the surveyor, MD and RPOD observed the set of double door's to the facility kitchen were propped open, not self-closing and latching. The set of doors were designed to not	K 321	1. The set of double doors to the facility's kitchen will be replaced in order to be self-closing, labeled, and separated by smoke resisting partitions. A waiver has been requested in the event the contractor can not meet completion date due to supply and demand issues. Doors are on order and expected to arrive on or before 2/25/24. Installation will take 2 days with completion being done by 2/29/24. Documentation from Eastern Door Service is attached to POC. The Director of Maintenance will oversee the installation project daily until completion. 2. All residents have the potential to be affected by the practice. 3. The Director of Maintenance/designee	

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K 321	Continued From page 7 have smoke resistant qualities, as the door's when closed were observed to have a gap between the meeting edge of both doors, along with a gap on both hinge sides of the frame, and no fire rating label was observed. The MD and RPOD both confirmed the above findings during the observations. The Administrator and Regional staff were informed of the findings at the Life Safety Code Exit Conference on 11/14/23. NJAC 8:39-31.2(e)	K 321	conducts monthly fire drills, and tests fire alarms monthly. In addition, until doors are installed, Campus Security will check kitchen area nightly for any potential hazardous conditions that may cause a fire and complete sign off fire safety log. Director of Maintenance/designee will check log daily for completion. Director of Maintenance/designee will conduct monthly audits of fire doors when installed to ensure compliance with doors functioning properly. 4. The Maintenance Director/designee, will present the reports on the audits of fire doors and fire safety sign off log in QAPI meetings monthly x3, then quarterly x2. Then the QAPI committee will determine if it requires to be continued, thereafter.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: *residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2. *cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or *cooking facilities in smoke compartments with	K 324		1/12/24

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K 324	Continued From page 8 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/14/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure that a smoke detector was installed within 20' of the cooking appliances in accordance with NFPA 96. This deficient practice was evidenced for 1 of 1 kitchen areas and observed by the following: At 10:22 AM, the surveyor, MD and RPOD observed in the main kitchen that no smoke detector was installed within 20' of the cooking appliances. An interview was conducted with the MD and RPOD during the observations, and they confirmed no smoke detectors were observed in the facility main kitchen. The Administrator and Regional staff were informed of the findings at the Life Safety Code exit conference on 11/14/23. NJAC 8:39-31.2(e) NFPA 96 NFPA 101 2012 edition, Life Safety Code 19.3.2.5.3* (12)	K 324	1. A smoke detector is scheduled to be installed within 20" of the cooking appliances by ADT on or before 1/12/24. 2. All residents have the potential to be affected by the practice. 3. Maintenance Team Members will conduct monthly audits of smoke detectors in cooking facilities to ensure compliance and functionality. 4. The Maintenance Director/designee, will present the reports on the audits of smoke detectors in cooking facilities in QAPI meetings monthly x3, then quarterly x2. Then the QAPI committee will determine if it requires to be continued, thereafter.	
K 353	Sprinkler System - Maintenance and Testing	K 353		12/21/23

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K 353 SS=E	Continued From page 9 CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 11/14/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to maintain the sprinkler system, ensuring the wall-ceiling assembly was smoke resisting in accordance with NFPA 101, 2012 Edition, Section 19.3.5, 19.3.5.1, 4.6.12 and 9.7.5 and NFPA 25, 2011 Edition, Section 5.1, 5.2.1.1, 8.4.4 and 8.4.4.1. The deficient practice of failing to provide a complete smoke resisting ceiling at the level of the installed sprinklers would not ensure prompt and proper operation of the sprinklers. The deficient practice was evidenced for 1 of 10 areas observed by the	K 353	1. The ceiling in the electrical room across from resident room C112 has a complete smoke resisting ceiling at the level of the installed sprinklers. Fire retardant sealant was applied to specified area. See attach photo demonstrating material used. 2. All residents have the potential to be affected by the practice. 3. Maintenance Team Members will conduct monthly audits of ceilings in electrical rooms to ensure compliance with smoke resisting ceiling.	

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K 353	Continued From page 10 following: At 10:45 AM, the surveyor, MD and RPOD observed in the electrical room across from resident room C-112 that above the electrical panels were conduit pipes leading into the the drop ceiling panels. The conduit pipes were observed to have orange foam filling the oversized drop ceiling tile cuts. The penetrations that were observed with an orange foam product that was not observed to have any known intumescent, endothermic or elastomeric caulking properties. An interview was conducted with the MD and RPOD where they stated that the MSDS and foam can could be provided, but as of the life safety code exit conference no further documentation on the product used was presented to the surveyor. The Administrator and Regional staff were informed of the finding at the Life Safety Code exit conference on 11/14/23.	K 353	4. The Maintenance Director/designee, will present the reports on the audits of ceilings in electrical rooms at QAPI meetings monthly x3, then quarterly x2. Then the QAPI committee will determine if it requires to be continued, thereafter.	
K 362 SS=E	NJAC 8:39-31.1(c), 31.2(e) Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 NEW Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.2 This REQUIREMENT is not met as evidenced	K 362		1/12/24

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K 362	Continued From page 11 by: Based on observation and interview on 11/14/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure that corridor walls were protected against the transfer of smoke, fire and fumes.This deficient practice was evidenced for 1 of 8 corridors observed by the following: During a tour of the B-Wing, in the presence of the facility's MD and RPOD, at 10:01 AM, the surveyor observed in the staff corridor that the kitchen wall was provided with a sliding glass serving hatch approximately 5' x 4' to the staff corridor. The serving hatch was not resistant to the passage of smoke, did not close automatically with the activation of the fire alarm and the glass was not identified to have a fire rating. The MD and RPOD both confirmed the findings and indicated the sliding glass windows did not close with the fire alarm and could not identify if the glass had a fire rating. The Administrator and Regional staff were informed of the finding at the Life Safety Code survey exit conference on 11/14/23. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.3.6.2, 19.3.6.2.7	K 362	1. The serving hatch in the staff corridor will be removed and the wall will be sealed in order to form a barrier to limit the transfer of smoke by contractor "Yes We Do" on or before 1/12/24. 2. All residents have the potential to be affected by the practice. 3. Maintenance Team Members will conduct monthly audits of corridor wall to ensure compliance. 4. The Maintenance Director/designee, will present the reports on the audits of corridor walls at QAPI meetings monthly x3, then quarterly x2. Then the QAPI committee will determine if it requires to be continued thereafter.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Doors protecting corridor openings shall be constructed to resist the passage of smoke.	K 363		11/22/23

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K 363	Continued From page 12 Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/14/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring complete bedroom door closure for confinement of smoke/fire products was identified in 10 of 30 resident room (RR) doors and 1 of 1	K 363	1. Resident room Door A219 was adjusted to eliminate the approximate 1/2" gap between the top of the door and the frame. 2. All residents have the potential to be affected by the practice. 3. Maintenance Team Members will conduct monthly audits of resident room doors to ensure compliance of no gaps existing.	

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K 363	Continued From page 13 rehabilitation therapy doors observed and was evidenced by the following: During the building tour on 10/14/23 from 9:15 AM to 01:45 PM, the surveyor in the presence of the MD, toured the facility and observed the following compromised RR doors. A-219 when closed the top of the door to the frame approximately 1/2" gap. At the time of observations, the surveyor interviewed the MD and RPOD, who both confirmed the above findings. The Administrator and Regional staff were informed of the findings at the Life Safety Code exit conference on 11/14/23. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	4. The Maintenance Director/designee, will present the reports on the audits of resident room doors in QAPI monthly x3, then quarterly x2 then QAPI committee will determine if it requires to be continued, thereafter.	
K 379 SS=E	Smoke Barrier Door Glazing CFR(s): NFPA 101 Smoke Barrier Door Glazing 2012 NEW Windows in smoke barrier doors shall be installed in each cross corridor swinging or horizontal-sliding door protected by fire-rated glazing or by wired glass panels in approved frames. 18.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review on 11/14/23 in the presence of the Maintenance Director (MD) and Regional Plant	K 379	1. a. The glass panels in kitchen set of double doors will be replaced with fire-rated glazing or wired glass panels in	2/29/24

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K 379	Continued From page 14 Operations Director (RPOD) it was determined that the facility failed to ensure openings in smoke barrier doors had fire-rated glazing or wired glass panels in steel frames in accordance with NFPA 101 (2012 Edition) Section 19.3.7.6 (1)(2). This deficient practice was evidenced for 2 of 4 doors observed by the following: 1). At 10:19 AM the surveyor, MD and RPOD observed the kitchen set of double doors, were provided with glass glazing that was unlabeled and observed to not have a fire rating. 2). At 11:35 AM, the surveyor, MD and RPOD observed the activity storage room door was provided with a frosted glass panel approximately 4' x 3'. The fire rating of the glass panel glazing was not labeled and identified. The surveyor interviewed the MD and RPOD during the above findings where they both confirmed and stated the door glass glazing was not labeled and identified for a fire rating resistance. The Administrator and Regional staff were informed of the findings at the Life Safety Code exit conference on 11/14/23. The code requires openings in smoke barrier doors to be fire-rated glazing or wired glass panels in steel frames to help stop smoke from traveling through the opening. NJAC 8:39-31.1(c), 31.2(e)	K 379	steel frames. Contractor cannot confirm installation date due to supply and demand issues. A waiver has been requested in the event the contractor can not meet completion date due to supply and demand issues. Fire doors with fire rated glass is scheduled to be delivered by 2/25/24. Contractor will install on or before 2/29/24. Installation is scheduled to take 2 day. The Director of Maintenance will oversee project daily until completed. b. The glass panel in the activity storage room door will be replaced with fire-rated glazing or a wired glass panel in a steel frame. Contractor cannot confirm installation date due to supply and demand issues. A waiver has been requested in the event the contractor can not meet completion date due to supply and demand issues. Glass is scheduled to arrive 1/22/24-1/25/24. Contractor will install on or before 2/1/24. Installation is scheduled to take 1 day. The Director of Maintenance will oversee project daily until completed. Please see email documentation attached. 2. All residents have the potential to be affected by the practice 3. The Director of Maintenance/designee conducts monthly fire drills, and tests fire alarms monthly. In addition, until doors are installed, Campus Security will check kitchen area nightly for any potential hazardous conditions that may cause a	

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K 379	Continued From page 15	K 379	fire and complete sign off fire safety log. Director of Maintenance/designee will check log daily for completion. Director of Maintenance/designee will conduct monthly audits of smoke barrier doors to ensure compliance. 4. The Maintenance Director/designee, will present the reports on the audits of fire safety log and smoke barrier doors at QAPI meetings monthly x3, then quarterly x2. Then the QAPI committee will determine if it requires to be continued, thereafter.	
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/14/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure GFCI (ground-fault circuit interrupter) protection was provided as per NFPA 70. This deficient practice was evidenced for 1 of 1 observations in	K 511	1. 1. The hydroculator in the physical therapy room is plugged into a GFCI protected outlet. Outlet was installed by PAR electric on 11/21/2023. 2. All residents have the potential to be affected by the practice	11/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315269	A. BUILDING **02** B. WING _____	**11/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE POINT	**THREE DAVID BRAINERD DRIVE** **MONROE TOWNSHIP, NJ 08831**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 511	Continued From page 16 the physical therapy rehabiltation department and was evidenced by the following: At 1:18 PM, the surveyor, MD and RPOD observed in the physical therapy room, that the hydroculator was plugged into a non-GFCI protected duplex wall outlet. The finding was observed by the MD and RPOD, and both confirmed that the hydroculator must be plugged into a GFCI protected outlet. The MD and RPOD both confirmed the finding, during the occupied physical therapy room observation. The Administrator and Corporate Staff were informed of the findings at the Life Safety Code Exit Conference on 1114/23. NJAC 8:39-31.2(e)	K 511	3. Maintenance Team Members will conduct monthly audits of GFCI protection to ensure compliance with hydroculator being plugged into GFCI outlet. Rehab staff was educated to ensure that hydroculator must be plugged into GFCI outlet. 4. The Maintenance Director/designee, will present the reports on the audits of GGCI protection in QAPI meeting monthly x3, then quarterly x2. Then the QAPI committee will determine if it requires to be continued, thereafter.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 18.7.6, 8.3.3.1 (LSC)	K 761		12/1/23

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K 761	Continued From page 17 5.2, 5.2.3 (NFPA 80) This REQUIREMENT is not met as evidenced by: Based on interviews and documentation review on 11/14/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director, it was determined that the facility failed to inspect fire doors annually in accordance with S&C 17-38-LSC. This deficient practice was identified for sixteen (16) of sixteen (16) fire doors observed and was evidenced by the following: At approximately 9:45 AM, the surveyor asked the MD to provide the annual testing requirements for fire door assemblies. The MD stated that currently he did the inspection's and provided an "Annual Fire Door Inspection Log". The surveyor observed the log that was dated and signed: 11/16/22, but the log provided was only for one fire door. The facility did not document completely the required annual testing of the fire door's in accordance with NFPA 80 and NFPA 105 Standard for Smoke Doors Assemblies and other Opening Protectives. No further policies and door inspections were provided. The Administrator and Regional staff was informed of the finding's at the Life Safety Code Exit Conference on 11/14/23. NJAC 8:39-31.1(c), 31.2(e) NFPA 80 and 105: Standard for fire doors assemblies and other opening protectives NFPA 101 2012 edition Life Safety Code 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* to	K 761	1. All 16 fire doors were inspected in accordance with S&C 17-38-LSC 2. All residents have the potential to be affected by the deficient practice. 3. Maintenance Team Members will inspect all fire doors annually in accordance with S&C 17-38-LSC 4. The Maintenance Director/designee, will present the reports on the inspections at QAPI meetings monthly x1, then annually x1. Then the QAPI committee will determine if it requires to be continued, thereafter.	

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	315269	A. BUILDING **02** B. WING _____	**11/20/2023**

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K 761	Continued From page 18 7.2.1.15.8 S&C 17-38-LSC NFPA 101- 2012 edition Life Safety Code 19.7.3 Maintenance of Means of Egress 19.7.3.1	K 761		
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/13/23 in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure electrical panels were locked in patient care areas of the facility as per NFPA 99. This deficient practice was evidenced for 1 of 6 electrical panels observed. At 11:38 AM, the surveyor, MD and RPOD observed that the green electrical wall panel by the C-201 day room was not locked to prevent guarding of live parts in patient care areas of the facility. The above observation was confirmed by the MD and RPOD. The Administrator and Corporate staff were informed of the finding at the Life Safety Code exit conference on 11/14/23.	K 911	1. The green electrical wall panel by the C201 day room was immediately locked. 2. All residents have the potential to be affected by the practice. 3.The Maintenance Team will conduct monthly audits of electrical panels in patient care areas of the facility to ensure compliance with locking panel. The Maintenance team was inserviced to keep all electrical panels locked in patient care areas. 4. The Maintenance Director/designee, will present the reports on the audits of electrical panels in patient care areas at QAPI meetings monthly x3, then quarterly x2. Then the QAPI committee will determine if it requires to be continued, thereafter.	11/21/23

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K 911	Continued From page 19	K 911		
K 915 SS=F	NJAC 8:39-31.2(e) Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Categories *Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. *General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. *Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1-1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 11/14/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the Life Safety Code (LSC) electrical panel could not be identified. This deficient practice was evidenced for 5 of 5 ATS panels observed by the following in accordance with NFPA 99. At approximately 12:15 PM, the surveyor interviewed the MD and RPOD,where they both	K 915	1. The LSC branch panel was labelled by PAR electric on 12/15/23. 2. All residents have the potential to be affected by the practice. 3. Maintenance Team Members will conduct monthly audits of ATS panels to ensure compliance of labelling. 4. The Maintenance Director/designee,	12/15/23

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K 915	Continued From page 20 indicated that they was not sure if the current (NFPA Essential Electrical System Classification Type) identified specifically a LSC panel. At approximately 01:15 PM, while observing the facility's generator transfer switches (5) in the electrical room, the surveyor could not identify the LSC branch panel from the panel identifications. The MD and RPOD both confirmed they could not identify the LSC branch panel at this time. The Administrator and Corporate staff were informed of the finding's at the Life Safety Code exit conference on 11/14/23.. NJAC 8:39-31.2(e) NFPA 99- 6.7.5.1.1 6.7.5.1.2 Life Safety Branch	K 915	will present the reports on the audits of ATS panels at QAPI meetings monthly x3, then quarterly x2. Then the QAPI committee will determine if it requires to be continued, thereafter.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test	K 918		1/10/24

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K 918	Continued From page 21 under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/14/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure a remote manual stop station for the 1000 KW exterior generator providing emergency power to 100 % of Health Care facility, was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice was evidenced for 1 of 1 generators by the following: At 10:14 AM, the surveyor, MD and RPOD, observed the exterior 1000 KW (kilowatt) diesel generator. The observation indicated that there was no remote manual stop station observed outside the area of the generator location.	K 918	1. A remote manual stop for the exterior generator is located outside the areas of the enclosure housing. A sign will be installed next to the manual stop on or before 1/10/24 2. All residents have the potential to be affected by the practice. 3. Maintenance Team Members will inspect the remote manual stop to ensure the stop and signage has not been removed. 4. The Maintenance Director/designee, will present the reports on the inspections of the remote manual stop in QAPI	

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K 918	Continued From page 22 An interview was conducted during the time of the observation with the MD and RPOD, who both stated and confirmed that the exterior generator did not have a remote manual stop station to prevent inadvertent or unintentional operation that was located outside the area of the enclosure housing the prime mover for the current generator in service. The Administrator and Corporate staff were informed of the findings at the Life Safety Code exit conference on 11/14/23. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	meetings monthly x3. Then the QAPI committee will determine if it requires to be continued, thereafter.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure.	K 920		11/22/23

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K 920	Continued From page 23 Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/14/2023, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to prohibit the use of extension cords and power cords, beyond temporary installation, as a substitute for adequate wiring, exceeding 75% of the capacity, in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.5, 19.5.1, 9.1, 9.1.2. NFPA 70, 2011 LSC Edition, Section 400.8 and 590.3 (D). NFPA 99, 2012 LSC Edition, Section 10.2.3.6 and 10.2.4. This deficient practice was evidenced for 2 of 2 orange extension cords and observed by the following: At 9:15 AM, the surveyor observed at the main entrance that an electric water fountain was being powered by 2-orange extension cords. The orange extension cords were plugged into an exterior gray duplex wall outlet then observed to be buried into the ground. The MD was interviewed during the observation where he stated the two (2) orange extension cords should not be used as a substitute for adequate wiring, The Administrator and Regional staff were informed of the finding's at the Life Safety Code	K 920	1. The 2 orange extension cords powering the electric water fountain were immediately removed. 2. All residents have the potential to be affected by the practice 3. Maintenance Team Members will inspect the electric water fountain to ensure it is not being powered by extension cords. The Maintenance team was inserviced not to use extension cords. 4. The Maintenance Director/designee, will present the reports on the inspections of the electric water fountain in QAPI meetings monthly x3. Then the QAPI committee will determine if it requires to be be continued, thereafter.	

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K 920	Continued From page 24 Exit Conference on 11/14/23. NJAC 8:39-31.2(e)	K 920		

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{K 000}	INITIAL COMMENTS Village Point was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 NEW Health Care Occupancies, specifically K321 and K379. The facility is requesting a time-limited waiver to achieve compliance Village Point is a two story (2), Type I Fire Resistant building (new construction), that was built in July 2018. The facility is divided into 6 smoke zones. The exterior 1000 KW diesel generator does 100% of the building. The facility is licensed for 120 beds.	{K 000}		
{K 321} SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 New Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a 3/4-hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet)	{K 321}		

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

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{K 321}	Continued From page 1 c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 and less than 100 square feet) g. Combustible Storage Rooms/Spaces (over 100 square feet) h. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: The facility remains not in compliance by ensuring fire-rated doors to hazardous area were self-closing, labeled and separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19,3,2,1,5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. The facility is requesting a time-limited waiver to achieve compliance.	{K 321}		
{K 379} SS=E	Smoke Barrier Door Glazing CFR(s): NFPA 101 Smoke Barrier Door Glazing 2012 NEW Windows in smoke barrier doors shall be installed in each cross corridor swinging or horizontal-sliding door protected by fire-rated glazing or by wired glass panels in approved frames. 18.3.7.9 This REQUIREMENT is not met as evidenced by: The facility is not in compliance due to failing to ensure openings in smoke barrier doors had fire-rated glazing or wired glass panels in steel	{K 379}		

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{K 379}	Continued From page 2 frames in accordance with NFPA 101 (2012 Edition) Section 19.3.7.6 (1)(2). This deficient practice was evidenced for 2 of 4 doors. The facility is requesting a time-limited waiver to achieve compliance.	{K 379}		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315269	A. Building 02 - VILLAGE POINT, 1ST/2ND FLOOR B. Wing	2/23/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE POINT	THREE DAVID BRAINERD DRIVE MONROE TOWNSHIP, NJ 08831

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0321	Correction Completed 01/12/2024	ID Prefix Reg. # NFPA 101 LSC K0379	Correction Completed 01/12/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
11/20/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO