STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS COMPLAINT#: NJ115081, NJ115142, NJ117798, NJ126319, NJ126468 CENSUS: 181 SAMPLE SIZE: 6	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609		10/2/19

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

Electronically Signed | 09/19/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 609	Continued From page 1 This REQUIREMENT is not met as evidenced by: C#: NJ115142 Based on interviews, Medical Record (MR) review, and review of other pertinent facility documents on 8/2/19, it was determined that the facility failed to report an Injury of Unknown origin to the New Jersey Department of Health (NJDOH), as well as follow the facility's own policy titled "Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Resident Property," for 1 of 6 sampled residents (Resident #1), reviewed for injury of unknown origin. This deficient practice was evidenced by the following: 1. According to Resident #1's "Admission Record (AR)," the Resident was admitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted] According to Resident #1's Minimum Data Set (MDS), an assessment tool dated [redacted] Resident #1 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the Resident was [redacted] impaired. The MDS also indicated that Resident #1 required assistance with Activities of Daily Living (ADLs). Review of Resident #1's Incident/Accident Report (IR) dated [redacted] at 4:45 p.m., showed Resident #1 stood up and lost balance, which caused the Resident to fall on the floor in a side lying position. The IR also revealed Resident #1 denied [redacted] at the time of the fall.	F 609	F609 Reporting of Alleged Violations 1. Resident #1 is no longer in the facility. The incident was reported to NJDOH on 10/02/19 at 2:50 PM. 2. Any resident with an injury of unknown origin was at risk to be affected by the deficient practice. An audit was done of incidents within the past 3 months to identify if any injuries of unknown origin were not reported. None were identified. 3. All Nurses and Nursing Supervisors will be re-educated on policy Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Resident property, were focus on the investigation and reporting of injuries of unknown origin to the DOH. 4. DON or designee will perform an audit of the shift reports and incident and accident reports for 90 days to identify any injuries of unknown origin that require (further) investigation and reporting to DOH. Any injury of unknown origin identified will be investigated and reported immediately to the DOH. All results of the audits will be reported to the QAPI committee.	

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Review of the Resident's Care Plan (CP) initiated [redacted], revealed the following: under Focus; "witnessed fall lying on floor left side position." Under Interventions, "staff to continue frequent rounding and place on fallen star program (a program used for residents with frequent falls)...."

Review of Resident #1's CP updated [redacted], included the following: Under Focus: The resident is at high risk for falls related to (r/t) unaware of safety needs.... Under Goal: The resident will be free of fall related injuries through the review date. Under Interventions: "Anticipate and meet the resident's needs...."

Review of Resident #1's "Progress Notes (PN)" dated [redacted] at 9:28 p.m., revealed that around 4:45 p.m., Resident #1 had a fall. The PN also showed that the Resident denied hitting his/her head on the floor. In addition, the PN revealed that Resident #1 was [redacted] and [redacted] to name with periods of confusion and forgetfulness." The PN further revealed that Resident #1 was able to move all [redacted] with weakness on [redacted]) and [redacted]).

Review of Resident #1's PN dated [redacted] at 2:38 a.m., revealed "no complaints of pain or discomfort." The PN also showed that Resident #1 had no injury r/t falls.

Review of Resident #1's PN dated [redacted] at 2:53 p.m., revealed that Resident #1 complained of [redacted] to the [redacted] with passive range of motion. The PN also showed that Resident #1 had multiple [redacted]) areas to [redacted] and [redacted] and [redacted]

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[redacted] to [redacted] with dressing.

Review of Resident #1's PN dated [redacted] at 11:02 p.m., revealed Resident #1 had [redacted]. The PN also showed that the Resident [redacted] was more swollen than the right.

Review of Resident #1's PN dated [redacted] at 11:33 p.m., revealed that the NP saw Resident #1 and ordered to send Resident #1 to the hospital to rule out [redacted]).

Review of Resident #1's Universal Transfer Form (UTF) dated [redacted] at 9:45 p.m., showed the "reason for transfer" was [redacted] and [redacted] to rule [redacted].

Review of Resident #1's PN dated [redacted] at 11:18 p.m., revealed the Resident was readmitted to the facility from the hospital with [redacted] due to the diagnosis of [redacted]."

Review of Resident #1's MR showed no documentation that the Resident had a [redacted] or injury to the [redacted] and [redacted] prior to [redacted]. The MR did not reveal how Resident #1 sustained the [redacted] and [redacted] In addition, the MR did not reveal that the unknown [redacted] was reported to the NJDOH.

During an interview with the Director of Nursing (DON), who was new to the facility, on 8/2/19 at 2:46 p.m., the DON stated that the facility reports injury of unknown origin to the NJDOH. The DON also stated if a resident has a fall and no injury was seen and after a few weeks the resident developed [redacted], this would be investigated

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F 609	Continued From page 4	F 609		

and reported to the NJDOH. In addition, the DON indicated that he/she was unaware if the [redacted] was reported to NJDOH or if an investigation was completed.

During a post survey interview with the DON on 8/5/19 at 2:31 p.m., the DON indicated the [redacted] was not reported because the previous DON concluded the [redacted] was from the previous fall. In addition, the DON indicated there was no documentation showing the investigation of the [redacted].

Review of the facility's policy titled "Abuse, Neglect, Mistreatment, and Misappropriation of Property," dated 5/2019, included but was not limited to the following:
Under g. Injuries of Unknown Origin: An injury should be classified as an injury of unknown source when both of the following conditions are met:
i. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident.
ii. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.
G. Reporting and Response: Under External Reporting, Initial reporting of allegation: If an incident or allegation is considered reportable, the Administrator or designee will make an initial (immediate or within 24 hours) report to the State Agency. A follow up investigation will be submitted to State Agency within five (5) working days.... Report the results of all investigations to the administrator or his or her designated

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F 609	Continued From page 5 representative and to other officials in accordance with State law, including immediate or 24 hour reporting to the State Agency, law enforcement and the follow up report to the State Agency, within 5 working days ...."	F 609		
F 610 SS=D	N.J.A.C: 8:39-13.4(c)2(v) Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: C#: NJ115142 Based on interviews, Medical Record (MR) review, and review of other pertinent facility documents on 8/2/19, it was determined that the	F 610	F610 Investigate/Prevent/Correct Alleged Violation 1. Resident #1 is no longer in the facility 2. All residents having an incident/accident/or injury of unknown origin are at risk for this deficient practice.	10/2/19

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F 610	Continued From page 6 facility failed to thoroughly investigate an Injury of Unknown origin, as well as follow the facility's own policy titled "Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Resident Property," for 1 of 6 sampled residents (Resident #1), reviewed for injury of unknown origin. This deficient practice was evidenced by the following: 1. According to Resident #1's "Admission Record (AR)," the Resident was admitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted] According to Resident #1's Minimum Data Set (MDS), an assessment tool dated [redacted] Resident #1 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the Resident was [redacted] impaired. The MDS also indicated that Resident #1 required assistance with Activities of Daily Living (ADLs). Review of Resident #1's Care Plan (CP) updated [redacted], included the following: Under Focus: The resident is at risk for falls, unaware of safety needs.... Under Goal: The Resident will be free of fall related injuries through the review date. Under Interventions: "Anticipate and meet the resident's needs...." Review of Resident #1's Incident/Accident Report (IR) dated [redacted] at 7:30 a.m., revealed that Resident #1 was found lying on the right side next to his/her bed. The IR also showed that the Resident was '[redacted]..."	F 610	A review of incident and accident reports from the prior 3 months were reviewed to ensure that thorough investigations were completed. 3. All nurses and Supervisors were re-educated on the policy Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Resident property with focus on investigating all injuries and injuries of unknown origin, that were un-witnessed and cannot be explained by the resident, are suspicious due to location, potential for possible abuse. The DON or designee are to be contacted for any injury of unknown origin. 4. DON or designee will audit the shift report and incident and accident reports for 90 days to ensure that all injuries are thoroughly investigated to identify cause. Any injury of unknown origin with no causal factor identified will be reported to the DOH. The results of this audit will be reported to the QAPI committee monthly.	

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F 610	Continued From page 7 Review of Resident #1's Incident/Accident Report (IR) dated [redacted] at 4:45 p.m. revealed that Resident #1 stood up and lost balance, which caused the Resident to fall on the floor and land on the "left side lying position." The IR also showed that Resident #1 [redacted] Review of Resident #1's "Progress Notes (PN)" dated [redacted] at 9:28 p.m., revealed that around 4:45 p.m., Resident #1 had a fall. The PN also showed that the Resident [redacted] and/ or hitting his/her [redacted] on the floor. In addition, the PN revealed that Resident #1 was [redacted], [redacted]) to name with periods of confusion and forgetfulness." The PN further revealed that Resident #1 was able to move all [redacted] with [redacted] on [redacted] and [redacted]). Review of Resident #1's PN dated [redacted] at 2:38 a.m., revealed "no complaints of [redacted] or [redacted] The PN also showed that Resident #1 had no injury r/t falls. Review of Resident #1's PN dated [redacted] at 2:53 p.m., revealed that Resident #1 complained of (c/o) [redacted] with passive range of motion. The PN also showed that Resident #1 had [redacted]) areas to [redacted] and [redacted] and [redacted] with dressing. Review of Resident #1's PN dated [redacted] at 11:02 p.m., revealed Resident #1 had [redacted]. The PN also showed that the Resident [redacted] was more [redacted] than the [redacted]	F 610		

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F 610	Continued From page 8 Review of Resident #1's PN dated [redacted] at 11:33 p.m., revealed that the NP saw Resident # 1 and ordered to send the Resident to the hospital to rule out [redacted]). Review of Resident #1's Universal Transfer Form (UTF) dated [redacted] at 9:45 p.m., showed the "reason for transfer" was [redacted] and [redacted] to rule [redacted]. Review of Resident #1's PN dated [redacted] at 11:18 p.m., revealed Resident #1 was readmitted to the facility from the hospital with [redacted] due to the diagnosis of [redacted]." Review of Resident #1's MR showed no documentation that the Resident had a [redacted] or injury to the [redacted] and [redacted] prior to [redacted]. The MR did not reveal how Resident #1 sustained the [redacted] to the [redacted] In addition, the MR did not show documentation that the unknown [redacted] was investigated. During an interview with the Director of Nursing (DON), who was new to the facility, on 8/2/19 at 2:46 p.m., the DON stated that the facility reports injury of unknown origin. The DON also stated if a resident has a fall and no injury was seen and after a few weeks the resident developed a fracture, this would be investigated and reported to the NJDOH. In addition, the DON indicated that he/she was unaware if the fracture was reported to NJDOH or an investigation was completed. During a second interview with the DON on	F 610		

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F 610	Continued From page 9	F 610		

8/2/19 at 4:06 p.m., the DON stated that he/she believed the [redacted] occurred from the previous fall. In addition, the DON stated the resident could have had [redacted] and had [redacted].

During a post survey interview on 8/5/19 at 2:31 p.m., the DON indicated the previous DON concluded the [redacted] was from the previous fall. In addition, the DON indicated there was no documentation showing the investigation for the [redacted]

Review of the facility's policy titled "Abuse, Neglect, Mistreatment, and Misappropriation of Property," dated 5/2019, included but was not limited to the following:
Under g. Injuries of Unknown Origin: An injury should be classified as an injury of unknown source when both of the following conditions are met:
i. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident.
ii. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.
Under E. Investigation: Procedure b. Investigation of Injury of Unknown Origin or Suspicious Injuries: must be immediately investigated to rule out abuse: i. injuries include, but not limited to, bruising of the inner thigh, chest, face, and breast, bruises of an unusual size, multiple unexplained bruises, and/or bruising an area not typically vulnerable to trauma.

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F 610	Continued From page 10 N.J.A.C: 8:39-13.4(c)2i-vi	F 610		
F 800 SS=B	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: C#: NJ126468 Based on interviews, Medical Record (MR) review, and review of other pertinent facility documents on 8/2/19, it was determined that the facility failed to provide meals which met the Resident's personal preference, as well as follow the facility's own policy titled "Food and Nutrition Management," for 1 of 6 sampled residents (Resident #2) reviewed for dietary preference. This deficient practice was evidenced by the following: According to Resident #2's "Admission Record, (AR)," the Resident was admitted to the facility on [redacted] with diagnoses which included but were not limited to: [redacted]	F 800	F800 Provided Diet Meets Needs of Each Resident 1. Resident #2 no longer resides in the facility 2. All Residents in the facility have the potential to be affected by the deficient practice. Registered dietitian will review all current Residents diet slips and diet order to ensure accuracy. 3. Registered dietitians, Food Services Director, Administrator, DON met to review, update and discussed the policy on food preferences. All Nursing will be re-educated on the food preferences policy. Nursing and dietitian staff will be educated on the updated policies and are providing patient preferences. 4. Registered Dietitians will review all diet orders and food preferences upon admission/readmission and as needed to update diet and preferences. Registered Dietitian will audit 10 Residents weekly x 90 days to ensure correct diet orders, diet preferences in place and present findings	10/2/19

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F 800	Continued From page 11 According to Resident #2's Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the Resident was cognitively [redacted] The MDS also indicated that Resident #2 required assistance with Activities of Daily Living (ADLs). Review of Resident #2's Care Plan (CP) created [redacted], included the following: Under Focus: The resident is at risk for [redacted] status.... Under Goal: The resident will consume at least 50% of most meals without signs and symptoms of [redacted] difficulty.... Under Interventions: "Provide diet as ordered...." Monitor intake at all meals,offer alternate choices as needed.... "Honor food preferences/ update PRN (as needed)...." Review of Resident #2's Hospital Records dated [redacted] included the following: Under Hospital Discharge Instructions: Diet: "You may return to your normal diet...." Under Daily Care Plan: Diet: "General, Chopped, [redacted]..."[redacted] twice a day. Under New Admission Intake Form: Diet: [redacted] Review of Resident #2's Diet Slip dated [redacted], indicated [redacted], No Added Salt Chopped Diet with thin Liquids. Review of Resident #2's Order Summary Report (OSR) showed no documentation that the Resident was ordered a [redacted] diet during his/her stay in the facility. Review of Resident #2's Progress Notes (PN) dated [redacted] at 1:18 p.m., written by the Nurse Practitioner (NP), "staff reports poor appetite.	F 800	during QAPI	

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VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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
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family/relative contacted by nursing for encouragement...."

Review of Resident #2's MR showed no documentation that Resident #2 was on a [redacted] diet.

During an interview with the Dietary Supervisor (DS) on 8/2/19 at 1:25 p.m., the DS stated when a Resident is on a special diet, it is usually written on the Resident's diet slip. The DS further stated dietary staff would not know the Resident's diet if it is not written on the diet slip.

During an interview with the Registered Dietician (RD) on 8/2/19 at 1:35 p.m., the RD stated, "when a Resident is on a [redacted] diet, I always go to the Resident and ask what they specifically mean...." The RD also indicated, [redacted] diet is now individualized." In addition, the RD stated, "if a resident is a [redacted] it would be written on the diet slip for dietary staff to know the Resident is a [redacted]" The RD stated he/she did not write the order that Resident #2 is a [redacted] and did not write it on the diet slip.

Review of the Facility's policy titled "Food Preference Policy" dated 11/2018 included but was not limited to the following: Under policy: "It is the policy of this facility to provide food preferences to residents within their dietary restrictions as ordered by the Medical Doctor (MD)." Under procedure: Food preferences are reviewed with the resident by a qualified staff member, if the resident is able to participate. Food preferences are communicated to the Food Service Director.... Residents can change their food preferences as desired based on verbal and nonverbal cues of food acceptance and

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F 800	Continued From page 13 preference. If the resident would like food preferences that are not recommended by the RD and the MD, the Resident will be educated by the RD on the risks and benefits of maintaining an appropriate diet based on medical history.	F 800		
F 835 SS=F	N.J.A.C: 8:39-17.4 (a)1 Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and review of facility provided documentation on 7/16/2019 and 7/26/2019, and 8/02/19, it was determined that the Administrator failed to implement a plan to replace and/or repair Packaged Thermal Air Conditioning (PTAC) units for 79 of 195 PTAC units located in various Resident rooms, Shower/Tub rooms and common Activity/ Dining rooms, as well ensure that the facility's policy for "Heat Emergency Response" was implemented. This failure to have a plan in place resulted with the facility being evacuated on 7/21/2019, due to excessive heat. This deficient practice is evidenced by the following: Ref. See Tag F- 0908.	F 835	F-835 Administration. " What corrective action will be accomplished for those residents affected by the deficient practice A shipment of the correct PTACH units has been delivered to the facility and has been installed. " How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken All residents are at risk of being affected by the deficient practice. The director of maintenance has taken a log of all areas in the facility that need a replacement PTACH unit, and additional	10/2/19

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F 835	Continued From page 14 During a tour of the facility on 7/16/19 at 9:24 a.m., with the Facility Maintenance Worker (FMW), the surveyor observed 24 New PTAC units model number [redacted] stored on pallets in the basement. At 9:27 a.m. the Administrator (Admin.) met the surveyor in the basement and stated that the PTACs were the wrong units. The surveyor then asked the Admin., "How long have these PTAC units been here and could you provide a copy of the purchase order for them. When are you getting the correct PTAC units." The Admin. stated; that he had only been Administrator for 3 weeks and that the units had been there since approximately May 2019. The Admin could not give a date as to when the correct PTAC units will be at the facility. The Admin. confirmed the PTAC units in the basement were the wrong type and could not be used as replacements in the Resident rooms. According to Administration, on 7/21/2019 at 11:15 a.m. a visitor called the local police due to excessive heat in the building. The Fire Department and Local Department of Health arrived. At 1:40 p.m., it was determined that due to excessive heat in the building, the Residents need to be evacuated to a local High School. On 7/26/2019 at 10:24 a.m., the surveyor made a request to the Admin to provide; - 1. A copy of the Police report for the incident that had occurred on 7/21/2019, where the building had to be evacuated. - 2. A Work acknowledgement ticket from the vendor who made the repairs to the buildings Air	F 835	orders have been placed to replace these units. All rooms without a working PTACH unit has a temporary AC unit. All temporary units were inspected for proper function and setup. " What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur; A preventative maintenance schedule for the PTACH units is in place to ensure proper functionality of the units. All temporary units will be inspected weekly to ensure proper placement and functionality. A maintenance book is located at each nurse□s station where an issue with the PTACH unit can be logged. Nursing staff will be educated on proper documentation of malfunctioning PTACH units. Administrator or designee will educate maintenance staff on the deficient practice and ensure proper maintenance of PTACH units. GE HVAC company is in contract with the facility to ensure proper maintenance of the Roof Top Units (RTU). The facility'□s policy for Heat Emergency Response has been reviewed, and updated to maintain resident safety and remain in compliance. " How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e. what quality assurance program will be put into practice. The date for correction	

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F 835	Continued From page 15 Conditioning system on 7/21/2019. - 3. A copy of air temperatures that were recorded on 7/21/2019. - 4. A copy of the facility's heat emergency plan. A review of the facility provided work acknowledgement ticket included: "7/21/19, Arrived onsite and spoke with Admin. about issues. The building is hot and is being evacuated by the Fire Department. Worker delivered portable AC units, installed them in the [redacted] Nursing stations. Next I inspected the cooling tower to ensure it was operating properly. Inspected the [redacted] heat pump. Unit has a defective compressor that was previously written up. (Worker)sent pictures and info (information) via text to (Worker) for replacement compressor for heat pump. Next I troubleshot the RTU (roof top unit) that serves the [redacted] and [redacted] hallways and Nursing stations found the unit to be operating with only 2 of 3 compressors and the condenser coil was dirty. Found that the compressor that was off was defective. Worker picked up new compressor and remained onsite to help with replacement." A review of the facility's "Heat Emergency Response" was performed and reads in part: If the temperature in a resident care area cannot be maintained below 81 degrees Fahrenheit, the highest ranking employee or their designee shall following perform or ensure the following: - Notify the State Department of Health. - Establish a log record to record dates, times and actions taken , every hour. The Director of Maintenance or authorized delegate, in a heat emergency shall acts as follows: - Take over the duties of the log record, every	F 835	and the title of the person responsible for correction of deficiency Administrator and Director of Maintenance will audit all maintenance logs on a weekly basis to identify issues or concerns with PTACH units for 3 months and then monthly for the next 3 months. Results of the audit will be will reviewed monthly by the VP of Clinical Services and VP of Operations, and at the facility quarterly QA meetings. Compliance 10/2/19 and ongoing.	

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F 835	Continued From page 16	F 835		

hour.

A review of the facility temperature log was performed. The following was recorded:
- Nursing staff recorded temperatures on 7/21/2019, in every Resident room. This was documented once and had no times written on the sheet.

The Maintenance department provided the following temperature logs recorded:
On 7/19/2019, once per shift (3 times daily) on the [redacted]. floors.
On 7/20/2019, once per shift (3 times daily) on the [redacted] floors.
On 7/21/2019, once per shift (3 times daily) on the [redacted]. floors.
These temperatures were recorded in common corridors and Day rooms. No resident room temperatures were recorded. The facility did not follow their own policy for recording temperatures during a heat emergency.

On 7/16/2019, at the exit conference, after identifying several non-functioning PTAC units, the surveyor asked the Admin. what was the facility plan for the replacement of non-functioning PTAC units around the building. The Admin. did not give an answer with a plan for the replacements or repairs of the 79 non-functioning PTAC units.

Post survey the Admin provided a copy of the police report for the incident of 7/21/2019 that reads in part:
- 7/21/2019, 11:39 AC not working.
- 7/21/2019, 11:39 Request Fire Department duty Officer.
- 7/21/2019, 12:20 Fire Department contacting

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F 835	Continued From page 17 Department of Health. - 7/21/2019, 12:31 Asked to contact Eastern High School for possible evacuation site. - 7/21/2019, 13:09 no maintenance on location. - 7/21/2019, 13:40 DPW bus for evac. - 7/21/2019 walking PTS (patients) can use door B-15. - 7/21/2019, 14:29 Officer at front door due to press and family. The facility had identified ongoing problems with several individual room PTAC units and Roof Top Units (RTU) since June 2019. The facility had purchased PTAC units which were the wrong type and have been sitting un-used on-site since May 2019. The facility did not send back the wrong PTAC units and order the correct PTAC units for replacement. The facility had no plan in place to correct the non-functioning PTAC units, which led to the building needed to be evacuated on 7/21/2019 due to excessive heat.	F 835		
F 908 SS=F	N.J.A.C: 8:39-9.2(a) Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation on 7/16/2019, 7/26/2019, and 8/02/19, in the presence of facility management, it was determined that the facility	F 908	F-908 Essential Equipment. " What corrective action will be accomplished for those residents affected	10/2/19

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F 908	Continued From page 18 failed to maintain their Packaged Thermal Air Conditioning (PTAC) units in a safe and optimal working condition, for 79 of 195 PTAC units located in various Resident rooms, Shower/Tub rooms and common Activity/ Dining rooms. This deficient practice was evidenced by the following: During the survey entrance on 7/16/2019 (day one) at 8:58 a.m., a request was made to Maintenance Director #1 (MD#1) to provide a copy of the facility lay-out which identifies the various rooms in the building. A request was also made for facility maintenance requests. The MD#1 said there are maintenance request log books on each of the 5 floors. The surveyor made a request to provide the maintenance log books for June and July 2019. At 9:05 a.m., the surveyor started a tour of the building on the [redacted]. The surveyor observed that the resident rooms have PTAC units located by the windows. The surveyor also observed the following Resident rooms had Portable Air Conditioner (PAC) units that were venting out of the Resident room windows in the following locations: Resident rooms #[redacted] #[redacted], #[redacted], #[redacted], #[redacted] #[redacted] and [redacted] floor Day/ Dining room had 2 PACs. At 9:20 a.m., the Facility Maintenance Worker (FMW) stated that some of the PTAC units need to be fixed or replaced. The surveyor then asked, "How long have the PTAC units in some of the rooms been down." The FMW told the surveyor some a year. The FMW also told the surveyor that there are 25 new PTAC units in the basement, but they were the wrong type.	F 908	by the deficient practice Maintenance Dept. have taken logs to identify areas that are at risk of getting to excessive heat and provided temporary cooling. " How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken All residents are at risk of being affected by the deficient practice. The director of maintenance has taken a log of all areas in the facility that need a replacement PTACH unit. Additional orders have been placed to replace these units, and temporary cooling units have been placed. Maintenance staff will be educated on maintaining the PTACH units in an efficient and optimal working condition. " What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur; A preventative maintenance schedule for the PTACH units is in place to ensure proper functionality of the units. A maintenance book is located at each nurse□s station where an issue with the PTACH unit can be logged. Nursing staff will be educated on proper documentation of malfunctioning PTACH units. The facility□s policy for Heat Emergency Response has been reviewed, and updated to maintain resident safety and remain in compliance. All temporary units	

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F 908	Continued From page 19 During a tour of the basement with the FMW at 9:24 a.m., the surveyor observed 24 New PTAC units model number [redacted] stored on pallets. At 9:27 a.m. the Administrator (Admin.) met the surveyor in the basement. The Admin. stated that he/she had only been the Administrator there for 3 weeks, and that the units had been in the facility since approximately May 2019. The Admin could not give a date as to when the correct PTAC units will be at the facility. The Admin. confirmed at that time, the PTAC units in the basement were the wrong type and could not be used as replacements in the Resident rooms. Later at 9:46 a.m. the surveyor continued the tour in the presence of the FMW and MD#1 and observed from the corridor the following; At 9:46 a.m., on the [redacted] rooms with PAC units venting out of the windows, Resident rooms, #[redacted], #[redacted], [redacted], [redacted]. floor Day/ Dining room, At 10:01 a.m., on the [redacted] rooms with PAC units venting out of windows, Resident rooms, [redacted] and Day/ Dining room had two (2). At 10:27 a.m., on the 2nd. floor, PACs in resident rooms, #[redacted], Day/ Dining room had two (2). Later at 11:02 a.m. a review of the facility provided maintenance request logs for June and July 2019 identified the following Air Conditioning requests;	F 908	are inspected weekly to ensure proper placement and function " How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e. what quality assurance program will be put into practice. The date for correction and the title of the person responsible for correction of deficiency Administrator and Director of Maintenance will audit all maintenance logs on a weekly basis to identify issues or concerns with PTACH units or temp cooling units for 3 months and then monthly for the next 3 months. Results of the audit will be will reviewed monthly by the VP of Clinical Services and VP of Operations, and at the facility quarterly QA meetings. Compliance 10/2/19 and ongoing.	

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F 908	Continued From page 20 On the [redacted] - 7/8/19, room [redacted] change AC filter, 7/2/19, room [redacted] AC making noise, 6/28/19, room [redacted] AC unit not cold, 6/20/19, room [redacted] AC FULL, 6/20/19, room [redacted] AC filter, 6/19/19, room [redacted] AC not working, 6/18/19, room [redacted] AC out of window, 6/18/19, room [redacted] AC out of window, 6/16/19, room [redacted] AC not working, 6/13/19, room [redacted] AC needs to be fixed (Comments: working on system,) 6/13/19, room [redacted] AC need to be fixed (Comments: working on system)6/9/19, room [redacted] tubing off back of AC, hot in there, 6/5/19, room #[redacted] Air Conditioner broken (Comments: tubing disconnected from unit from window) On the 4th. floor: - 7/12/19, room [redacted] Portable AC not working (we need more units), 7/12/19, room [redacted] Air Conditioner broken, 7/7/19, room [redacted] No AC (Comments: needs AC unit, Family must be notified when done- ASAP), 6/28/19, room [redacted] no AC(Comments: no portables right now), 6/27/19, room [redacted] Portable AC please check, 6/25/19, room [redacted] please check AC water needs to be drained, 6/17/19, Air broken rooms [redacted] "No Units", 6/14/19, room [redacted] AC unit not working, 6/5/19, room [redacted] portable AC unit not working, 5/30/19, room [redacted] Air not working very hot, 5/30/19, room [redacted] AC not working (Comments: compressor maybe cycling), 5/30/19, room [redacted] AC not working, 5/30/19, room [redacted] AC not working, 5/30/19, room [redacted] AC not working, 5/30/19, room [redacted] AC not working, 5/29/19, room [redacted] Air not working in room very hot, has been checked numerous times, still doesn't work. On the [redacted]	F 908		

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- 7/10/17, room [redacted] family states room is too hot, 7/10/19, room [redacted] air conditioner blowing warm air, 7/9/19, kitchen AC not turning on (Comments: pending), 6/7/19, room [redacted] portable AC disconnected, 6/6/19, room [redacted] need AC it very hot, 6/6/19, Dining room AC portable not working, 5/30/19, room [redacted] AC exhaust, 5/30/19, room [redacted] air conditioner blowing only hot air, 5/30/19, room [redacted] air conditioner blows only hot air, 4/8/19, room [redacted] air conditioner not working.

On the [redacted]. floor:
- 7/15/19, room # [redacted] air conditioner not working, 7/15/19, room [redacted] no air conditioning, 7/7/19, room [redacted] no air conditioning (Comments: in process of new units), 6/28/19, rooms [redacted] and [redacted], The air conditioner not working all came out warm air, 6/26/19, Day room the left hand side portable Air Condition Vent came out from window, 6/20/19, rooms [redacted] and [redacted] AC hose spewing water.

At 11:01 a.m. a review of the facility provided Purchase order dated 5/16/2019, reads in part; " 25 item # 14501 Model [redacted] console."
These were the New PTAC units that needed to be sent back.

During the exit on 7/16/2019, the surveyor asked the Admin. when the facility planned to repair and/or replace the non-functioning PTAC units. The Admin. did not answer the surveyor.

On 7/26/2019 (day 2) at 10:24 a.m., a request was made to the Admin. and Maintenance Director #2 (MD#2) to provide a list of all of the

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PTAC units in the building that are non-functioning and either in need of repair or replacement.

The MD#2 provided a copy of the facility lay-out for all 5 floors marking the areas where the non-functioning PTAC units are located. A review of the facility provided lay-outs identify the following areas as having non-functioning PTAC units:

On the 1st. floor:
- No PTAC unit inside the Residents family room, Resident rooms [redacted] and [redacted], and the [redacted] Day/Dining room has 5 non-functioning PTAC units and residents Bath/ Shower room and Exam room. There are 11 of 27 PTAC units identified by the facility as non-functioning on the [redacted].

On the 2nd. floor:
- Nurses station, Resident Bath/ Shower room, Resident rooms, [redacted] and 2 non-functioning PTAC units in the [redacted]. There are 20 of 42 PTAC units identified by the facility as non-functioning on the [redacted].

On the 3rd. floor:
- Residents Bath/ Shower room, Resident rooms, [redacted], and the [redacted] floor Day/Dining room has 3 non-functioning PTAC units. There are 18 of 42 PTAC units identified by the facility as non-functioning on the third floor.

On the [redacted]

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F 908	Continued From page 23 - Two (2) Residents Bath/ Shower rooms, Residents rooms [redacted], and the [redacted]. floor Day/Dining room has 3 non-functioning PTAC units. There are 16 of 42 PTAC units identified by the facility as non-functioning on the third floor. On the 5th. floor: - Two (2) Residents Bath/ Shower rooms, Resident [redacted] and the [redacted] Day/Dining room has 3 non-functioning PTAC units. There are 14 of 42 PTAC units identified by the facility as non-functioning on the [redacted]. At 3:22 p.m., during an interview with the Admin., the surveyor asked what is the facility plan was if it gets hotter or other PTAC units fail to function properly. The Admin said they would get more PAC units around the rooms. The facility has a total of 79 of 195 PTAC units that are non-functioning. N.J.A.C. 8:39 -31.2 (e).	F 908		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060408	A. BUILDING: _____ B. WING _____	C 08/02/2019

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S1680	8:39-25.2(b)(1)&(2) Mandatory Nurse Staffing (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a) above) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day	S1680		10/2/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/19/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060408	A. BUILDING: _____ B. WING _____	C 08/02/2019

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S1680	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on review of staffing schedules provided by the facility for the week of 9/2/18, it was determined that the facility failed to provide at least the minimum staffing to meet the nursing staffing requirements for 1 of 7 days. This deficient practice was evidenced by the following: For the week of 9/2/18 Required staffing hours: 550.50 Date Actual Staffing Hours Difference 9/2/18 504 -46.50 In a post survey email on 8/16/19 at 12:56 p.m., the staffing coordinator stated: "If and when we are short, during the week, the on call manager will stay...If it falls on the weekend, on call will come in."	S1680	S1680 Failure to maintain mandatory Nurse staffing 1. There were no Residents affected by the deficient practice with mandatory nurse staffing. 2. All Residents at the facility had the potential to be affected by the deficient practice with mandatory nurse staffing. Facility will review and calculate and ensure mandatory nurse staffing is met 3. All Unit Managers and Staffing Coordinator will be re-educated on proper documentation/ calculation of all acuities to assure mandatory nurse staffing is met 4. DON or Designee will ensure all Unit managers and Staffing Coordinator is re-educated on proper documentation/calculation of all acuities. Also, DON or Designee will review acuities and ensure required staffing is in place. The results will be reviewed and presented during QAPI.	