STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315427	A. BUILDING _____ B. WING _____	C 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT PITMAN	535 N OAK AVE PITMAN, NJ 08071

(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 in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint NJ #: 00161215 Survey Date: 7/14/23 Census: 59 Sample: 15 + 2 closed records 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 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	F 623		8/3/23

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

Electronically Signed | 08/03/2023

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F 623	Continued From page 1	F 623		

paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal

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F 623	Continued From page 2	F 623		

hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).

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F 623	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to notify a representative from the Office of the State of Long-Term Care Ombudsman about a resident's emergency transfer to the hospital. This deficient practice was identified for 1 of 1 resident, (Resident #16) reviewed for hospitalization as was evidenced by the following: On 07/06/23 at 10:51 AM, during the initial tour the surveyor observed Resident #16 sitting in a wheelchair in their room. At that time, the surveyor interviewed Resident #16 who stated that he/she was doing good and had no concerns. A review of the progress note dated 04/19/23 at 21:54 (9:54 PM), reflected that Resident #16 was sent to the hospital and admitted with a diagnosis of NJ EX Order. 264b1 and NJ EX Order. 264b1 A review of the facility's Notice of Emergency Transfer signed by a nurse dated NJ EX Order. 264b1, revealed that the resident was sent out to the emergency room on NJ EX Order. 264b1 for NJ EX Order. 264b1. A further review revealed, "1. A copy of this notice must be provided to the resident/resident representative, as well as the Office of the Ombudsman." A review of the resident's medical records and pertinent facility documents reflected that there was no documentation that a representative from the Office of the New Jersey Long-Term Care Ombudsman was notified in writing regarding the	F 623	1.Resident #16 returned to the community with no negative outcome from the cited practice. A late transfer/discharge notification has been completed and sent to the ombudsman office and the resident□s representative. A faxed confirmation has been placed in binder. The interim Social Worker and nursing staff was provided immediate education upon the surveyor□s communication of concerns. 2.All residents emergently transferred out to the hospital have the potential to be affected by this cited practice. An audit was completed on all residents emergently transferred out to the hospital in last 6 months and any issues identified were immediately corrected. 3.The license nursing staff and the newly hired social worker will be provided with inservice education on the community□s discharge and transfer policy and notification requirements upon a resident□s transfer to the hospital. All transfers to the hospital will be reviewed the next business day in the morning stand up meeting to ensure a copy of the Notice of Transfer/Discharge has been completed timely to the ombudsman and resident representative. Ongoing education will be provided during onboarding of any newly hired licensed nursing staff or social worker to ensure compliance. 4.The Healthcare director will conduct a quality monitoring audit of written notifications to the ombudsman and	

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F 623	Continued From page 4 hospitalization. On 07/07/23 at 12:30 PM, the surveyor inquired about the notification of the emergency transfer to the hospital for Resident #16. At that time, the Licensed Nursing Home Administrator (LNHA) stated that the notification to the Ombudsman's office was not completed for the resident. On 07/10/23 at 10:17 AM, in the presence of the LNHA, the surveyor interviewed the Social Worker (SW) who stated that she started her position at this facility last NJ EX Order. 264b1, but had worked as a SW prior. The surveyor continued to interview the SW who stated that when a resident was transferred out to the hospital, there was an assessment that should have been filled out by social services and then sent out to the family and the Ombudsman's office. She explained the assessment form was the Notice of Emergency Transfer and that the form documented the reason for the transfer. The SW stated that it was important that the form was completed and sent to the family representative to ensure the family knew of the transfer, and to the Ombudsman's office to see if there was anything that needed to be followed up on. On 07/10/23 at 10:20 AM, the surveyor continued the interview and the LNHA stated that for a while they did not have a SW and that the facility had to utilize the Assisted Living (AL) SW. The LNHA further stated that the AL/SW had covered for three (3) months from April to June of 2023. When asked who was responsible for ensuring the notification was sent out, the LNHA stated that the SW was responsible for sending out the notifications. At that time, both the SW and the LNHA acknowledged that the notice of transfer	F 623	resident representative following an emergent discharge to the hospital weekly x 4 weeks then monthly x 3 months. Findings will be corrected immediately as indicated and reported to the Healthcare director and reviewed with the Nursing Home Administrator in the quarterly QAPI (Quality Assurance Performance Improvement) committee meeting. Monitoring audit schedule will be modified as warranted based on the findings.	

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should have been completed.

On 07/10/23 at 10:44 AM, the surveyor interviewed the Registered Nurse (RN) who stated that when a resident was transferred to the hospital the form called Notice of Emergency Transfer should have been completed. She explained that with their old Electronic Medical Record (EMR) it was easier to know what needed to be completed but in NJ EX Order. 264b1 they switched over to a new EMR and they were learning the new system and "honestly forgot about it" because it did not remind them that it needed to be completed like the old system. The RN stated that they started the form and gave it to the SW to be completed. She further stated that if they forgot, the SW would also remind them that it needed to be started. The RN then stated that since they did not have a full time SW for a while, they "simply forgot that it needed to be done and were just reminded on Friday NJ EX Order. 264b1 that it should be getting done."

On 07/11/23 at 12:13 PM, in the presence of the Acting Director of Nursing (DON), the Infection Preventionist (IP), the Contracted Administrator and the survey team, the surveyor interviewed the LNHA who stated that the Notice of Emergency Transfer form was completed and the family was notified but "it was missed a few times" and that it was not sent to the Ombudsman's office. She further stated that the SW was responsible for sending the form to the Ombudsman's office and that it should have been sent out the next day or within the next few days. The LNHA stated that the AL/SW was not educated on notifying the Ombudsman's office of the emergency transfer. The LNHA acknowledged that a notification of the emergency transfer was not sent out and that it

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F 623	Continued From page 6 should have been sent to the NJ Ombudsman Office. A review of the facility's, "Discharge and Transfers Policy," revised 07/10/23, included, "Written notice will be provided by nursing/social work to the NJ [New Jersey] OOIE (Office of the Ombudsman for the Institutionalized Elderly) of all emergency leave of absence (LOA)/transfer of residents to an acute care setting on an emergency basis. A copy of this notice must be provided to the resident/resident representative, as well as to the Office of the Ombudsman .... Confirmation of the fax transmission to the ombudsman shall be noted in the resident's chart ... ...A copy of the notices for Emergency Transfers to the hospital may be sent when practicable to the office of ombudsman on a monthly basis as long as list meets requirements. List of all discharges and leave of absences must be sent to the NJ Ombudsman office monthly via fax or email by the social worker/designee of each community." NJAC 8:39-4.1(a)(32)	F 623		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation it was determined that the facility failed to accurately complete the Minimum Data Set (MDS), an assessment tool utilized to facilitate	F 641	1. Resident #9, Resident #22, Resident #43, Resident #44, Resident #46, Resident #56, and Resident #65 remain the community and had no adverse outcome from this cited practice. A	8/3/23

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F 641	Continued From page 7 the management of care for 7 of 17 residents, (Resident #9, #22, #43, #44, #46 #56, and #65) reviewed for accurately coding the MDS. This deficient practice was evidenced by the following: 1.) On 07/07/23 at 12:04 PM, the surveyor observed Resident #9 in the main dining room on the NJ EX Order floor seated next to other residents. The resident was unable to tell the surveyor how long he/she resided at the facility but told the surveyor that he/she used to NJ EX Order. 264b1 and took care of many different NJ EX Order. 264b1 The surveyor reviewed the medical record for Resident #9. A review of the residents Admission Record (an Admission Summary) indicated that the resident had resided at the facility since NJ EX Order and had diagnoses which included but were not limited to NJ EX Order. 264b1 NJ EX Order. 264b1 NJ EX Order A review of Resident #9's quarterly MDS dated NJ EX Order. 264b1, revealed that Section NJ EX Order. 264b1 NJ EX Order. 264b1 and Section NJ EX Order. 264b1 were not completed. On 07/10/23 at 11:14 AM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who told the surveyor that she regularly took care of the resident, and the resident was NJ EX Order. 264b1 with NJ EX Order. 264b1. The CNA further stated that the resident's NJ EX Order was NJ EX Order and the resident was NJ EX Order when she provided care to the resident.	F 641	modification of the quarterly MDS assessments identified were completed for Resident #22 on NJ EX Order. 264b1 and Resident #46 on NJ EX Order. 264b1 upon the surveyor notification of concern. Residents #9, #43, #44, #56, #65 had a MDS assessment modification completed NJ EX Order. 264b1 on the quarterly MDS assessments identified by the surveyor. The interim social worker will be provided inservice education on timely completion of the MDS. 2. All residents have the potential to be affected by this cited practice. An MDS assessment audit was completed for the May, June, and July MDS assessment schedule look back period to ensure compliance. Issues identified were immediately corrected with a modified MDS assessment completed. 3. The social workers who are responsible for completing section NJ EX Order. 264b1 of the MDS assessment will be provided inservice education which include a review of the RAI (Resident Assessment Instrument) user manual section NJ EX Order. 264b1 with emphasis on the importance of timely completion and accuracy of the MDS (Minimum Data Set) assessment by the Medicare Reimbursement Specialist. The Medicare Reimbursement Specialist will also provide inservice education on Section NJ EX to the MDS coordinator. Prior to closing the MDS assessment, the MDS coordinator will validate the accuracy of section NJ EX Order. 264b1 The MDS coordinator will continue to provide a monthly MDS schedule to the social work and interdisciplinary team and will notify the	

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F 641	Continued From page 8 On 07/12/23 at 9:29 AM, the surveyor interviewed the residents Licensed Practical Nurse (LPN) who stated that the resident was NJ EX Order. 264b1 to NJ EX Order. 264b1 with NJ EX Order. 264b1 at times. The LPN further stated that the resident's NJ EX Order. was NJ EX Order, and she was not involved in completing the MDS. On 07/12/23 at 9:47 AM, the surveyor interviewed the Minimum Data Set Coordinator (MDS/C) who stated that, "everything fell apart in March" because there was no long-term care Social Worker (SW) available to complete the MDS's at that time. The MDS/C told the surveyor that the SW from the communities Assisted Living facility was helping complete the MDS's for the residents and she had minimal experience doing so. The MDS/C further stated that Section NJ E and Section NJ E of the resident's MDS were not completed, and it should have been. The MDS/C told the surveyor that accurate completion of the MDS helped facilitate the management of care for the resident and it was important to fill the information out correctly because it guided in the development of the resident's care plan. 2.) On 07/07/23 at 11:27 AM, the surveyor observed Resident #46 sitting in his/her room in a NJ EX Order. 264b1, completing a word search. The resident stated that everything was great, and he/she liked living at the facility. The surveyor reviewed the medical record for Resident #46. A review of the resident's Admission Record reflected that the resident resided at the facility since NJ EX Order. 264b1 and had diagnoses which	F 641	Healthcare Director immediately when section NJ EX Order. 264b is not timely completed to ensure compliance. Continued non-compliance will result in corrective disciplinary action. 4. A MDS validation audit will be completed by the Medicare Reimbursement Specialist during the scheduled MDS (Minimum Data Set assessment) look-back period to ensure accuracy of Section NJ EX Order. 264 and Section NJ E and NJ E for 100% completion weekly x 4 weeks, then will complete a MDS validation audit of 50% scheduled MDS assessments completed weekly x 2 months. Findings will be reported to the Healthcare Director/Nursing Home Administrator and reported to the quarterly QAPI (Quality Assurance Performance Improvement) committee to ensure compliance is sustained ongoing and to determine the need for further monitoring and corrective action as warranted.	

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F 641	Continued From page 9 included but were not limited to [redacted]. A review of the [redacted] and [redacted] 3 Order Summary Report did not reflect a physcian's order for the use of an [redacted] medication. A review of the resident's quarterly MDS dated [redacted], reveled in Section [redacted] Antipsychotic Medication Review that the resident had a gradual dose reduction of an [redacted] medication when the resident had never been prescribed or administered an [redacted] medication. On 07/12/23 at 9:33 AM, the surveyor interviewed the resident's LPN who stated the resident was [redacted], and [redacted] with minima[redacted]. The surveyor reviewed the resident's medications in the presence of the LPN who stated that the resident was receiving an [redacted] medication, not an [redacted] medication. The LPN told the surveyor that to her knowledge, the resident had never been perscribed an[redacted] medication. On 07/12/23 at 9:37 AM, the surveyor interviewed the MDS/C who stated that in [redacted], the facility eliminated the MDS Coordinator position, and she took on a new role with MDS at the facility which made her responsible for only competing the Medicare portion of the MDS's with the assistance from the Regional MDS Coordinator. The surveyor reviewed Resident #46's quarterly MDS dated [redacted], in the presence of the MDS/C who stated that the	F 641		

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resident was never on an NJ EX Order. 264b1 medication and the MDS had been coded inaccurately.

On 07/14/23 at 10:58 AM, the surveyor interviewed the facility's Licensed Nursing Home Administrator (LNHA) who stated that the MDS's were missed.

3.) On 07/06/23 at 10:55 AM, the surveyor observed Resident #44 resting in his/her NJ EX Order. 264 NJ EX Orde. Resident #44 stated that he/she wasn't feeling well but had informed the nurse and that the nurse was getting his/her medication. The resident stated they had a history of NJ EX Ord but that the staff was good at assessing and providing care to them.

According to the Admission Record, Resident #44 had diagnoses which included, NJ EX Order. 264b1 .

Review of Resident #43's quarterly MDS dated NJ EX Order. 264b1 revealed that Section NJ EX O NJ EX Order. 264b1 NJ EX Order. 264b and Section NJ EX - NJ EX Order. were not completed.

On 07/10/23 at 10:17 AM, the surveyor interviewed the SW in the presence of the LNHA who stated that she started her position at this facility last Wednesday NJ EX Order. 264b1 but has worked as a SW prior.

On 07/10/23 at 10:20 AM, the surveyor continued the interview and the LNHA stated that for a while they did not have a SW and that the facility had to utilize the Assisted Living SW. The LNHA further stated that the Assisted Living SW had covered for three NJ EX O months from NJ EX Order. 264b1 .

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F 641	Continued From page 11 On 07/11/23 at 10:38 AM, the surveyor and the MDS/C reviewed the MDS for Resident #44. At that time, the MDS/C confirmed Section [redacted] and Section [redacted] of the resident's quarterly MDS dated [redacted], were not assessed. She stated that she signed off on it but that indicated "it was completed but not accurate." She stated that it was important for the MDS to be accurate and complete because "it showed a clear and concise record of the resident." The MDS/C acknowledged that the quarterly MDS for Resident #44 should have been completed accurately. 4.) On 07/06/23 at 11:10 AM, the surveyor observed Resident #56 resting in bed with his/her eyes closed. According to the Admission Record, Resident #56 had diagnoses which included, [redacted] Review of Resident #56's quarterly MDS dated 04/07/2023, revealed that Section [redacted] and Section [redacted] were not completed. On 07/11/23 at 10:40 AM, the surveyor and MDS/C reviewed the MDS for Resident #56. At that time, the MDS Coordinator confirmed Section [redacted] and Section [redacted] of the resident's quarterly MDS dated [redacted], were not assessed. She acknowledged that the quarterly MDS for Resident #56 should have been completed accurately. 5.) According to the Admission Record, Resident #22 had diagnoses which included, but were not	F 641		

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limited to, NJ EX Order. 264b1 .

Review of Resident #22's quarterly MDS dated NJ EX Order. 264b1, revealed that Section NJ - NJ EX Order. 264b1 NJ EX Order. 264b1 and Section NJ EX Order. 264b1 were not completed.

On 07/11/23 at 10:15 AM, the surveyor interviewed the CNA who stated Resident #22 was NJ EX Order. 264b1, and was typically in a NJ EX Order. 264b1.

On 07/11/23 at 10:21 AM, the surveyor interviewed the Registered Nurse (RN) who stated Resident #22 was NJ EX Order. 264b1 NJ EX Order. 264b1 and NJ EX Order. 264b1 and was typically NJ EX Order. 264b1 and NJ EX Order. 264b1

6.) According to the Admission Record, Resident #43 had diagnoses which included, but were not limited to, NJ EX Order. 264b1

Review of Resident #43's quarterly MDS dated NJ EX Order. 264b1, revealed that Section NJ EX Order. 264b1 NJ EX Order. 264b1 and Section NJ EX Order. 264b1 were not completed.

On 07/11/23 at 10:15 AM, the surveyor interviewed the CNA who stated Resident #43 was NJ EX Order. 264b1 and had NJ EX Order. 264b1.

On 07/11/23 at 10:21 AM, the surveyor interviewed the RN who stated Resident #43 was NJ EX Order. 264b1 only and had NJ EX Order. 264b1 NJ EX Order. 264b1

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F 641	Continued From page 13 7.) According to the Admission Record, Resident #65 had diagnoses which included, but were not limited to NJ EX Order. 264b1. Review of Resident #65's admission MDS dated NJ EX Order. 264b1, revealed that Section NJ EX Order. 264b1 NJ EX Order. 264b1 and Section NJ EX Order. 264b1 were not completed. On 07/11/23 at 10:15 AM, the surveyor interviewed the CNA who stated Resident #65 was NJ EX Order. 264b1 and was typically in a NJ EX Order. 264b1 NJ EX Order. 264b1. On 07/11/23 at 10:21 AM, the surveyor interviewed the RN who stated Resident #65 was NJ EX Order. 264b1 only and was typically in a NJ EX Order. 264b1. On 07/11/23 at 10:32 AM, the surveyor interviewed the MDS/C who stated that the SW was responsible for completing Section NJ EX Order. 264b1 of the MDS, however, the facility did not have a designated SW since NJ EX Order. 264b1 and the SW from the Assisted Living facility was assisting the facility during the vacancy. The MDS/C further stated that a nurse could complete Section NJ EX Order. 264b1 and NJ EX Order. 264b1 of the MDS if the SW was unavailable, and that staff interviews could be conducted to compete the sections if the resident was not able to be interviewed. The MDS/C also explained that the importance of a complete and accurate MDS was to "show a clear and concise record of the resident." The surveyor and the MDS/C reviewed the aforementioned MDS assessments for Resident #22, #43, and #65 and the MDS Coordinator verified that Sections NJ EX Order. 264b1 should have been completed.	F 641		

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F 641	Continued From page 14 On 07/11/23 at 12:18 PM, in the presence of the survey team, the surveyor interviewed the Director of Nursing (DON) who stated that she expected her staff to complete MDS assessments in their entirety. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI Manual), dated October 2018, included in Section C: Cognitive Patterns, "Attempt to conduct the interview with ALL residents," and, "Determine if the resident is rarely/never understood ... If rarely/never understood, skip to ... Staff Assessment of Mental Status." Further review of the RAI Manual included in Section D: Mood, "Attempt to conduct the interview with ALL residents," and, "Determine whether the resident is rarely/never understood ... If rarely/never understood, skip to ... Staff Assessment of Mental Status." A review of the facility's MDS Coordinator Job Description revised [redacted] indicated that the MDS Coordinator was responsible for, "the accurate and timely completion of all Resident Assessment Instrument documents as required by regulatory agencies. Conducts concurrent MDS review to assure it accurately reflects resident status and maximize reimbursements for Medicare A residents. Monitors the overall process and tracking of RAI/MDS documentation and transmission. The Coordinator will ensure timely, accurate and complete assessment of the resident's health ad functional status during the entire assessment period. He/she will integrate nursing, dietary, social recreation, restorative, rehabilitation and physician services to ensure appropriate reimbursement for Medicare/Medicaid residents."	F 641		

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F 641	Continued From page 15 A review of the Facility's Resident Assessment Instrument (RAI) MDS Completion Policy and Procedure last approved and dated 7/11/23, indicated, "The Resident Assessment Instrument otherwise referred to as the MDS shall be completed in accordance with the Rules and Regulations set forth in Section 1819(f) (6) (A_B) for Medicare and the 1919 (f) (6) (A-B) for Medicaid in the Social Security Act, As amended by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987)." The facility's Resident Assessment (RAI) MDS Completion Policy and Procedure further indicated that the MDS's purpose was an assessment tool that the facility utilized to identify resident care problems which could be addressed in the residents individualized care plan. NJAC 8:39-11.1	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to provide nail care to a resident that was dependent on the staff for activities of daily living. This deficient practice was identified for 1 of 2 residents, (Resident #3) reviewed for Activities of Daily Living (ADLs) and was evidenced by the following:	F 677	1. Resident #3 remains in the community and [redacted] care was provided on [redacted] The interim Director of Nursing will follow up with the individual staff identified as CNA#1 and CNA #2 caring for the resident and will provide education on Resident #3 plan of care and education counseling regarding ADLs with emphasis on [redacted] care.	8/3/23

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F 677	Continued From page 16 On 07/06/23 at 11:02 AM, the surveyor observed Resident #3 lying in bed. The resident's NJ EX Ord were observed to be NJ EX Order. 264b1 under them and NJ EX Order on the NJ EX Order. 264b1 were observed to be NJ EX Order. 264b1, and NJ EX Order 26 On 07/07/23 at 10:33 AM, the surveyor observed the resident lying in bed, dressed, clean and appeared comfortable. The surveyor observed that the residents NJ EX Order on NJ EX Order NJ EX Order were NJ EX Order NJ EX Order 2 and some were NJ EX Order. 264 The resident was pleasant and NJ EX Order. 264b0 to specific details regarding time and place. The resident stated that his/her NJ EX Order. 264 was not what it used to be. The resident showed the surveyor his/her NJ EX Order 2 and when the surveyor asked the resident the last time, he/she had their NJ EX Order. 264b the resident stated that he/she did not know when the last time that their NJ EX Ord were cut but that "they were a mess". The surveyor asked the resident if he/she would like his/her NJ EX Order. 264b1 and cleaned and the resident stated, "Sure." On 07/07/23 at 10:40 AM, the surveyor interviewed the Certified Nursing Assistant (CNA #1) and asked the CNA if ADLs were performed for Resident #3, and she stated that ADLs were performed that morning and the resident was washed and dressed but did not want to get out of bed. The CNA then got called to another room and could not be further interviewed that that time. On 07/07/23 at 10:59 AM, the surveyor interviewed CNA #2 who stated that she had been employed through the agency and added that she worked at the facility frequently and was familiar with Resident #3. CNA #2 stated that	F 677	2. All residents with NJ EX Order. 264b1 and that require assist with their ADLs have the potential for this cited practice. A NJ EX Ord inspection was completed on all residents and no other residents were identified to require NJ EX Ord care. 3. Inservice education will be provided to current license nurses and certified nursing aides on the community□s nail care policy with emphasis on the proper inspection of NJ EX Ord with morning and evening resident care by the director of nursing and staff resident service educator. NJ EX Ord care will be added to the point of care documentation for the certified nursing assistance to ensure completion and compliance. The nurse mentor during business days will review the point of care report for completion of NJ EX Ord care on all residents that require assist with ADLs. On scheduled shower days, the charge nurse and the household coordinator will be responsible to check NJ EX Order. 264b1 and that NJ EX Ord care has been provided. Nails requiring care will be provided NJ EX Ord care timely by the direct caregiver. Based on findings, corrective disciplinary action will be provided as warranted. As part of the onboarding of new hired nursing staff, education on NJ EX Ord care will be provided to ensure compliance. 4. The Director of Nursing and/or the nurse mentor will randomly inspect NJ EX Ord of 10% of the resident population 2x per week for 4 weeks, then weekly x1 month and then monthly x 3 months. Results will be reported to Healthcare Director and Nursing Home Administrator and reviewed	

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F 677	Continued From page 17 when she performed ADLs, the resident was washed and dressed. She stated that Resident #3 preferred to wear pajamas and refused to get out of bed. She also added that the resident was incontinent and wore protective briefs for vanity and hygiene. She stated that all residents in the facility were provided with baths or showers twice a week. She stated that residents had the option of having a bath or a shower. She stated that baths were put on the schedule every morning. She further stated that CNAs cleaned the resident hands, but did not NJ EX Order. 264b1. CNA #2 told the surveyor that "the nurses do that". She explained that NJ EX Order were done in activities where the residents NJ EX Order were filed and painted. She stated that the staff did not touch the NJ EX Order. 264b1. On 07/07/23 at 11:10 AM, the surveyor observed residents in the activities room and the Activities Assistant (AA) was NJ EX Order. 264b1 resident NJ EX Order. The AA explained to the surveyor that resident NJ EX Order were filed and painted every Friday by the AA in the activity room. She also stated that the AA were not allowed NJ EX Order the resident NJ EX Order and that it was the responsibility of the nurses to cut the resident NJ EX Order. She continued to explain that she made rounds in the morning to visit every resident in their room to find out if they needed anything. She stated at that time, she would inform the residents that she was NJ EX Order and NJ EX Order. 264b1. She stated that if a resident was not able to leave their room and wanted their NJ EX Order done, she would go to the resident's room and NJ EX and NJ EX Order their NJ EX Order. On 07/10/23 at 11:30 AM, the surveyor observed Resident #3 in bed. The resident showed the surveyor his/her hands and the residents NJ EX Order continued to be NJ EX Order, some were observed	F 677	in the quarterly QAPI (Quality Assurance Performance Improvement) committee. Nail inspection will continue until substantial compliance is met with corrective action as warranted.	

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NJ EX Order. 264b1 with NJ EX Order. 4J EX Order. 264b1. CNA #3 was in the hallway and the surveyor conducted an interview with her at that time. CNA #3 stated that the resident always had NJ EX Order. 264b1 however they should not be NJ EX Order. 264b1. The CNA went to the nurse and asked the Licensed Practical Nurse (LPN) if she could cut Resident #3's NJ EX Order. The LPN stated that there was a change in the NJ EX Or policy and that resident nails were not to be cut only filed. The LPN stated that the CNAs that had been caring for Resident #3 should have told the nurse that the resident's NJ EX Order. were NJ EX Order. 26 or NJ EX Order. 2 so that the nurse could have NJ EX Order. them.

On 07/11/23 at 10:12 AM, the surveyor attempted to telephone interview the Responsible Party (RP). There was no answer, so the surveyor left a message.

On 07/11/23 at 10:16 AM, the surveyor interviewed the Registered Nurse Unit Manager (RN/UM) who stated that she had been employed in the facility for approximately six years. She stated that NJ EX Or care was part of showering or bathing, and NJ EX Order. care should be done "on a needed basis." She stated that the NJ EX O care process included cleaning and NJ EX Order. 264b1. She continued to add that residents' NJ EX Order. were a part of the ADLs that were performed daily.

On 07/11/23 at 10:26 AM, the surveyor interviewed the Household Coordinator who identified herself as the lead CNA. The lead CNA stated that she saw Resident #3's NJ EX Order. and agreed that the NJ EX Order. needed to be NJ EX Order. and NJ EX Order. 264b1. She stated that she NJ EX Order. 264b1 the resident's NJ EX Order. as much as the resident would allow her to do. She stated that she educated the CNAs on proper NJ EX Or care. She added that she

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F 677	Continued From page 19 would continue to check on Resident #3's [redacted] and would [redacted] the resident's [redacted] if the resident allowed her to do so. On 07/11/23 at 12:16 PM, the surveyor interviewed the Acting Director of Nursing (DON) who stated that resident [redacted] should be observed daily to assure that they were [redacted]. The DON stated that residents were bathed two times a week and that their [redacted] should have been cleaned and [redacted] during bath time. The DON stated that she would provide the [redacted] care policy to the surveyor. The surveyor reviewed the medical record for Resident #3. According to the Admission Record, Resident #3 was admitted to the facility with diagnoses that included but were not limited to [redacted]. The quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted], indicated that Resident #3 had [redacted] and required [redacted] with activities of daily living. The surveyor reviewed Resident #3's Care Plan (CP) which indicated that the resident had a [redacted] related to [redacted] The CP was initiated on [redacted] and was revised on [redacted] The CP indicated that the resident required [redacted] with personal hygiene.	F 677		

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F 677	Continued From page 20 On 07/12/23 at 8:52 AM, the surveyor was provided with a copy of Resident #3's CP. A further review of the care plan included an intervention for ADLs dated [NJ EX Order. 264b1], that indicated that the resident would have their [NJ EX Order. 264b1] and [NJ EX Order. 264b1] on bath days (Monday and Thursday on the 6:00 AM - 2:00 PM shift). On 07/14/23 at 10:30 AM, the DON did not have any additional information to provide. The facility policy, "Resident Nail Care," with a last revised date of 07/11/23, indicated that residents would receive nail care when needed to maintain good grooming, hygiene, and skin integrity. The policy also indicated that the purpose for [NJ EX Order. 264b1] was to help a prevent the spread of infection, prevent bodily injury, maintain integrity of the nail and to prevent the accumulation of dirt and microorganism NJ EX Order. 264b1. The policy also indicated that resident [NJ EX Order. 264b1] are to be kept short and were to be inspected on bath/shower days and file the nails often.	F 677		
F 812 SS=E	NJAC 8:39-27.1(c),27.2 (g) 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	F 812		8/3/23

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F 812	Continued From page 21 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation it was determined that the facility failed to: a.) properly handle and store potentially hazardous foods in a manner that is intended to prevent the spread of food borne illnesses and b.) maintain kitchen utensils in a manner to prevent microbial growth and cross contamination. This deficient practice was evidenced by the following: On 07/06/23 from 9:11 AM to 9:45 AM, the surveyor, accompanied by the Executive Chef (EC), observed the following in the kitchen: In the dry storage room: 1.) There was a rolling metal cart that contained 12 plastic-wrapped, circular baked items, that the EC identified as apple cakes, with no label or date. The EC stated they were made today and were good for three days. The EC further stated they should be labeled with today's date and the use-by date.	F 812	1. No residents were identified for this cited practice. Upon awareness of the surveyor observations, all outdated food items were immediately discarded. All Food items without labels, expired use by dates, or incomplete labels were also immediately discarded. All food items identified by the surveyor on the middle shelf with liquid spillage were discarded immediately, the ice cream was discarded, and the ice scoop was washed and properly stored. Corrective action will be provided to the production and food handling staff responsible for proper labeling and storing of food items. 2. All residents that receive food from the kitchen have the potential to affected by this cited practice. All food in the main kitchen has been inspected to ensure proper labeling, dating, expirations. Issues identified were immediately corrected. 3. Inservice re- education on the community□s policy on Date Marking Ready to Eat TCS/PHF Foods, the In Use Utensil, Between Use Storage policy, and the Preventing Cross Contamination	

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F 812	Continued From page 22 In the main kitchen walk-in refrigerator: 2.) On a middle shelf, there was a plastic-wrapped metal container of strawberries with a use-by date of 07/04/23. The EC threw away the strawberries. 3.) On a cart, there was a plastic-wrapped metal container of salad mix. The label was incomplete, and the EC was unable to determine the use-by date. The EC threw away the salad mix. 4.) On a middle shelf, there was a plastic-wrapped metal container of meat, that the EC identified as NJ Ex Order 204(b) ham. There was orange-tinted clear liquid pooled on top of the plastic wrap. The EC stated the liquid was possibly drippings from a metal container on the shelf above. The EC threw away the NJ Ex Order 204(b) ham. 5.) On a middle shelf, there was a plastic-wrapped metal container of liquid, that the EC identified as shrimp scampi sauce with a use-by date of 07/05/23. The EC threw away the shrimp scampi sauce. 6.) On a top shelf, there was a plastic-wrapped metal container of meat, that the EC identified as sausage. There was clear liquid pooled on top of the plastic wrap. The EC stated he did not know where the liquid came from and threw away the sausage. In the outside walk-in freezer: 7.) On a middle shelf, there was plastic-wrapped open bag of frozen pierogis that was not labeled	F 812	policy will be provided to the production and food handling dietary staff with strong emphasis on dating, labeling, discarding, and proper storage of ice cream scoops. The Food Service Director will implement a competency checklist with the production and food handling staff and with new hires to ensure staff compliance and understanding of food storage including labeling, dating, removing expired food items, and proper storage of ice scoops. The Utility, Cook and Homemaker duties inspection checklist will be revised to ensure compliance of labeling, dating, and removing expired food items. Additional ice cream scoops have also been purchased with a new process implemented to place the used ice cream scoop in the dirty dish bin immediately after use and to utilize a clean scoop as needed to ensure compliance. 4. A random kitchen inspection audit will be completed by the Dietician, and the General Manager daily to check on food labeling, expiration and storage, and ice cream containers x 4 weeks, and then weekly x 4 weeks, and then monthly to ensure on going compliance. Any deficient practices identified through these audits will be followed up on with corrective action and re-education. Findings will be reported at the daily Stand-Up Meeting with the healthcare director and reviewed with the Nursing Home Administrator in the quarterly QAPI (Quality Assurance Performance Improvement) committee meetings. This will continue until substantial compliance	

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	315427	A. BUILDING _____ B. WING _____	C 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT PITMAN	**535 N OAK AVE PITMAN, NJ 08071**

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F 812	Continued From page 23 with an open or use-by date. The EC removed the bag of frozen pierogis. On 07/07/23 at 11:29 AM, the surveyor, accompanied by the Area Manager (AM), observed the following in the [redacted] Floor Dining Room: In the top drawer of a cabinet: 8.) There was an open package of hamburger buns that was re-sealed with a plastic twist tie that was not labeled. The AM stated the dietary staff followed the manufacturer's date on the bread packaging. The manufacturer's use-by date was 07/05/23. The AM threw away the hamburger buns 9.) There was an open package of rye bread that was re-sealed with a plastic twist tie with a use-by date of 07/03/23. The AM threw away the rye bread. 10.) There was an open package of club wheat bread that was re-sealed with a plastic twist tie with a use-by date of 07/03/23. The AM threw away the club wheat bread. In the ice cream freezer: 11.) There was an open container of ice cream without a lid. The AM stated there should be a lid covering the ice cream. 12.) There was metal container next to the freezer with an ice cream scoop that was submerged in a white, opaque liquid. The metal container was open and exposed to air. The AM stated the ice cream scoop must have been used	F 812	is met.	

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F 812	Continued From page 24	F 812		

between meal service and should have been sent down to the kitchen to be washed before the lunch service.

On 07/10/23 at 11:28 AM, the surveyor interviewed the Area General Manager (AGM) who stated that all prepared or opened food items should have been labeled with a "prep and print" label which included an open date, use-by date, the shelf life, and the name of the employee who printed the label. The AGM further stated that food items are checked daily for out-of-date items which are thrown away. When asked about the ice cream scoop kept in the dining room, the AGM stated that if the ice cream scoop was used outside of mealtimes, it should have been placed on the "dirty cart" to be brought to the kitchen for sanitization.

Review of the facility's kitchen Daily Cleaning Assignments, dated 07/08/23, included, "Check Walkins for Out of Date Product Daily."

Review of the facility's, "Date Marking Ready to Eat TCS/PHF Foods" policy, dated 04/01/22, included, "Refrigerated, ready to eat, TCS/PHF food prepared and held in a food establishment must be clearly marked with a consume by/discard date," and, "Food that is required to be date marked must be discarded if it: ... is in a container or package that does not bear a date or day."

Review of the facility's, "Preventing Cross Contamination" policy, dated 04/01/22, included, Packaged food may not be stored in direct contact with ice or water if the food is subject to entry of water because of the nature of its packaging, wrapping, or container," "Food must

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F 812	Continued From page 25 be covered/protected from environmental contamination during storage and transportation," and, "Utensils and equipment used for both raw and ready to eat foods must be cleaned and sanitized between uses." Review of the facility's In-Use Utensils, Between Use Storage policy, undated, included "During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored: ... In a clean, protected location." 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;	F 880		8/3/23

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F 880	Continued From page 26 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct 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.	F 880		

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F 880	Continued From page 27 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of facility documentation, it was determined that the facility failed to follow appropriate infection control practices for hand hygiene. This deficient practice was identified during a dining observation on 1 of 2 units, [redacted] floor dining room) and was evidenced by the following: On 07/07/23 the surveyor observed the following: At 12:09 PM, a Certified Nursing Aide (CNA) in the second floor dining room was handed a plate of food at the door of the kitchenette. The CNA held the plate with her thumb on top of the plate and her fingers on the bottom of the plate and served it to Resident #61. The CNA then went to the small refrigerator in the dining room and touched the door handle, then returned to the door of the kitchenette and was handed another plate of food. The CNA held the plate with her thumb on top of the plate and her fingers were observed on the bottom of the plate. The CNA served the plate to Resident #39. The CNA then went back and opened the small refrigerator with the door handle, removed a small foil wrapped butter, unwrapped the butter and handed it to Resident #61. The CNA then asked Resident #8 for a beverage choice, went to the beverage dispenser area, grasped a plastic cup, went to the counter area where there was a metal bin of ice covered with plastic wrap, removed the plastic wrap, grasped the handle of the scoop that was resting on the ice, filled the cup with ice, replaced the scoop back on the ice, and then replaced the	F 880	1. Residents #61 is no longer in the community. Residents #39, #8, remain in the community and were not adversely affected by this cited practice. Upon the surveyor notification, the CNA identified, was provided immediate education on appropriate meal hand hygiene when serving food and drinks to residents. A random hand hygiene competency will be completed on the same CNA identified during a meal service weekly x 2 weeks to ensure compliance. 2. All residents receiving meals and drinks from staff during mealtime have the potential to be affected by this cited practice. 3. The Director of Nursing and the Food Service General Manager will provide inservice education on proper meal hand hygiene when serving food and drinks to residents with return demonstration. The charge nurse and the nurse mentor will be assigned to observe serving of meals at mealtime to ensure compliance. On spot education and demonstration will be provided as needed. Meal hand hygiene education and competency will be included in onboarding of new nursing and agency staff to ensure compliance. 4. The Infection Preventionist will utilize a hand hygiene audit checklist tool and observe hand hygiene practices for 1 random staff member for 5 Days a week on various day and evening shifts x 4	

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F 880	Continued From page 28 plastic wrap over the ice. The CNA then filled up the cup with juice from the beverage dispenser and handed the cup to Resident #8. Upon resident request, the CNA then returned to the small refrigerator, opened the door, removed coffee creamer, and placed them on the table in front of Resident #58. There was no hand hygiene observed at any time during the surveyors observations. On 07/07/23 at 12:13 PM, the surveyor interviewed the CNA who acknowledged she did not perform hand hygiene when she served the residents in the dining room. She stated that hand hygiene should have been performed before and after serving each resident their plated food or drink. The CNA further stated that it was important to perform hand hygiene between each resident to prevent cross contamination. On 07/07/23 at 12:27 PM, the surveyor interviewed the second floor Registered Nurse (RN) and informed her of the dining room observation. The RN stated that the CNA did not perform hand hygiene correctly during meal pass and that the CNA should have performed hand hygiene between each resident, when handling the butter, when touching the refrigerator handle, and any time touching plated food. The RN stated that it was important to perform hand hygiene when food was served to decrease transmission of any infection. On 07/07/23 at 12:37 PM, the surveyor interviewed the second floor Unit Manager (UM) who stated that in the dining room, the homemaker prepared and plated the meals and handed them to the CNA who delivered the meal to the residents. She stated that hand hygiene	F 880	weeks during a mealtime. The observation will be to observe a staff member perform proper meal hand hygiene while passing meals and drinks to residents at mealtime to ensure that proper meal hand hygiene is practiced. The monitoring will continue until 4 consecutive weeks of Zero negative findings is achieved. Afterwards, 3 staff members will be monitored weekly for a Period of 2 months to ensure ongoing compliance. After that, one staff member will be monitored weekly x3 months. Findings will be reported to the Healthcare Director and reviewed with the Nursing Home Administrator in the quarterly QAPI (Quality Assurance Performance Improvement) committee meeting. Audits will be adjusted based on the outcomes until substantial compliance is met with corrective action as warranted.	

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should have been performed before the meal service and in between each resident's meal pass. The surveyor informed the UM of the CNA dining room observation. The UM acknowledged that the CNA did not perform hand hygiene correctly and that she should have washed her hands between residents, when she touched the refrigerator, and that she should have worn gloves when she touched the butter for the resident. The UM stated that it was important to perform hand hygiene correctly for the safety and wellbeing of the residents and the staff.

On 07/07/23 at 12:50 PM, the surveyor interviewed the Acting Director of Nursing (DON) who stated that in the dining room the homemaker plated the food, and the CNA served the residents. The DON stated that hand hygiene should have been performed in the dining room if the staff touched anything dirty before they touched anything clean. The surveyor informed the DON of the CNA dining room observation. The DON acknowledged that the CNA did not perform hand hygiene correctly and that she should have cleaned her hands after touching dirty areas such as the refrigerator handle. The DON stated that it was important to use proper hand hygiene when in the dining area for the prevention of sickness.

On 07/11/23 at 12:01 PM, the Licensed Nursing Home Administrator was made aware of the 07/07/23 [redacted] floor CNA dining room observation.

Review of facility documentation, "Orientation Competency Checklist-Healthcare CNA," signed and dated by the CNA on 04/27/23, revealed Hand Washing Competency with return

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demonstration, was completed on 04/27/23, and the Dining and Serving Process with lecture/discussion, was completed on 04/28/23. The Staff Development Coordinator signed and dated the document on 5/18/23.

Review of facility policy, "Hand Hygiene," last revised 03/23/2023, revealed, Purpose: To prevent the transmission of pathogenic micro-organism from resident to resident and from inanimate surfaces to residents by the hands of all healthcare providers.

Procedure: Clean hands before and after routine resident care activities, including entering and exiting the resident care areas and after hand-contaminating activities.
Hand hygiene should be done (even when gloves are used): Before and after contact with each resident. After contact with an inanimate object that is potentially contaminated. Before handling food or eating.

Indications for hand antisepsis with an alcohol based hand rub: After touching a patient or the patient's immediate environment.

Each associate must utilize the 5 moments of hand hygiene approach recommended to clean their hands: 5. After touching resident surroundings.

NJAC 8:39-19.4 (m)(n)

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	030801	A. BUILDING: _____ B. WING _____	C 07/14/2023

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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: Complaint # NJ00161215 The facility was 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. Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct	S 560	1. No residents were identified or affected by this cited practice. Efforts to hire community staff will continue until there is adequate staff to serve all residents. Until that time, community will utilize staffing agencies, offer overtime to community staff to fill any open spots in the schedule. 2. All residents have the potential to be affected by this cited practice. 3. Contracts with additional staffing agencies have been secured to supplement community staff. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listings, job fairs, shift differentials and referral bonuses are being utilized to become more competitive	8/3/23

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

Electronically Signed | 08/03/23

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S 560	Continued From page 1 care staff to resident ratios for the day shift, as mandated by the State of New Jersey. This deficient practiced was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 01/29/23 to 02/04/23, 02/12/23 to 02/18/23, 03/26/23 to 04/01/23, 04/16/23 to 04/22/23, 05/07/23 to 05/13/23, 06/18/23 to 06/24/23 and 06/25/23 to 07/01/23, the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift as documented below:	S 560	in the marketplace. Weekly recruitment meetings are ongoing with the management team and biweekly with the home office that includes the executive director, nursing home administrator and the associate resource director (Human Resource). Ongoing education will be provided to the staff regarding call offs and how it affects the community, the residents, and their peers by the resident service staff educator and the DON as needed. Managers to provide assist as applicable based on job training and qualifications to support nursing until staffing requirements are met. Staffing patterns will be reviewed in the daily stand up and shift report to ensure staffing patterns are at acceptable level. The administrator will communicate with families monthly to make them aware of staffing patterns and recruitment efforts until staffing stabilizes. License staff and certified nurse aides will be provided inservice education on the importance of communication and notifying the DON (Director of Nursing) or Administrator if they are unable document or to meet the needs of the residents related to staffing. The community census will be adjusted by suspending admissions temporarily to meet staffing requirements as needed. 4. The Administrator and the DON (director of nursing) will review staffing schedules daily as part of the daily standup meeting to ensure adequate staffing for all shifts. The administrator and the Associate Resource Director (HR) will continue to review recruitment and staffing weekly. This will remain an ongoing practice until staffing requirements are	

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S 560	Continued From page 2 1). For the week of Complaint staffing from 01/29/2023 to 02/04/2023, there were no deficient practices in staffing identified as submitted. 2). For the week of Complaint staffing from 02/12/23 to 02/18/23, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -02/12/23 had 6 CNAs for 62 residents on the day shift, required 8 CNAs. -02/13/23 had 6 CNAs for 62 residents on the day shift, required 8 CNAs. 3). For the week of Complaint staffing from 03/26/2023 to 04/01/2023, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -02/14/23 had 6 CNAs for 57 residents on the day shift, required 7 CNAs. 4). For the week of Complaint staffing from 04/16/2023 to 04/22/2023, there were no deficient practices in staffing identified as submitted. 5). For the week of Complaint staffing from 05/07/2023 to 05/13/2023, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -05/13/23 had 6 CNAs for 55 residents on the day shift, required 7 CNAs. 6). For the two weeks of staffing from 06/18/2023 to 07/01/2023 for the Standard survey the facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows: -06/20/23 had 6 CNAs for 59 residents on the day	S 560	maintained. The social worker will conduct a random resident satisfaction survey of care weekly x 1month and then monthly x 3 months and then quarterly as it relates to staffing challenges.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030801	A. BUILDING: _____ B. WING _____	C 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT PITMAN	535 N OAK AVE PITMAN, NJ 08071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3 shift, required 7 CNAs. -06/21/23 had 6 CNAs for 59 residents on the day shift, required 7 CNAs. -06/24/23 had 6 CNAs for 60 residents on the day shift, required 7 CNAs. -06/25/23 had 7 CNAs for 61 residents on the day shift, required 8 CNAs. -07/01/23 had 6 CNAs for 58 residents on the day shift, required 7 CNAs. On 07/13/23 at 11:10 AM, the surveyor interviewed the facility's Staffing Coordinator who stated the staffing requirements were 1 CNA for 8 residents on the 7:00 AM - 3:00 PM shift, 1 CNA for 10 residents on the 3:00 PM - 11:00 PM shift and one CNA for 14 residents on the 11:00 PM to 7:00 AM shift.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
030801 Y1	A. Building B. Wing Y2	8/15/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT PITMAN	535 N OAK AVE PITMAN, NJ 08071

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 08/03/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 7/14/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ **YES** ☐ **NO**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315427 Y1	A. Building B. Wing Y2	8/15/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT PITMAN	535 N OAK AVE PITMAN, NJ 08071

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 F0623	Correction	ID Prefix F0641	Correction	ID Prefix F0677	Correction
Reg. # 483.15(c)(3)-(6)(8)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.24(a)(2)	Completed
LSC	08/03/2023	LSC	08/03/2023	LSC	08/03/2023
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	08/03/2023	LSC	08/03/2023	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?
7/14/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
030801 Y1	A. Building B. Wing Y2	8/15/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT PITMAN	535 N OAK AVE PITMAN, NJ 08071

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 08/03/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
7/14/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO