STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315060	A. BUILDING _____ B. WING _____	06/21/2022

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ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	220 ST MARY'S DRIVE CHERRY HILL, NJ 08003

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F 000	INITIAL COMMENTS Survey Date: 06/21/22 Census: 174 Sample: 39 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.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		7/29/22

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

Electronically Signed | 07/11/2022

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documents, it was determined that the facility failed to ensure the dining experience was provided in a manner to promote dignity and respect. This deficient practice was cited during the last standard survey dated 01/31/20. This deficient practice was identified for 1 of 14 residents (Resident #123) observed for dining and evidenced by the following: On 06/07/22 at 10:47 AM, during the initial tour of the facility, the surveyor observed Resident #123 in their room being cared for by a Certified Nursing Assistant (CNA). The Resident was not responsive to the surveyor's greeting. The CNA, with the assistance of two other nursing staff members, transferred the resident from the bed to a recliner chair using a mechanical lift.	F 550	Plan of Correction F 550, Level E Completion Date: 7/29/2022 Corrective Action • CNA #4 and CNA #5 provided 1:1 in-service on Residents Rights • CNA #4 and CNA #5 provided 1:1 in-service on Meal service in a Dignified Manner ID Other Residents • Any resident who requires staff assistance for meals Systemic Change • In-service to all nurses ad certified nursing assistants on “Resident Rights” • In-service to all nurses and certified	

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F 550	Continued From page 2 Review of the Admission Record reflected that the resident was admitted to the facility with diagnoses which included, but were not limited to, [redacted] Review of Resident #123's Annual Minimal Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], indicated Resident #123 was [redacted] and totally dependent on staff for feeding assistance. On 06/09/22 at 1:02 PM, the surveyor observed CNA #4 bring Resident #123's meal tray to the room and began feeding the resident their meal while standing alongside the resident's recliner chair. At that time, the surveyor asked CNA #4 if standing alongside the resident was appropriate while assisting with feeding the resident, and CNA #4 responded, "I don't like to sit because I get lazy, and I like to stand to see them chew their food." On 06/13/22 at 1:11 PM, the surveyor observed CNA #5 bring Resident #123, who was resting in a recliner chair, into his/her room and began to set up the resident's meal tray in preparation to assist feeding the resident. CNA #5 proceeded to feed Resident #123 while standing alongside the resident. On 06/14/22 at 12:21 PM, the surveyor interviewed CNA #6 regarding the proper procedure when providing feeding assistance to residents, and CNA #6 stated that the proper	F 550	nursing assistants on "Meal Service in a Dignified Manner" • Licensed nurse will monitor meals in all locations Monitoring • "Dignified Meal Service Audit" will be completed by Nursing Administration: 3 audits weekly x's 2 weeks then 3 audits monthly x's 1 then 3 audits quarterly x's 2 • Results will be brought to QA/QAPI on a quarterly basis.	

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F 550	Continued From page 3	F 550		

technique was to sit alongside the resident, facing them; and if need be, the staff would re-arrange the furniture to fit a chair to allow staff to sit, to ensure residents are comfortable during their meal.

On 06/14/22 at 12:38 PM, the surveyor interviewed CNA #5 regarding standing while feeding Resident #123 the previous day, and CNA #5 stated that they didn't want to kill time to get a chair because they have so many other things to do.

On 06/14/22 at 12:44 PM, the surveyor interviewed the Unit Manager/Registered Nurse #2 (UM/RN #2) who informed the surveyor that to preserve resident dignity, staff must follow procedure and always sit alongside the residents while providing feeding assistance. UM/RN #2 also stated that, if necessary, staff should move furniture, or bring residents to the day room/dining room to allow more space to fit a chair along side the resident to sit while providing feeding assistance.

On 06/15/22 at 10:09 AM, the surveyor interviewed the Director of Nursing (DON) who stated that all staff, including agency, full time, and part time were expected to follow proper procedure when providing feeding assistance, which included sitting next to the resident. The DON informed the surveyor that this was to preserve resident dignity. When the surveyor informed the DON of the staff observations, the DON stated, "That is not appropriate at all, they should have found a chair and fed the patient. I understand they are busy, but we still have to do what's right by the patient."

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F 550	Continued From page 4 Review of the facility's policy and procedure titled "Assistance with Feeding," revised on 2/2021, reflected " ...2. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity for example: a. Not standing over residents while assisting them with meals ..." NJAC 8:39-4.1 (a)(12)	F 550		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) obtain a physician order (PO) for a [redacted] and b.) ensure that an [redacted] was functioning properly and adequately [redacted] resident with a history of [redacted]	F 686	Plan of Correction F 686, Level D Completion Date: 7/29/2022 Corrective Action • Physician order obtained for low air loss mattress of Resident #52 • Physician order obtained to check	7/29/22

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F 686	Continued From page 5 This deficient practice was identified for 1 of 6 residents (Residents #52) reviewed for [redacted] and was evidenced by the following: 1.) During the initial tour of the [redacted]'s Unit on 06/07/22 at 10:47 AM, the surveyor observed Resident #52 lying in bed with eyes closed. The surveyor observed the resident on an air mattress; however, the pump that inflated the air mattress was not on and functioning. Review of Resident #52's Admission Record revealed that the resident was admitted to the facility with diagnoses which included, but were not limited to, Ex.Order 26.4(b)(1) [redacted] Review of Resident #52's Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 04/01/22, reflected that Resident #52 was Ex.Order 26.4(b)(1) [redacted] required Ex.Order 26.4(b)(1) to total dependence with Activities of Daily Living. The MDS further revealed that the resident was Ex.Order 26.4(b)(1) [redacted] Review of Resident #52's Braden Scale, an evidenced-based tool that predicts the risk for	F 686	functioning of low air loss mattress every shift for Resident #52 • Air mattress was replaced for resident #52 ID Other Residents • Any resident who utilizes a low air loss mattress Systemic Change • Physician orders will be obtained for any resident utilizing a low air loss mattress • Physician orders will be obtained to check function of low air loss mattress every shift • In-service to nursing staff on “Usage of Low Air Loss Mattress” • In-service to nursing staff/maintenance staff on “Maintenance of Low Air Loss Mattress” Monitoring • Low Air Loss Mattress Audit will be completed by Nursing Administration: 3 audits weekly x’s 2 weeks then 3 audits monthly x’s 1 then 3 audits quarterly x’s 2 • Chart Audit for Physician Orders pertaining to Low Air Loss Mattress will be completed by Nursing Administration: 3 audits weekly x’s 2 weeks then 3 audits monthly x’s 1 then 3 audits quarterly x’s 2 • Results will be brought to QA/QAPI on a quarterly basis. The Plan of Correction is the facility□s credible allegation of compliance. Preparation and/or execution of this plan	

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F 686	Continued From page 6 developing a hospital- or facility-acquired pressure ulcer or injury, dated 03/28/22, revealed Resident #52 had Ex.Order 26.4(b)(1) for the development of pressure ulcers. Review of Resident #52's Interdisciplinary Care Plan revealed that the facility's Interdisciplinary Team identified a "Focus" that the resident was "at risk for Ex.Order 26.4(b)(1)" due to Ex.Order 26.4(b)(1) and limited mobility. Interventions included, but were not limited to, an air mattress initiated on 04/01/22. Review of an Interdisciplinary Team progress note dated 04/20/22 revealed that Resident #52 was being treated for a Ex.Order 26.4(b)(1), a treatment was in place to the resident's Ex.Order 26.4(b)(1) and an air mattress was in place on the bed. Review of the Order Summary Report for Active Orders as of 06/14/22 did not reflect a physician's order for an air mattress. Review of the 06/01/22 - 06/30/22 Treatment Administration Record did not reflect a physician's order for an air mattress or accountability for the functioning and placement of the air mattress. On 06/15/22 at 10:10 AM, the surveyor interviewed the DON who confirmed that the nurses should have obtained a physician's order for an air mattress and to check function/placement of the air mattress every shift. 2.) On 06/08/22 at 10:17 AM, the surveyor observed Resident #52 with eyes opened lying in bed. The surveyor further observed an air	F 686	of correction does not constitute an admission or agreement by the providers of the truth of the facts alleged or conclusions set forth in the statement of deficiencies . The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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F 686	Continued From page 7	F 686		

mattress on the resident's bed with an alarm that was sounding. The Hospice Health Aid (HHA) entered the room and silenced the audible alarm on the air pump. The surveyor interviewed the HHA, at that time, who stated that she would notify the nurse concerning the air mattress pump alarm that was sounding.

On 06/09/22 at 10:30 AM and at 12:08 PM, the surveyor observed Resident #52 lying in bed with eyes closed. The surveyor observed that the air mattress pump alarm was sounding. The surveyor further observed a red-light indicator on the air mattress pump which reflected "low pressure."

On 06/09/22 at 1:21 PM, the surveyor observed Certified Nursing Assistant #1 (CNA) entering Resident #52's room. The surveyor observed that Resident #52's bed was positioned at a 45-degree angle with an audible alarm for the air mattress pump sounding. |The surveyor interviewed CNA #1 who stated that the air pump alarm was sounding and attempted to adjust the alarm by turning the air pump for the air mattress on and off.

On 06/09/22 at 1:27 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that nobody mentioned to her that the air pump alarm for the air mattress was "beeping" but that she would put in a maintenance work order in to have the air mattress pump inspected.

On 06/09/22 at 1:39 PM, the surveyor interviewed the Registered Nurse/Regional Clinical Nurse who stated that she would replace the malfunctioning air mattress.

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F 686	Continued From page 8 On 06/09/22 at 1:44 PM, the surveyor observed the air mattress pump was powered on, however there was a red-light illuminating on the air pump which indicated "low pressure". On 06/14/22 at 12:16 PM, the surveyor interviewed CNA #2 who stated that maintenance sets up the air mattress and that any issues with the air mattress were reported to maintenance. On 06/15/22 at 10:10 AM, the surveyor interviewed the Director of Nursing (DON) who stated that it was the nurse's responsibility to check the placement and function of the air mattress every shift; and that if there was no alarm sounding, that the air mattress was working fine. However if an alarm was sounding, the nurses should reset the alarm to see if that corrected the issue. She added that the alarm sounding could indicate that there was an imbalance of the air pressure. The DON further stated that if the alarm continued to sound, then the nurse should have contacted the maintenance department. The DON confirmed that the functioning of an air mattress was important in preventing pressure ulcers. The DON further stated that it was important to assure that a resident's air mattress was functioning properly, because if it was not functioning correctly, that it could put the resident at risk for developing pressure ulcers. Review of the facility's "Support Surfaces Guidelines" policy, with the revision date of 07/21, reflected that support surfaces would be used as a guideline for the assessment of appropriate pressure reducing and relieving	F 686		

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F 686	Continued From page 9 devices for residents at risk for skin breakdown. "General Guidelines" included that redistributing support surfaces were to promote comfort for all bed or chair bound residents, prevent skin breakdown, promote skin circulation, and provide pressure relief or reduction. NJAC 8:39- 11.2 9 (a), 27.1(e)	F 686		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate	F 755		7/29/22

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F 755	Continued From page 10 reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documents, it was determined that the facility failed to a.) ensure that 1 of 2 nurses on 1 of 4 units (Greentree Unit) properly disposed of one medication during medication pass, and b.) ensure accurate completion of a Drug Enforcement Agency (DEA) Form-222 (a federal narcotic requisition form), to enable accurate reconciliation of controlled-dangerous substances (medications, that due to their high potential for abuse, are tracked with detail) for 1 of 1 DEA Form-222 reviewed . The deficient practice was evidenced by the following: 1. On 06/08/22 at 8:50 AM, the surveyor observed the Registered Nurse (RN) prepare a resident's medication. She placed a bingo card (a method of packaging medications in an enclosed blister pack with a cardboard backing) that contained one Farixga (a medication used to treat Type 2 Diabetes) 10 milligram (mg) tablet directly over a plastic medication cup. When she pressed on the bingo card to dispense the medication, the pill fell from the bingo card and landed on top of a sheet of paper on top of the medication cart instead of inside of the medication cup. The RN stated, "That was the last one I had." She placed the tablet in a	F 755	Plan of Correction F 755, Level D Completion Date: 7/29/2022 Corrective Action " Physician order obtained to reschedule medication for later time " Pharmacy contacted and will dispense medication to facility immediately " Chemical solvent for medication disposal placed on Greentree Unit medication cart #2 " DEA 222 Form reconciled by DON/ADON ID Other Residents " Any resident receiving medications by licensed nurse " Medications ordered and received utilizing DEA 222 Form Systemic Change " In-service on Medication Disposal to licensed nurses " Review of instructions for use of DEA 222 Form " Disposal Solvent to be located in Nursing Office	

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F 755	Continued From page 11 separate medication cup and locked it in the medication cart while she attempted to replace the dosage. At 9:12 AM, the surveyor accompanied the RN to the first-floor medication room where she confirmed with the Registered Nurse/Unit Manager #2 that there were no additional quantities of Farixga available for immediate dosage replacement. At 9:15 AM, the surveyor observed the RN as she removed the Farixga tablet from the locked medication cart and discarded it directly into the sharp's container (a needle and sharp instrument disposal unit) that was attached to the side of the medication cart. When interviewed, the RN stated that was how she normally discarded medications. At 9:35 AM, in a later interview with the RN, she stated that there was supposed to be a chemical solvent or medication disposal system that was used for the destruction of medications available on her medication cart. She stated that she disposed of the Farixga in the sharps container since there was no chemical solvent available on the medication cart at that time. She stated that there was a storage closet down the hall where additional quantities of chemical solvent were stored, and she did not have a key to access it. She further stated that there were also additional quantities of chemical solvent available in the first-floor medication room. On 06/10/22 at 11:02 AM, the surveyor interviewed the Director of Nursing (DON) who stated that there were drug disposal systems	F 755	Monitoring " Audit will be completed by Nursing Administration on Medication Disposal: 3 weekly x□s 2 then 3 monthly x□s 2, then quarterly x□s 2 " Audit will be conducted by Nursing Administration on use of DEA 222 Form x□s 1 " Results will be brought to QA/QAPI on a quarterly basis. Plan of Correction The Plan of Correction is the facility□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the providers of the truth of the facts alleged or conclusions set forth in the statement of deficiencies . The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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available on each medication cart to waste medications. She stated that the RN should have thrown the medication to be wasted into the drug disposal system. She stated in past practice, we utilized the sharp's container. She further stated that, "sharps containers were for sharps only."

On 06/14/22 at 11:39 AM, the surveyor interviewed Licensed Practical Nurse #4 (LPN) who stated that she worked at the facility for six years and the drug disposal system had been available since she started working at the facility. She stated that if she dropped a medication, she discarded it in a drug disposal system. She then opened the bottom drawer of her medication cart and demonstrated the availability of the medication disposal system. LPN #4 stated that if it were not available on her cart, she would phone the supervisor to obtain another. She further stated that the drug disposal systems were plentiful and were available in the first-floor medication room and in the storage closet to which not everyone had access to.

The surveyor reviewed the undated facility policy, "Discarding and Destroying Medications" which revealed the following:

Medications will be disposed of in accordance with federal, state and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances.

For unused, non-hazardous controlled substances that are not disposed of by an authorized collector, the EPA (Environmental Protection Agency) recommends destruction and

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disposal of the substance with other solid waste following the steps below:

...Mix medication either liquid or solid, with an undesirable substance. Undesirable substances include sand, coffee grounds, kitty litter, drug buster or other absorbent materials. Place the waste mixture in a sealable bag, empty can, or other container to prevent leakage. If an undesirable substance is not accessible, medication may be discarded in a locked sharps container.

2. On 06/14/22 at 12:00 PM a review of the facility's DEA Form-222 revealed the facility did not complete the "number of packages received" and the "date the medication was received" in Part 5, as instructed on the face of DEA Form-222, within each section and in the directions on the back of the form itself. The inaccuracies were as follows:

Order Form Number: 220317355, dated 03/03/22 did not indicate the number received or the date received for Items 1, 2, 3, 4, 5, 6, 7, or 8.

During an interview with the surveyor and team on 06/14/22 at 1:07 PM, the Director of Nursing (DON) and Administrator confirmed that they obtained a copy of the finalized DEA-222 Form from the provider pharmacy staff. They acknowledged that the provided copy of the DEA Form-222 was incomplete, specifically as related to the number of items received upon delivery and the date on which the referenced items were received. In addition, the DON and Administrator confirmed that the directions on the front and

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F 755	Continued From page 14 back of the form should be part of the reconciliation process and that a copy of the completed form, as described, should have been retained in the facility's records. During an interview with the survey team and administrative staff on 06/15/22 at 1:22 PM, the DON and Administrator reiterated they understood the surveyor's concerns regarding the incomplete DEA-222 Form and the absence of retaining a copy of the form for their records. Review of instructions titled, "INSTRUCTIONS FOR DEA FORM 222" obtained from facility records, revealed directions in Part 5, that indicated the actions that must be completed upon controlled substance receipt. These include the purchaser filling out this section on its copy of the form, including the number of items received and date received upon delivery of such items. Review of the facility's policy titled, "6.0 Inventory Control of Drugs" revealed an effective and revised date of 10/01/2018. According to the policy, it is necessary for controlled drugs to be inventoried and documented under proper conditions with regards to security and state/federal regulations.	F 755		
F 761 SS=D	NJAC 8:39-29.6(a) and 8:39-29.7 Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 761		7/29/22

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F 761	Continued From page 15 instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documents, it was determined that the facility failed to a.) store medications within acceptable temperature ranges for 1 of 2 medication storage areas (Rosegarden Unit) reviewed as part of the medication storage and labeling task and b.) properly secure medication within the nursing cart for 1 of 2 nurses observed on 1 of 2 units (Rosegarden Unit) during medication administration. This deficient practice was evidenced by the following: 1). On 06/10/22 at 11:47 AM, the surveyor	F 761	Plan of Correction F 761, Level D Completion Date: 7/29/2022 Corrective Action " Refrigerator on Rosegarden Unit replaced " Digital thermometer placed in Rosegarden Unit refrigerator " Medication from Rosegarden refrigerator disposed, re-ordered medication " Medication cart locked " 1:1 in-service provided to licensed nurse	

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F 761	Continued From page 16 entered the Rosegarden Unit (RU) medication room and observed the refrigerator temperature at ranges between 31.8 and 35.4 degrees Fahrenheit (F), in the presence of the Licensed Practical Nurse #1 (LPN) over the course of approximately 10 minutes. In addition, there was a fluorescent orange sign on the door of the refrigerator, indicating to maintain the temperature between 36-46 F and a temperature refrigerator log on top of the refrigerator. During an interview with the surveyor on this date and time, the surveyor questioned LPN #1 regarding the observed temperature on the thermometer. LPN #1 referred the surveyor to the Licensed Practical Nurse/Unit Manager #1 (LPN/UM). During an interview with the surveyor on 06/10/22 at 12:00 PM, LPN/UM #1 stated that the thermometer in the refrigerator was replaced earlier on the same day, approximately 40 minutes prior to the surveyor's observation. LPN/UM #1 further stated that the surveyor's observation of the out of range temperature may have been the result of the new thermometer being incorrect, rather than an actual problem with the refrigerator itself. LPN/UM #1 further stated that she would continue to monitor the situation as a result of the surveyor's observation and follow-up with any additional action that may be needed. During the same interview, the surveyor asked LPN/UM #1 who was responsible for checking the refrigerator temperatures. LPN/UM #1 stated temperature checks for the refrigerator were checked and recorded by staff on the 11:00	F 761	ID Other Residents " Residents who utilize medications that need to store at refrigerated temperature " Residents who could open medication carts if not locked Systemic Change " In-service on Medication Refrigeration Temperatures by Nursing Administration to licensed nurses " In-service on Medication Administration Safety by Nursing Administration to licensed nurses " Back Up refrigerator available if alteration in refrigerator temperature " Signage of temperature parameters on medication refrigerator Monitoring " Refrigerator Temperature Audit will be completed by Nursing Administration: 2 audits weekly x□s 2 weeks then 2 audits monthly x□s 1 then 2 audits quarterly x□s 2 " Medication Administration Audit will be completed by Nursing Administration: 2 audits weekly x□s 2 weeks then 2 audits monthly x□s 1 then 2 audits quarterly x□s 2 " Results will be brought to QA/QAPI on a quarterly basis. Plan of Correction The Plan of Correction is the facility□s credible allegation of compliance. Preparation and/or execution of this plan	

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F 761	Continued From page 17 PM-7:00 AM (overnight) shift. If, however, there was a problem with the refrigerator in the interim, any nurse or staff member could report the problem to a nursing unit manager to initiate corrective actions. On 06/10/22 at 1:33 PM, the surveyor observed a temperature of 34.3 F on the thermometer in the RU medication room refrigerator, in the presence of the LPN #1. During an interview with the surveyor at this time, LPN #1 stated that that LPN/UM #1 was looking into the matter but was not aware of further details regarding the current process. On 06/13/22 at 11:28 AM, the surveyor observed a temperature reading of 44.1 F on the thermometer, in the medication room of the RU, in the presence of LPN/UM #1. The surveyor referred LPN/UM #1 to the surveyor log, on top of the refrigerator, which revealed temperature readings with days, dates, and temperatures as follows: Friday (06/10/22) at 30 F, Saturday (06/11/22) at 30 F, Sunday (06/12/22) at 31 F, and Monday (06/13/22) at 30 F. During an interview with the surveyor at this time, LPN/UM #1 stated that the referenced temperatures, over the weekend, were recorded by two per-diem (staff that work on an as needed basis) LPN staff members and the temperatures were incorrect. When asked about this further, LPN/UM #1, confirmed that she was not present and did not work in the building during the weekend. When asked how she would know that	F 761	of correction does not constitute an admission or agreement by the providers of the truth of the facts alleged or conclusions set forth in the statement of deficiencies . The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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the recorded temperatures were incorrect, LPN/UM #1 clarified that she was assuming that the recorded temperatures were incorrect.

As a result, LPN/UM #1 stated that she will check the items in the refrigerator. She stated that she would remove the medications, dispose of them in accordance with policies, and replace them with new medications, if necessary. When the surveyor asked LPN/UM #1 if the process described should have already occurred, LPN/UM #1 acknowledged that the process described should have already been completed, due to the deviations in temperature.

During the referenced time and date, the surveyor, in the presence of LPN/UM #1, observed that the following items were present in the referenced refrigerator:

-two, 2.5 milliliter (mL) bottles of Latanoprost 0.005% Eye Drops for Glaucoma
-two, 1 mL bottles of Tuberculin 5TU/0.1 mL for Tuberculosis skin testing
-one, 3 mL pen of Ozempic 4 mg/3 mL for Diabetes Mellitus (DM)
-one, 3 mL pen of Basaglar 100-units/mL for DM
-one, 3 mL pen of Lantus 100-units/mL for DM
-one, 10 mL bottle of Lantus 100-units/mL for DM
-one, 3 mL bottle of Humalog 100-units/mL for DM
-seven capsules of Dronabinol 2.5 mg for appetite stimulation
-12 syringes of Lorazepam 0.5 mg/0.5 mL gel for agitation/anxiety

During the same interview, LPN/UM #1 stated that medication replacement, as described, did

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not occur because the refrigerator temperatures were checked again on Friday, 06/10/22 in the afternoon, and were within acceptable range. Finally, LPN/UM #1 stated she understood the surveyor's concerns regarding these matters.

During an interview with the survey team and administrative staff on 06/15/22 at 1:17 PM, the Regional Clinical Manager stated that further action and replacement of the medications should have occurred at the time that the refrigerator temperature deviations were observed. The facility's administrative staff indicated they understood the surveyor's and team's concerns regarding the referenced matter.

Review of a policy titled, "Policies and Procedures" for the subject of "Storage of Medications" revealed an effective date of 03/17 and a revision date of 10/21. The policy indicated a need for the facility to store all drugs and biologicals in a safe, secure, and orderly manner. In addition, the policy indicated that nursing staff shall be responsible for maintaining medication storage in a clean, safe, and sanitary manner but did not specify any guidance regarding appropriate temperature ranges.

2. On 06/09/2022 at 8:40 AM, the surveyor observed LPN #3 prepare medications for Resident #143. Afterwards, the LPN entered the resident's room to administer the medications without locking the medication cart. While in the resident's room, the nurse turned her back to the medication cart and washed her hands in the resident's sink.

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On 06/09/2022 at 8:50 AM, the surveyor observed LPN #3 prepare medications for Resident #121. Afterwards, the LPN entered the resident's room to administer the medications without locking the medication cart. While in the resident's room, the LPN turned her back to the medication and the resident's privacy curtain was between the nurse and the medication cart.

During an interview with the surveyor on 06/09/2022 at 9:05 AM, the LPN stated the medication cart should be locked when not within eyesight of the nurse to prevent residents from going into the medication cart.

During an interview with the surveyor on 06/09/2022 at 9:10 AM, LPN/UM #1 stated the medication cart should be locked before going into a resident's room to prevent anyone from accessing the medication cart.

During an interview with the surveyor on 06/10/2022 at 11:40 AM, the Director of Nursing stated the nurse should lock the medication cart any time the nurse turns his/her back to the medication cart to prevent anyone from taking anything from the medication cart.

Review of the facility's Administering Medications policy, revised 03/2019, included, "During administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse."

Review of the facility's Storage of Medications policy, revised 10/2021, included, "Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts and

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F 761	Continued From page 21 boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others." NJAC 8:39-29.4(h)	F 761		
F 804 SS=D	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 review of other facility documents, it was determined that the facility failed to ensure the safe and appetizing temperatures of hot and cold food and drink was served to the residents. This deficient practice was identified for 6 of 6 residents interviewed during the Resident Council Meeting and confirmed during the lunchtime meal service on 06/10/22 for 1 of 4 nursing units (St. Mary's Unit) tested for food temperatures and was evidenced by the following: On 06/09/22 at 10:35 AM, the surveyors met with the residents for the Resident Council Meeting. Six out of six residents stated that they were displeased with the food temperatures and that	F 804	Plan of Correction F 804, Level D Completion Date: 7/29/2022 Corrective Action " Below or above adequate temperature foods discarded " Trays reassembled for residents whose trays were discarded due to inadequate food temperatures ID Other Residents " Residents who receive food from the Dietary Department	7/29/22

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F 804	Continued From page 22 hot food items were not consistently served hot enough. On 06/10/22 at 12:41 PM, the surveyor observed an open food truck arrive on the first floor. The surveyor pulled two trays from the food truck. The surveyor observed that the trays were not on warming plates, and the uninsulated dome food lids did not fit securely over the plates. The surveyor further observed Certified Nursing Assistants (CNAs #1 and #7) started to deliver meal trays to residents at 12:44 PM. On 06/10/22 at 12:52 PM, the Food Service Director (FSD) arrived to the St. Mary's Unit with his calibrated thermometer. After the last meal tray was delivered to a resident at 1:21 PM, the FSD took the temperatures of the following items in the presence of the surveyor: Puree consistency: 2-ounce (oz) cup of Alfredo sauce - 99.8 degrees Fahrenheit (F) 4 oz cup of fortified mashed potatoes - 99.1 degrees F 4 oz green beans - 102.8 degrees F 4 oz pineapple tidbits - 68.2 degrees F 4 oz super pudding - 66 degrees F 6 oz nectar thick coffee - 119.5 degrees F Regular consistency: 6 oz soup of the day - 124.2 degrees F 4 oz shrimp Alfredo - 94.6 degrees F 4 oz pasta linguini - 95.4 degrees F 4 oz green beans - 90.1 degrees F 4 oz pineapple tidbits - 61.2 degrees F	F 804	Systemic Change " In-service on Proper Food Temperatures for dietary staff " In-service on Use of Heat Keep Surfaces for dietary staff " Food Committee formed and will meet monthly after Resident Council starting 7/22 " 3 service areas opened for meal distribution " Purchase of the following: insulated cart enclosures, insulted plate heat keeper and insulated dome covers " Activity staff to assist with meal distribution Monitoring " Meal Temperature Audit will be completed by Dietary Management: 2 audits weekly x□s 2 weeks then 2 audits monthly x□s 1 then 2 audits quarterly x□s 2 " Tray Assembly Audit will be completed by Dietary Management: 2 audits weekly x□s 2 weeks then 2 audits monthly x□s 1 then 2 audits quarterly x□s 2 " Timely Tray Distribution Audit will be completed by Dietary Management: 2 audits weekly x□s 2 weeks then 2 audits monthly x□s 1 then 2 audits quarterly x□s 2 " Results will be brought to QA/QAPI on a quarterly basis. Plan of Correction The Plan of Correction is the facility□s credible allegation of compliance.	

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F 804	Continued From page 23 4 oz whole milk - 63.0 degrees F 6 oz coffee decaf - 114.1 degrees F On 06/10/22 at 1:28 PM, the surveyor interviewed the FSD. The FSD stated that hot foods should be above 140 degrees F and cold foods should be below 41 degrees F in order to prevent food-borne bacteria. The FSD agreed that the temperatures of the food were not maintained at appetizing temperatures for the residents. The FSD acknowledged that the facility should be using properly fitted insulated dome covers but stated that many had broken seals and the facility needed to order new ones. The FSD stated that "Timeliness in passing trays has been an ongoing issue. It usually takes about 15 minutes, never 40 minutes." The FSD further stated that the dietary staff kept a food temp (temperature) log when foods were taken out of the oven and refrigerator and again before the food truck left the unit. The FSD ensured that those temperatures were accurate on the tray-line to avoid "food temp danger zones." On 06/10/22 at 1:47 PM, the surveyor interviewed Registered Nurse/Unit Manager #1, who stated that all available staff was expected to help with the meal service and acknowledged that it should not have taken 40 minutes to pass the lunch trays. On 06/10/22 at 1:53 PM, the surveyor interviewed CNA #7 who stated that, "Today's meal service was a disgrace. I was embarrassed by how long it took to pass out trays and feed residents."	F 804	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the providers of the truth of the facts alleged or conclusions set forth in the statement of deficiencies . The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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F 804	Continued From page 24 On 06/15/22 at 1:00 PM, the survey team discussed the above observations and concerns with the Administrator, Director of Nursing, Regional Clinical Nurse, and Regional Administrator. No further information was supplied. Review of the facility's policy "Food and Nutrition Services Policies and Procedures" dated 11/30/17, reflected that cold foods should be maintained at a temperature of 41 degrees F or below and hot foods should be maintained at a temperature of 135 degrees F or higher. Review of the Food and Drug Administration guidelines for maintaining foods at safe temperatures reflected at or below 41 degrees F (for cold foods) or at or above 135 degrees F (for hot foods). NJAC 8:39-17.4(e)	F 804		
F 807 SS=D	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure a resident's preference for milk was honored while on fluid restrictions.	F 807	Plan of Correction F 807, Level D Completion Date: 7/29/2022	7/29/22

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F 807	Continued From page 25 This deficient practice was identified for 1 of 2 residents (Resident #86) reviewed for choices and was evidenced by the following: On 06/07/22 at 11:08 AM, the surveyor observed, from the hallway, Resident #86's name outside the resident's room with a picture of a "pitcher" near the resident's name, and the surveyor further observed Resident #86 in his/her room sitting in a gerichair speaking with another resident. Review of the Admission Record (an admission summary) reflected that the resident had been admitted with diagnoses which included, but were not limited to, Ex.Order 26.4(b)(1) [redacted] Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 04/28/22, reflected that the resident was Ex.Order 26.4(b)(1), and was able to Ex.Order 26.4(b)(1) [redacted] by staff. Review of the Initial Nutrition Risk Assessment, dated 01/20/22, revealed the Registered Dietician (RD) was able to interview the resident. The evaluation included "food preference: wants free milk, coffee with honey." The RD's recommendations included to continue Resident #86's diet and fluid restrictions as ordered. Review of Resident #86's Interdisciplinary Care Plan revealed a "Focus" for nutrition and Ex.Order 2 [redacted] The surveyor observed the Care Plan	F 807	Corrective Action " Resident interviewed by Dietitian for fluid preferences " Fluid preferences placed on physician order ID Other Residents " Any resident on fluid restrictions Systemic Change " Those residents who are on fluid restrictions will have fluid preferences placed on physicians order " In-service on Fluid Restrictions will be completed by Nursing Administration to nursing staff Monitoring " Audit will be completed by Nursing Administration on Fluid Preferences: 3 weekly x□s 2 then 3 monthly x□s 2, then quarterly x□s 2 Plan of Correction The Plan of Correction is the facility□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the providers of the truth of the facts alleged or conclusions set forth in the statement of deficiencies . The plan of correction is prepared and/or executed solely because	

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F 807	Continued From page 26 did not address the resident's fluid preferences. Review of the Nutrition Note dated 01/27/22 revealed that Resident #86 spoke with the dietitian and requested low far milk with his/her meals. The Nutrition Note further reflected that resident was educated to ask the nurse for low fat milk because the nurse was recording the resident's fluid intake, and Resident #86 verbalized an understanding. The Nutrition Note further reflected that the RD documented that the nurse was made aware of the resident's preference. Review of the Order Summary Report for Active Orders as of 06/13/22, did not include the resident's fluid preferences in the Ex.Order 26.4(b)(1) order. Review of the June 2022 Medication Administration Record (MAR) did not include the resident's fluid preferences in the Ex.Order 26.4(b)(1) order. On 06/13/22 at 10:39 AM, during an interview with the surveyor, Certified Nursing Assistant #3 (CNA) stated that she was aware that the resident was on Ex.Order 26.4(b)(1) because there was a sign of a "pitcher" on the resident's door by the resident's name, and that she would ask the nurse what to fluids give to the resident. On 06/13/22 at 10:41 AM, during an interview with the surveyor, Licensed Practical Nurse #2 (LPN) stated that she reviewed the MAR to determine the amount of fluid to offer a resident on fluid restrictions. LPN#2 added that she would offer the resident four ounces of water during the	F 807	it is required by the provisions of federal and state law.	

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F 807	Continued From page 27 medication pass. On 06/13/22 at 10:45 AM, during an interview with surveyor, the Registered Nurse/Unit Manager #3 (RN/UM) confirmed there were no fluids on the meal tray of Resident #86 and that the fluid was passed by the nurse or CNA as instructed by the nurse. The RN/UM #3 also stated that the nurse would review the Ex.Order 2 [redacted] in the physician order and on the MAR. She further stated that a picture of a "pitcher" on the door meant a resident was on Ex.Order 26.4(b)(1). On 06/13/22 at 11:55 AM, during an interview with surveyor, Resident #86 stated that he/she does not receive fluid with meals but wants milk in the morning and at night. Resident #86 confirmed that breakfast did not include milk for that meal although he/she wrote it on the breakfast meal ticket. On 06/13/22 at 12:45 PM, the surveyor observed Resident #86's lunch meal tray in the dining room which contained the meal without any fluid. On 06/14/22 at 11:27 AM, during a follow-up interview with surveyor, Resident #86 stated that every meal does not include drinks on the meal tray and that he/she only received water throughout the day. Resident #86 also stated that meals were brought by staff and that he/she had to ask staff for a drink. On 06/14/22 at 11:43 AM, the surveyor observed Resident #86's overbed table with a note affixed on the corner. The note contained Resident #86's name with the handwritten message, "Milk,	F 807		

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F 807	Continued From page 28	F 807		

please." At this time, the RN/UM #3 came into the room. The resident told the RN/UM #3 that he/she would like to have milk with his/her breakfast and the RN/UM #3 replied that the resident would have to ask the nurse for the milk.

On 06/14/22 at 12:10 PM, during an interview with surveyor, LPN #2 stated that Resident #86 did not ask for any fluids today and admitted that she was unfamiliar with the policy for food preferences.

On 06/14/22 at 01:47 PM, during an interview with surveyor, the Regional Dietician stated that fluid preferences were obtained through resident interview and the dietary aids and nursing staff were informed of the resident's preferences. She further stated that the care plan would be updated with the resident's preferences and a physician order would be obtained for the resident's preferences. The Regional Dietician confirmed that a resident with a food preference should not have to ask for what they want every day, provided that it is something dietary has available.

On 06/15/22 at 10:20 AM, during an interview with surveyor, the Director of Nursing (DON) stated that when a resident was on Ex.Order 2 physician order reflected the amount of Ex.Order 26. the resident should receive on each shift and a picture of a "pitcher" would be placed outside of the resident's room. The DON further stated that dispensing of fluid to a resident on Ex.Order 26.4(b)(1) was the responsibility of the nurses. The DON acknowledged that residents informed the dietitian of their food preferences and the preferences should have been

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F 807	Continued From page 29 incorporated in the physician orders and included on the meal ticket. The DON confirmed that the staff should have asked the resident for their preferred fluid with their meal, as food preferences are a resident's right and should be honored. Review of the facility's 10/19 "Fluid Restriction" policy included that "Fluids are defined as beverages offered to residents" and that "Nursing will be responsible for providing the entire amount of fluids as ordered by the physician." Review of the facility's undated "Food Preference Policy" reflected that it is the policy of the facility to allow residents to make choices that reflect individualized, day-to-day meal preferences. NJAC 8:39-17.4 (c), (e)	F 807		
F 812 SS=E	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.	F 812		7/29/22

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F 812	Continued From page 30 §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 review of other facility documents, it was determined that the facility failed to a.) properly store potentially hazardous foods in a manner that is intended to prevent the spread of food borne illnesses, b.) maintain equipment in a manner to prevent microbial growth and cross contamination and c.) maintain adequate infection control practices during food service in the kitchen. This deficient practice was observed and evidenced by the following: On 06/07/22 from 09:48 AM-11:03 AM, the surveyor toured the kitchen in the presence of the Director of Dietary (DD) and observed the following: 1. The surveyor observed the DD with facial hair was not wearing a beard restraint. The DD acknowledged that he wore a surgical mask and was not wearing a beard restraint. He stated it was important to wear hairnets to prevent contamination of the food. 2. In the walk-in refrigerator, there were two opened packages of American cheese wrapped with clear plastic wrap that had no open or use by dates. The DD acknowledged that the packages should have been dated to determine if they were expired or spoiled. The DD removed them from the refrigerator.	F 812	Plan of Correction F 804, Level D Completion Date: 7/29/2022 Corrective Action " Facial hair policy updated " Facial hair restraint given to employees with facial hair " Opened packages discarded " Unlabeled items discarded " Cutting boards discarded and replaced " Paper products discarded " Oven cleaned " Spices discarded ID Other Residents " Residents who receive prepared food from the Dietary Department Systemic Change " In-service on Facial Hair Restraint for dietary staff " In-service on Food Storage/Labeling/Dating for dietary staff " In-service on Equipment Cleaning for dietary staff " Oven cleaning log updated " Cutting Board Cleaning/Sanitation Policy updated " Pre-Wrapped utensils purchased	

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F 812	Continued From page 31 3. In the walk-in freezer, there was a large silver tray containing unwrapped light pink frozen pieces of meat that were exposed to air. The DD identified them as fish filets and acknowledged they should have been wrapped and that they were not stored correctly. 4. On the drying rack, there were three white cutting boards with black smudges. The DD stated they were clean and sanitized after each use. He stated that they just needed to be sanded down. 5. In the paper product storage area, there were three opened boxes with plastic bags containing spoons, forks and knives that were opened and exposed to air. The DD stated that the plasticware was used in the red and yellow zones (isolation areas) and that they should have been covered to prevent debris, dust and dirt exposure. 6. In the top convection oven, there was black, greasy debris on the inside doors and black and orange debris on the floor of the oven. The DD acknowledged the debris and stated the oven needed to be cleaned to prevent cross contamination and allow proper heating temperatures. 7. On the spice rack, there was one opened 16 ounce jar of Spanish paprika marked 03/04/12, one opened 16 ounce jar of celery seed with no dates, one opened 16 ounce jar of ground cumin with no dates, one opened 5 ounce jar of dill weed with no dates, and one opened 23 ounce jar of Montreal steak seasoning with no dates.	F 812	Monitoring " Facial Hair Audit will be completed by Dietary Management: 2 audits weekly x□s 2 weeks then 2 audits monthly x□s 1 then 2 audits quarterly x□s 2 " Labeling/Storage Audit will be completed by Dietary Management: 2 audits weekly x□s 2 weeks then 2 audits monthly x□s 1 then 2 audits quarterly x□s 2 " Cleaning Audit will be completed by Dietary Management: 2 audits weekly x□s 2 weeks then 2 audits monthly x□s 1 then 2 audits quarterly x□s 2 " Results will be brought to QA/QAPI on a quarterly basis. Plan of Correction The Plan of Correction is the facility□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the providers of the truth of the facts alleged or conclusions set forth in the statement of deficiencies . The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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The DD stated that spices got dated when they were delivered and that he was unsure when they were opened. He further stated that it was important to date them to know how fresh they were.

8. On 06/14/22 at 12:21 PM, the surveyor observed the new Food Service Director (FSD) with facial hair wearing a surgical mask as he served food to residents in the main dining room. The FSD was not observed wearing a facial hair restraint.

The surveyor interviewed the FSD at that time, and the FSD explained to the surveyor that if facial hair was one inch or shorter that no beard cover was needed and that it was the responsibility of the DD or FSD to measure and monitor beard length. The FSD was unable to state the process for staff members who entered the kitchen with facial hair, nor was he able to indicate if there was a beard measurement record log kept.

On 06/14/22 at 12:32 PM, the Administrator and the Director of Nursing (DON) were made aware of the surveyor's observations of the FSD. The Administrator acknowledged that if a kitchen staff member had facial hair that a surgical mask did not do the same job as a beard net and that a beard net should be worn to prevent food contamination. She further stated that she would have to review the policy on beard length.

9. On 06/15/22 at 10:04 AM, the surveyor observed in the sink area of the kitchen, a pot washer (PW) with facial hair who wore a surgical mask. The PW was not observed wearing a facial

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F 812	Continued From page 33	F 812		

hair restraint.

The surveyor interviewed the PW at that time who acknowledged that he should have worn a beard net and that a beard net was required to be worn for any facial hair to prevent hair from falling into the food. He further stated he was unsure how long his facial hair was and that no one measured his beard length.

10. On 06/15/22 at 10:08 AM, the surveyor observed a cook (food preparer) in the kitchen with facial hair wearing a surgical mask and a white beard guard over his mask.

The surveyor interviewed the cook at this time and the cook stated that no one measured his beard.

On 06/15/22 at 11:51 AM, the surveyor interviewed the DD who stated the beard length guidance was a standard and that the DD, FSD or a supervisor was responsible for measuring beard length of staff members and that no log was kept. The DD further stated that if facial hair measured more than one inch long, then that was when a beard net was needed.

On 06/15/22 at 12:59 PM, the surveyor interviewed the Administrator, in the presence of the DON, the Regional Clinical Nurse, and the Regional Administrator, who stated that she was unsure where the beard length policy guidance came from and that facial hair was measured "by looking" at the facial hair.

The surveyor reviewed the facility's undated policy titled, "All food items must be labeled and

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F 812	Continued From page 34	F 812		

dated," which revealed Procedure: 1. All food items must be labeled with either a manufacturer label or handwritten label. 2. All food products, upon receiving, must be dated with receiving date.

The surveyor reviewed the facility's policy titled, "Labeling and Dating," dated 11/28/17, which revealed Process: 1. All food products, upon receiving, must be dated with the receiving date cold and dry storage items, this includes, bulk items (BBQ sauce, Mayo, Spices, Bases). 2. All food items must be labeled with either a manufacturer label or handwritten label.

The surveyor reviewed the facility's policy titled, "Refrigerated/Frozen Storage," dated 11/30/17, which revealed Process: 1. Refrigeration: 1.4 All foods are labeled with name of product and the date received and "use by" date once opened. Manufacturer "use by" dated are used until opened. 2. Freezer: 2.4 Food is dated when received and with "use by" date when opened. Manufacturer "use by" dates are used until opened. 2.5 Foods are kept in original container. If removed from original container, foods are completely covered and labeled with the name of product and "use by" date.

The surveyor reviewed the facility's policy titled, "Dry Storage," dated 11/30/17, which revealed Process: 3. Supply Storage: 3.1 Disposable products intended for food service are stored in a sanitary manner using covered, closed, sanitary containers or enclosed food quality plastic bags.

The surveyor reviewed the facility's policy titled, "Personal Hygiene," dated 11/28/17, which

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F 812	Continued From page 35 revealed Process: 7. Hair restraints such as hats, hair coverings, or nets are worn to effectively keep hair from contacting exposed food. Facial hair coverings are used to cover all facial hair. NJAC 8:39-17.2(g)	F 812		
F 880 SS=D	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 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	F 880		8/8/22

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F 880	Continued From page 36 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 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:	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315060	A. BUILDING _____ B. WING _____	06/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	220 ST MARY'S DRIVE CHERRY HILL, NJ 08003

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F 880	Continued From page 37 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to minimize the potential spread of infection to residents during medication administration for 1 of 2 nurses observed during the medication pass on 1 of 2 units (Greentree Unit). This deficient practice was observed and evidenced by the following: On 06/08/22 at 8:42 AM, the surveyor observed the Registered Nurse (RN) prepare medications for one resident. The RN opened the top drawer of the medication cart and stated that there was no enteric coated aspirin available for administration. She stated that she needed to go to the first-floor medication storage room to obtain the medication. At 8:50 AM, the surveyor accompanied the RN to the elevator where she pressed the button with her index finger to signal the elevator; and once inside the elevator, she pressed the button with her same index finger to go to the first-floor medication storage room. The RN informed the Registered Nurse/Unit Manager #2 (RN/UM) who was present, that she needed a bottle of enteric coated aspirin. The RN/UM #2 went into the medication room and obtained the medication and handed it to the RN. The surveyor and the RN returned to the elevator and the RN pressed the button with her same index finger to signal the elevator; and once inside, she pressed the button with her same index finger to return to the second floor. The surveyor observed the RN did not perform hand	F 880	Plan of Correction F 880, Level D Completion Date: 8/8/2022 Corrective Action " 1:1 in-service provided to licensed nurse on proper hand hygiene ID Other Residents " Residents who receive medications from licensed nurses Systemic Change " In-service to nursing staff on Hand Hygiene " In-service to licensed nurses on Medication Administration " Root Cause Analysis was conducted, Licensed Nurses stated she did wash her hands but not for the length needed, stating she was nervous from being observed and miscalculated scrubbing time outside of water flow. " Directed in-service training to appropriate staff with staff competency validated by the Director of Nursing, Medical Director, or Infection Preventionist, as follows: ¿ Nursing Home Infection Preventionist Training Course Module 1 - Infection Prevention & Control Program https://www.train.org/main/course/l081350/ Provide the training to: Topline staff and	

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F 880	Continued From page 38 hygiene when she returned to the medication cart before she began to prepare the medications. The surveyor observed the RN as she opened the bottle of enteric coated aspirin, broke the seal with the tip of a pen, and pulled out a piece of cotton that was contained within the bottle with her bare hand and discarded it. She began to prepare additional medications that were contained within the bingo cards (a method of packaging medications via an enclosed blister pack with a cardboard backing) from the medication cart. When she attempted to press on the bingo card that was placed over a plastic medication cup to release the pill (Farixga, a medication used to treat Type 2 Diabetes), the pill fell onto a piece of paper on top of the medication cart. She stated, "That was the last one I had." The RN then donned a single glove, picked up the pill and placed the pill into a second medication cup and locked the medication cup in the medication cart. She doffed (removed) the glove and did not perform hand hygiene before she continued to prepare other medications for administration. At 9:01 AM, the RN entered the resident's room and handed the resident the cup of medication. She then picked up a disposable cup that contained water that was on the overbed table with the same bare hand and handed it to the resident. She stated that the cup was "sweating" and felt wet, as the facility no longer utilized insulated Styrofoam cups. The RN did not perform hand hygiene after she administered the medications to the resident. She returned to the medication cart and utilized the computer, as she signed out the medications that were	F 880	infection preventionist ¿ CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID-19 Out! https://youtu.be/7srwrF9MGdw ¿ Provide the training to: Frontline staff CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: ¿ Clean Hands https://youtu.be/xmYMUly7qiE Provide the training to: Frontline staff ¿ CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Use PPE Correctly for COVID-19 https://youtu.be/YYTATw9yav4 ¿ Provide the training to: Frontline staff Nursing Home Infection Preventionist Training Course Module 5 - Outbreaks https://www.train.org/cdctrain/course/l081803/ ¿ Provide the training to: Topline staff and infection preventionist Nursing Home Infection Preventionist Training Course ¿ Module 4 - Infection Surveillance https://www.train.org/cdctrain/course/l081802/ Provide the training to: Topline staff and infection preventionist only Nursing Home Infection Preventionist Training Course ¿ Module 7 - Hand Hygiene	

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F 880	Continued From page 39 administered in the electronic medical record. At 9:12 AM, the RN stated that she needed to return to the first floor medication room to obtain Farixga to replace the pill that she dropped on the medication cart. The RN did not perform hand hygiene before she left the nursing unit via the elevator and went to the first floor medication room. At 9:18 AM, the RN returned to the second floor via elevator and did not perform hand hygiene before she pushed the medication cart down the hall and placed it in front of a resident's room who was due for medications. At that time, she used alcohol-based hand rub (ABHR) prior to accessing the medication cart. At 9:24 AM, the surveyor observed the RN as she washed her hands in a resident room prior to medication administration. She turned on the faucet, wet her hands, obtained soap and began to lather and wash her hands out of the stream of running water for 10 seconds and then continued to rub her hands together under the stream of running water for an additional 10 seconds before she rinsed her hands that were already under the stream of running water, dried them off with a paper towel, discarded the paper towel, and obtained an additional paper towel to turn off the faucet before she discarded it. At 9:38 AM, during a follow-up interview with the RN, she stated that she thought that she performed hand hygiene prior to the medication administration but she must have been nervous. The RN stated that she sang happy birthday twice to determine the appropriate amount of	F 880	https://www.train.org/main/course/l081806/ Provide the training to: All staff including topline staff and infection preventionist ¿ Nursing Home Infection Preventionist Training Course Module 6A - Principles of Standard Precautions https://www.train.org/main/course/l081804/ Provide the training to: All staff including topline staff and infection preventionist ¿ Nursing Home Infection Preventionist Training Course Module 6B - Principles of Transmission Based Precautions https://www.train.org/main/course/l081805/ Provide the training to: All staff including topline staff and infection preventionist Monitoring " Hand Hygiene Audit will be completed by Nursing Management: 2 audits weekly x□s 2 weeks then 2 audits monthly x□s 1 then 2 audits quarterly x□s 2 " Results will be brought to QA/QAPI on a quarterly basis. Plan of Correction	

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F 880	Continued From page 40 time to wash her hands. She stated that she was required to wash her hands out of the stream of running water for 20 seconds. The RN confirmed that she had both ABHR and sanitizing hand wipes available on top of her medication cart. She further stated that by not washing her hands or performing hand hygiene prior to and after medication administration and after she touched the elevator buttons, she risked the spread of infection. On 06/08/22 at 12:11 PM, the surveyor interviewed the RN/UM #2 who stated that the RN was required to perform hand washing prior to medication administration and could have used hand sanitizer up to three times before she was required to wash her hands again. She stated that cross-contamination could result if hands were not washed prior to handling medications, the computer keyboard and the medication cart. She stated that the RN was required to wash her hands out of the stream of running water for 20 seconds in accordance with the facility policy. On 06/09/22 at 11:25 AM, the surveyor interviewed the Infection Preventionist (IP) who stated that she expected that nursing would have utilized ABHR in between each resident during medication pass. She stated that nursing was also required to wash their hands prior to donning and after doffing gloves. The IP stated that if nursing had come into contact with high touch surfaces such as the elevator buttons and did not perform hand hygiene prior to medication pass, it could have exposed the resident to bacteria. The IP described the process for hand washing: Turn on the faucet, wet hands, get	F 880	The Plan of Correction is the facility□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the providers of the truth of the facts alleged or conclusions set forth in the statement of deficiencies . The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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F 880	Continued From page 41 soap, rub vigorously for 20 seconds or more out of the stream of water, then rinse from the wrist down, get a paper towel, dry hands, and obtain a second paper towel to turn off the faucet. She further stated that the nurse was required to wash her hands out of the stream of running water for a full 20 seconds because if the process was not followed, bacteria and germs could remain on the hands. On 06/10/22 at 11:02 AM, the surveyor interviewed the Director of Nursing (DON) who stated that she expected nursing to wash their hands or use ABHR prior to handling medications, as it was an "infection issue" if hand hygiene was not performed first. The DON stated that nursing should also sanitize their hands after they left the resident's room, after medication administration, and before they did anything else. She stated that staff were instructed to sanitize their hands after they doffed their gloves to ensure that both staff and residents were safe from infection. The DON further stated that her expectation for handwashing was to lather and rub out of the stream of running water for 20 seconds, and stated that if the RN only rubbed her hands out of the stream of running water for 10 seconds, it was not enough time to ensure that the bacteria were removed from the hands for best practice. The surveyor informed the DON that the facility handwashing/hand hygiene policy was reviewed and indicated that handwashing was required to be performed under running water for 20 seconds. The DON stated that our policy should not have indicated that washing hands under running water for 20 seconds was permissible and agreed to furnish the surveyor with an updated policy.	F 880		

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F 880	Continued From page 42 The surveyor reviewed the facility policy, Handwashing/Hand Hygiene, with an effective date 01/2019, which revealed the following: This facility considers hand hygiene the primary means to prevent the spread of infections. The policy reflected that ...All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: ...Before and after direct contact with residents; before preparing or handling medications; after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; after removing gloves; and the use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. The policy further reflected the Procedure Washing Hands: Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) under a moderate stream of running water ... The surveyor reviewed the Hand Hygiene policy (revised 06/10/22) which revealed the following: Washing Hands. Turn on faucet and run water until desired temperature is achieved ... and to Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer)... The surveyor reviewed the facility policy,	F 880		

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F 880	Continued From page 43 "Administering Medications" (Revised 3/2019) which revealed the following: Staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. NJAC 8:39-19.4 (a)	F 880		

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	30402	A. BUILDING: _____ B. WING _____	06/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION &	220 ST MARY'S DRIVE CHERRY HILL, NJ 08003

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on 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. This was evident for 14 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, codified at N.J.S.A. 30:13-18 (the Act), which	S 560	S560 8:39-5.1(a) Mandatory Access to Care I. Corrective action(s)accomplished for resident(s)affected: " No residents were identified II. Residents identified having the potential to be affected and corrective action taken: " The deficient practice has the potential to affect all residents residing in the facility. III. Measures will be put into place to ensure the deficient practice will not recur:	7/29/22

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

Electronically Signed — 07/11/22

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S 560	Continued From page 1 established minimum staffing requirements in nursing homes. "Direct care staff member" means any registered professional nurse, licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021: One CNA to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 05/22/22-05/28/22 and 05/29/22-06/04/22, the staffing-to-resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift are documented below: -05/22/22 had 16 CNAs for 172 residents on the day shift, required 21 CNAs. -05/23/22 had 15 CNAs for 171 residents on the day shift, required 21 CNAs. -05/24/22 had 19 CNAs for 170 residents on the day shift, required 21 CNAs. -05/25/22 had 20 CNAs for 167 residents on the day shift, required 21 CNAs.	S 560	" Bonuses are offered for double shifts, extra shifts, weekend shifts and perfect attendance. " The staff has been re-educated on the call out and lateness policy by Nursing Management and Nurse Educator. " Advertisements signs for open CNA positions are placed in front of the building. " The facility is recruiting on multiple employment search engines and multiple social media platforms for CNA□s. " Depending on the needs of the day Nursing management to include Unit Mangers, Supervisors and ADON will be evaluated to assist with resident care Staffing Coord will call, text, email CNA□s to take a shift as needed. " We offer sign on bonuses and competitive rates for CNA□s. " We have contracts with multiple agencies to assist us as needed and continue to contract with the new agencies. " We have converted many of our existing staff from other departments into nursing as a promotion. " We have a referral program that offers a referral bonus to encourage our staff to recruit CNA's to join us. " We have staff appreciation parties, as well as giveaways to help with staff retainment. " We try to keep a close relationship with each and every employee to ensure they have the tools necessary to succeed. IV. Corrective actions will be monitored to ensure the deficient practice will not recur:	

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S 560	Continued From page 2 -05/26/22 had 17 CNAs for 167 residents on the day shift, required 21 CNAs. -05/27/22 had 17 CNAs for 167 residents on the day shift, required 21 CNAs. -05/28/22 had 16 CNAs for 167 residents on the day shift, required 21 CNAs. -05/29/22 had 18 CNAs for 172 residents on the day shift, required 21 CNAs. -05/30/22 had 18 CNAs for 172 residents on the day shift, required 21 CNAs. -05/31/22 had 18 CNAs for 172 residents on the day shift, required 21 CNAs. -06/01/22 had 18 CNAs for 171 residents on the day shift, required 21 CNAs. -06/02/22 had 17 CNAs for 171 residents on the day shift, required 21 CNAs. -06/03/22 had 15 CNAs for 171 residents on the day shift, required 21 CNAs. -06/04/22 had 14 CNAs for 171 residents on the day shift, required 21 CNAs. During an interview with the surveyor on 06/16/22 at 9:16 AM, the Staffing Coordinator stated that the staff-to-resident ratios were 1:8 on day shift, 1:10 on evenings and 1:14 on night shift. She further stated that the facility is staffed appropriately, but there are call outs. NJAC 8:39-5.1(a)	S 560	" The Director of Nursing/Designee will conduct weekly C.N.A. staffing schedule audits. " The Director of Nursing/Designee will report audit findings to the Administrator. The Administrator/Designee will analyze and trend findings and report outcomes to the QA Committee quarterly with follow up to recommendations, as necessary. Completion date: 7/29/2022 Plan of Correction The Plan of Correction is the facility□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the providers of the truth of the facts alleged or conclusions set forth in the statement of deficiencies . The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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
315060 Y1	A. Building B. Wing Y2	9/28/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	220 ST MARY'S DRIVE CHERRY HILL, NJ 08003

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 F0550	Correction	ID Prefix F0686	Correction	ID Prefix F0755	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	07/29/2022	LSC	07/29/2022	LSC	07/29/2022
ID Prefix F0761	Correction	ID Prefix F0804	Correction	ID Prefix F0807	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(d)(1)(2)	Completed	Reg. # 483.60(d)(6)	Completed
LSC	07/29/2022	LSC	07/29/2022	LSC	07/29/2022
ID Prefix F0812	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	07/29/2022	LSC	08/08/2022	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?
6/21/2022	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
30402 Y1	A. Building B. Wing Y2	9/28/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	220 ST MARY'S DRIVE CHERRY HILL, NJ 08003

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 07/29/2022	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 6/21/2022	☐ 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
	315060	A. BUILDING **01** B. WING _____	**06/21/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	**220 ST MARY'S DRIVE** **CHERRY HILL, NJ 08003**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is not 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		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the	E 004		8/15/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315060	A. BUILDING **01** B. WING _____	**06/21/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	**220 ST MARY'S DRIVE** **CHERRY HILL, NJ 08003**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 004	Continued From page 1 requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documents on 06/21/22, the facility failed to establish and maintain the facility contracts and agreements at least annually. This deficient practice was evidenced by the following: At 12:05 PM, during review of the facility documents and interview, it was observed that facility contracts and transfer agreements were not updated at least annually. The following contracts and transfer agreements not properly updated are listed: 1. Generator fuel company agreement for fueling the fire pump and generator with diesel fuel in the event of an emergency was dated: 09/30/2020 2. Pharmacy Services Provider Agreement: dated 02/01/2019;	E 004	E-004 (F) Develop EP Plan, Review and Update Annually This provider submits the following plan of correction in good faith and to comply with Federal Law. This plan is not an admission of wrongdoing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. It is the goal of this facility to ensure that the Emergency Preparedness Plan gets an annual review. 1. Facility contracts and transfer agreements will be annually updated even if date of expiration is greater than a year. The facility will update Generator Fuel supplier, Pharmacy, Foo Service provider, Oxygen supplier, compactor supplier, medical transport agreement and backup agreement, Laboratory agreement, diagnostic services	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315060	A. BUILDING **01** B. WING _____	**06/21/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	**220 ST MARY'S DRIVE** **CHERRY HILL, NJ 08003**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 004	Continued From page 2 3. Food Service Provider: dated 05/01/2020 (good for 12-months will be updated annually); 4. Oxygen Cylinder Product Sale Agreement: dated 01/11/2016; 5. Compactor services agreement: dated 09/30/2020; 6. Medical Transportation Agreement I : dated 12/28/2019; 7. Medical Transportation Agreement II : dated 02/15/2018, (document indicates agreement shall remain in effect for a period of one-year); 8. Clinical Laboratory Services Contract: dated 11/02/2015; 9. Facility Diagnostic Services: dated 12/18/2015; and 10. Facility to Facility Transfer Agreement (The Pines at Voorhees) signed by St Mary's: 07/25/2020; signed by Voorhees: 7/21/2020. For LTC Facilities at §483.73(a): Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The findings were verified by the Maintenance Director at the time of the review of the facility documents. The Administrator was informed of the findings at the Life Safety Code exit conference on	E 004	agreement, facility transfer agreement, and any other agreements determined by staff. 2. The full EP manual will be reviewed annually. 3. Education completed with Maintenance staff regarding annual reviews and updates. 4. Every month Maintenance Director or designee will review random sections of EP for compliance. This information will then be entered on a log will be presented to monthly QAPI meeting Date of Compliance: 8/15/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315060	A. BUILDING **01** B. WING _____	**06/21/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	**220 ST MARY'S DRIVE** **CHERRY HILL, NJ 08003**

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E 004	Continued From page 3 06/21/22. NJAC 8:39-31.2(e), 31.6(i)	E 004		
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 06/14/22 and 06/15/22 and St. Mary's Center for Rehabilitation and Healthcare was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. St. Mary's Center for Rehabilitation and Healthcare is a two story, Type II Protected building that was built in January 1986. The facility is divided into 13 smoke zones.	K 000		
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observations on 06/14/22 and 06/15/22, it was determined that the facility failed to ensure that illuminated exit signs were in two	K 293	K-0293 (E) NFPA 101 Exit Signage This provider submits the following plan of correction in good faith and to comply	8/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315060	A. BUILDING **01** B. WING _____	**06/21/2022**

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K 293	Continued From page 4 (2) locations to clearly identify the exit access path to reach an exit discharge door. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 On 06/14/2022 during the survey entrance at 9:08 AM, a request was made to the Director of Plant Operations (DPO) to provide a copy of the facility layout which identified the various rooms and smoke compartments. Starting at 9:33 AM on 06/14/2022 and continued on 6/15/2022, in the presence of facility's DPO, a tour of the building was conducted. During the tour on 06/15/22, the surveyor observed the following locations that failed to to have illuminated exit signs to clearly identify the exit access route: 1. At 9:18 AM, one (1) illuminated exit sign above the exit access door in the outside enclosed center courtyard near elevator number 3. 2. At 11:12 AM, one (1) illuminated exit sign	K 293	with Federal Law. This plan is not an admission of wrongdoing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. It is the practice of the facility to maintain illuminated exit signage in the courtyards 1. Illuminated Exit sign will be installed in 2 enclosed courtyards. 2. Facility wide exit sign inspection for June has been completed on June 28th and all existing illuminated exit signs functioning as per design. 3. Education completed with Maintenance staff to observe during rounds. 4. Every month Maintenance Director or designee will check a random floor of the facility to ensure exit signs are functioning. This information will then be entered on a log will be presented to monthly QAPI meeting Date of Compliance: 8/15/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 293	Continued From page 5 above the exit access door in the outside enclosed center courtyard adjacent to the residents' dining room. The findings were verified and confirmed by the DPO during the observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 06/15/2022 at 12:43 PM. Fire Safety Hazard. NJAC 8:39 -31.1 (c) NFPA Life Safety Code 101	K 293		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced	K 351		8/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 351	Continued From page 6 by: Based on observations and interview on 06/14/22 and 06/15/22, it was determined that the facility failed to provide proper fire sprinkler coverage to all areas of the facility, as required by National Fire Protection Association (NFPA) 13 for Installation of Sprinkler Systems. The New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. The deficient practice was observed and evidenced by the following: On 06/14/2022 during the survey entrance at 9:08 AM, a request was made to the Director of Plant Operations (DPO) to provide a copy of the facility layout which identified the various rooms and smoke compartments. On 06/14/22 at 9:33 AM, in the presence of facility's DPO, a tour of the building was conducted. Along the tour, the surveyor observed that the facility failed to provide proper fire sprinkler protection in the following location: 1. At 9:35 AM, an inspection inside the facility's basement level Service Hall stairwell was performed. The surveyor observed no evidence of a fire sprinkler coverage inside the eight foot three inch by three foot nine inch lower level landing area. The findings were verified and confirmed by the DPO during the observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 06/15/2022 at 12:43 PM.	K 351	K-0351 (D) NFPA 101 Sprinkler System-Installation This provider submits the following plan of correction in good faith and to comply with Federal Law. This plan is not an admission of wrongdoing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. It is the practice of the facility to ensure building wide sprinkler coverage and can function as designed 1. Missing sprinkler head in service hall stairwell will be installed. 2. Facility wide sprinkler head inspection has been completed for June on June 28th. 3. Education completed with Maintenance staff to observe sprinklers, ceiling tiles, tamper switches and sprinkler escutcheons during rounds and check for proper building wide coverage. 4. Every month Maintenance Director or designee will check sprinkler system components on a random floor of the facility. This information will then be entered on a log will be presented to monthly QAPI meeting Date of Compliance: 8/15/2022	

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K 351	Continued From page 7 Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351		
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations and review of other facility documents on 06/14/22 and 06/15/22, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection. This deficient practice was identified for 2 of 9 set of smoke barrier doors tested and was evidenced by the following: Reference 1: 8.5.4.1, Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grills. The clearance under the	K 374	K-0374 (E) NFPA 101 Subdivision of Building Spaces-Smoke Barrier This provider submits the following plan of correction in good faith and to comply with Federal Law. This plan is not an admission of wrongdoing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. It is the practice of the facility to ensure smoke barrier door free resist the passage of smoke. 1. Doors were repaired to allow for closure on June 28th, 2022	8/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 374	Continued From page 8 bottom of a new door shall be a maximum of 3/4 of an inch. On 06/14/2022 during the survey entrance at 9:08 AM, a request was made to the Director of Plant Operations (DPO) to provide a copy of the facility layout which identified the various rooms and smoke compartments. A review of the facility provided layout identified the building was a two-story building with nine sets of double smoke barrier doors in the facility. On 06/14/22 at 9:33 AM, in the presence of facility's DPO, a tour of the building was conducted. Along the tour the DPO and surveyor tested nine sets of double smoke barrier doors in the corridors with the following results: 1. At 10:19 AM, one set of double smoke doors, on the second floor Greentree Unit near the Social Services office, when both doors were released from their magnetic hold-open devices and allowed to self close into their frame, revealed it was not resistant to the transfer of smoke. The surveyor observed a gap greater than 1/8 of an inch between the meeting edges. One door did not fully close into its frame and left a 3/8 of an inch gap. This test was repeated two additional times with the same results. 2. At 10:48 AM, one set of double smoke doors, on the second floor Holly Avenue hall next to resident room #203, when both doors were released from their magnetic hold-open devices and allowed to self close into their frame,	K 374	2. Doors throughout the facility were checked to allow for closure on June 28th, 2022 3. Education completed with Maintenance staff regarding monitoring doors to ensure they close properly. 4. Every month Maintenance Director or designee will check random doors throughout the facility to ensure the doors fully close. This information will then be entered on a log will be presented to monthly QAPI meeting Date of Compliance: 8/15/2022	

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K 374	Continued From page 9 revealed it was not resistant to the transfer of smoke. The surveyor observed a gap greater than 1/8 of an inch between the meeting edges. One door did not fully close into its frame and left a two (2) inch gap. This test was repeated two additional times with the same results. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. The findings were verified and confirmed by the DPO during the observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 06/15/2022 at 12:43 PM.	K 374		
K 912 SS=E	N.J.A.C. 8:39-31.1(c), 31.2(e) Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations on 06/14/2022, in the	K 912	K-0912 (F) NFPA 101 Electrical Systems-	8/15/22

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ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	**220 ST MARY'S DRIVE** **CHERRY HILL, NJ 08003**

(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 912	Continued From page 10 presence of facility management, it was determined that the facility failed to ensure that 3 of 11 electrical outlets located next to a water source were equipped with proper working Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: On 06/14/2022 during the survey entrance at 9:08 AM, a request was made to the Director of Plant Operations (DPO) to provide a copy of the facility layout which identified the various rooms in the facility. Starting at 9:33 AM, in the presence of facility's DPO, a tour of the building was conducted. Along the tour the surveyor tested eleven (11) electrical outlets located in wet locations. When the surveyor used a Ground-Fault Circuit Interrupter (GFCI) tester to de-energize the electrical outlets, three (3) electrical outlets had not de-energize, as required by code in the following locations: 1. At 10:14 AM, inside resident room #236's bathroom, one GFCI electrical outlet when tested did not de-energize. 2. At 12:21 PM, inside the first floor doctor's office near the Sub-Acute unit, one Duplex electrical outlet, located twelve inches to the right of the bathroom sink when tested, did not de-energize. 3. At 12:30 PM, inside the Physical Therapy	K 912	This provider submits the following plan of correction in good faith and to comply with Federal Law. This plan is not an admission of wrongdoing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. It is the practice of the facility to protect electrical wiring in accordance with NFPA99 2012 edition, 6.3.2.2.6.2. Electrical Testing of GFCI and Installation 1. New GFCI outlets have been installed in 3 locations that failed to de energize as designed on June 28th, 2022 2. A facility wide inspection of all installed GFCI has been completed on June 28th, 2022 3. Education completed with Maintenance staff regarding testing and inspection of GFCI and electrical systems will be conducted. 4. Every month Maintenance Director or designee will check random areas of the facility s to ensure proper generator testing. This information will then be entered on a log will be presented to monthly QAPI meeting Date of Compliance: 8/15/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315060	A. BUILDING **01** B. WING _____	**06/21/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 912	Continued From page 11 resident's bathroom, one GFCI electrical outlet, located eight inches to the right of the sink when tested, did not de-energize. The findings were verified and confirmed by the DPO during the observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 06/15/2022 at 12:43 PM. NJAC 8:39 -31.2 (e) NFPA 99	K 912		

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
315060 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/28/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	220 ST MARY'S DRIVE CHERRY HILL, NJ 08003

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0293	08/15/2022	LSC	K0351	08/15/2022	LSC	K0374	08/15/2022
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0912	08/15/2022	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
6/21/2022	☐ YES ☐ NO