STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315022	A. BUILDING _____ B. WING _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
MEADOW LAKES	**300 MEADOW LAKES EAST WINDSOR, NJ 08520**

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F 000	INITIAL COMMENTS Survey Date: 01/11/23 Census: 44 Sample: 34 + 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 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that a significant change assessment was completed for Resident #14, 1 of 15 residents reviewed for an evaluation of a significant change in the resident's condition. The deficient practice was evidenced by the following:	F 637	1. No harm reached Resident # 14 on the Quarterly MDS dated 11/11/22. The window for a resubmission of a corrected assessment have already lapsed. 2. All residents who have recent changes in the last 30 days have been reviewed to ensure all comprehensive assessments were communicated, implemented and assessed accurately.	2/3/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/03/2023

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F 637	Continued From page 1 The surveyor reviewed Resident #14's medical record and noted the following: According to the Face Sheet, Resident #14 was readmitted to the facility with diagnoses that included but were not limited to EX Order 26 § 4b1 [redacted] The Admission Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care, dated 08/11/22, revealed that the resident had a brief interview for mental status (BIMS) score of [redacted] which indicated that the resident was EX Order 26 § 4b1. The MDS showed that the resident NJ Exec. Order 26:4.b.1 [redacted] The Quarterly MDS, dated 11/11/22, revealed the resident had EX Order 26 § 4b1 [redacted] The resident was coded as [redacted] for walk-in room and corridor which meant that NJ Exec. Order 26:4.b.1. There was no documented evidence that a significant change assessment was initiated when a EX Order 26 § 4b1 were identified on the 11/11/22 assessment. During an interview with the surveyor on 01/10/23 at 11:44 AM, the Corporate MDS/Registered Nurse (CMDS/RN) stated that a Significant Change MDS (Sig change MDS) assessment	F 637	3. DON and designee with the MDS Nurse reviewed the RAI Comprehensive Assessment facility policy. All pertinent changes, including, but not limited to, improvements in condition, decline in condition and significant changes will be reviewed daily. Such changes will also be documented on the 24hour report. Clinical Team will review all changes related to residents daily at morning Clinical Meeting 1/18/23. 4. DON and designee with the MDS Nurse will conduct audits of RAI comprehensive assessments weekly x 4, then monthly x 3 then quarterly x 2. Results of audits will be submitted as a QAPI to ensure compliance and reassessed for further action until the quarterly review x 2 was accomplished.	

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F 637	Continued From page 2	F 637		

would be completed within 14 days of identifying the change in condition. The CMDS/RN further stated that a Sig change MDS would automatically be completed if the resident was admitted to [EX Order 26 § 4b1], had a decline or improvement in two areas of function, and if the change in condition would not self-resolve within 14 days. The CMDS/RN added that if the resident went on therapy and had some improvement but was not back to baseline, then the completion of a Sig change MDS would depend on the number of functional areas affected.

During a follow up interview with the surveyor on 01/11/23 at 11:22 AM, the CMDS/RN stated the resident met the criteria for a [NJ Exec. Order 26:4.b.1] and had a revision to the Care Plan. The resident was placed on [EX Order 26 § 4b1] due to a [EX Order 26 § 4b1] sustained on 10/29/22 and that the biggest areas affected were [NJ Exec. Order 26:4.b.1] The CMDS/RN added that a Sig change MDS was not completed because the resident was on [NJ Exec. Order 26:4.b.1] with a goal to return to the prior level of function, supervision level. The CMDS/RN added that Resident #14 was [NJ Exec. Order 26:4.b.1] and was [NJ Exec. Order 26:4.b.1]

Review of Resident #14's Care Plan revealed a "Problem", initiated on 11/17/22, that "I [NJ Exec. Order 26:4.b.1] he CP included interventions initiated on 11/17/22, that [EX Order 26 § 4b1] [EX Order 26 § 4b1]

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F 637	Continued From page 3	F 637		

Review of Resident #14's 09/12/22 [NJ Exec. Order 26:4.b] [redacted] Discharge summary indicated that the resident required [EX Order 26 § 4b1] [redacted]

Review of Resident #14's 11/07/22 [NJ Exec. Order 26:4.b.1] indicated that prior to [EX Order 26 § 4b1], the resident was [EX Order 26 § 4b1] [redacted] The [NJ Exec. Order 26:4.b.1] further indicated that now, Resident #14 required [EX Order 26 § 4b1] [redacted]

Review of Resident #14's 11/05/22 [NJ Exec. Order 26:4.b.1] [redacted] Evaluation and Plan of Treatment documents indicated the resident's new baseline was [EX Order 26 § 4b1] [redacted] The resident required [EX Order 26 § 4b1] [redacted]

During an interview with the surveyor on 01/11/23 at 11:44 AM, the Director of Therapy/PT, (DT) stated that Resident #14 [NJ Exec. Order 26:4.b.1] [redacted] upon readmission to the facility. The DT added that the resident was [NJ Exec. Order 26:4] and that the resident indicated that he/she [NJ Exec. Order 26:4.b.1] [redacted] due to the [EX Order 26 § 4b] . The DT reviewed the 11/07/22 [NJ Exec. Order 26:4.b.1] with the surveyor and stated the resident required [NJ Exec. Order 26:4.b.1] [redacted] which meant that Resident #14 required [EX Order 26 § 4b1] .

Review of the facility's "MDS Policies and Procedures," revised October 1, 2019, indicated "6. A Significant Change in Status Assessment (MDS) will be done on return from the hospital, when a determination has been made that the

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F 637	Continued From page 4 resident meets the criteria of a significant change. (Based on comparison of resident's pre and post hospital status.)" 8:39-11.2(i)	F 637		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to clarify as needed pain medication orders in accordance with professional standards. This deficient practice was identified for Resident #11, one of 5 residents reviewed for unnecessary medications and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist."	F 658	1. Resident #11 was interviewed and [redacted] were sequenced on January 10, the same day this concern was brought to the team's attention. 2. All [redacted] ordered for all residents were reviewed on January 10 for proper sequencing as ordered by the Physician. 3. All licensed staff will be educated by DON or designee on or before February 6, 2023 on clarifying [redacted] orders, ensuring [redacted] have a sequence and indication as ordered by the Physician. Clinical team will review all residents with [redacted] for appropriate order and [redacted]. 4. DON or designee will audit 5 residents with [redacted] ordered for proper indication and sequencing as ordered by the Physician weekly x4 weeks, then monthly x 3 and quarterly x 2. Results of audits will be submitted as a	2/6/23

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F 658	Continued From page 5 Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." During tour of the C-unit on 01/04/23 at 11:54 AM, the surveyor observed Resident #11 sitting in the recliner. The resident was awake, alert, and able to verbalize needs. According to the Face Sheet, Resident #11 had diagnoses that included, but were not limited to: EX Order 26 § 4b1 [redacted] Review of the Quarterly Minimum Data Set (MDS), dated 11/09/22, an assessment tool utilized to facilitate the management of care, reflected that Resident #11 Brief Interview for Mental Status (BIMS) score was [redacted] which indicated that the resident was EX Order 26 § 4b1 and had received as needed [redacted] in the last five days. The MDS further indicated that the resident had [redacted] and had to EX Order 26 § 4b1 [redacted] because of [redacted] Review of Resident #11's "Resident Medication	F 658	QAPI to ensure compliance and reassessed for further action until the quarterly review x 2 was accomplished.	

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F 658	Continued From page 6	F 658		

Profile" Physician Order Sheet (POS) revealed a prn physician order (PO) dated 09/22/22, for EX Order 26 § 4b1 EX Order 26 § 4b1 [redacted]. The PO included an instruction notation that: "No more that 5 grams in 24 HRS [hours]." The POS revealed a second prn PO, dated 11/09/22, for EX Order 26 § 4b1 50 mg and to administer one half tablet [1/2 tablet=25 mg] every 12 hours prn for [redacted]. The prn [redacted] medication orders did not include instructions on which medication to administer depending on the resident's [redacted] level.

Review of Resident #11's 11/22 and 12/22 Medication Administration Record (MAR) revealed that the resident was administered EX Order 26 § 4b1 [redacted]

Review of Resident #11's 11/22 and 01/23 MAR

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F 658		F 658		

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revealed that the resident was administered EX Order 26 § 4b1 on:

- EX Order 26 § 4b1 [redacted]

During an interview with the surveyor on 01/10/23 at 12:36 PM, the Licensed Practical Nurse (LPN) #1 stated that she would assess the resident's NJ Exec. O level when administering EX Order 26 § 4b1 medications. LPN #1 further stated she would review the resident's POs to see if the resident had EX Order 26 § 4b1 medications ordered. LPN #1 added that there were instructions within the PO that indicates which prn EX Order medication to administer depending on the resident's EX Order level. The surveyor questioned what the facility's practice was if there were no instructions in the prn NJ Exec. Order 26:4b. LPN # 1 stated that she would assess the resident's EX Order level and if the resident's EX Order level was EX Order, she would offer the EX Order 26 § 4b1. LPN #1 added that she would administer the other medication if the resident's EX Order level was EX Order 26 § 4. LPN #1 did not indicate that she would clarify the prn EX Order 2 medication orders with the physician.

During an interview with the surveyor on 01/10/23 at 1:10 PM, LPN #2 stated the nurse should

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F 658	Continued From page 8 check the resident for EX Order every shift. LPN #2 stated if the resident had more than one prn EX Order medication, the PO would include additional instructions indicating which medication to administer depending on the resident's EX Order 26 level. LPN #2 stated that she considered a resident EX Order scale of 1-4 was EX Order 26 § 4b1 and 5-10 was NJ Exec. Order 26:4.b.1 to EX Order 26 § 4b1. LPN #2 added that if there were no additional instructions in EX Order 26 § 4b1 medication orders, she would clarify the EX Order 26 § 4b1 medication orders with the physician. During an interview with the surveyor on 01/10/23 at 1:50 PM, the Regional Nurse Consultant (RNC) stated that EX Order 26 § 4b1 medications should have a sequence and indications in the PO instructing which EX Order 26 § 4b1 medication to administer depending on the resident's EX Order level. During a follow-up interview with the surveyor, the RNC stated he expected the nurses to clarify Resident #11's prn EX Order 2 medication orders with the physician.	F 658		
F 689 SS=D	NJAC 8:39-29.2(d), 29.3(a) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		2/3/23

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F 689	Continued From page 9 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow a physician's order for a [NJ Exec. Order 26:4.b.1] for 1 of 3 residents (Resident #39) reviewed for [NJ Exec. Order 26:4.b.1]. The deficient practice was evidenced by the following: During the tour of the B unit on 01/04/23 at 10:20 AM, the surveyor observed Resident #39 sitting on the side of their bed with their legs hanging towards the floor. The surveyor observed that there was no [NJ Exec. Order 26:4.b] near the resident's bed or visible anywhere in the resident's room. When interviewed, Resident #39 stated that they had several medical diagnoses and that they had been in the facility's healthcare unit for about 2 years. According to the Admission Record, Resident #39 was admitted to the facility with diagnoses that included, but were not limited to: [EX Order 26 § 4b1] [redacted] Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 12/02/22, revealed staff identified Resident #39 as [EX Order 26 § 4b1]. The MDS also indicated that the resident had [NJ Exec. O] [redacted] that resulted in [NJ Exec. Order 26:4.b] since the	F 689	1. Resident 39 is affected by the deficient practice. [NJ Exec. O] was immediately put in place. 2. All residents that are at [NJ Exec. Order 26 4.b.1] have the potential to be affected by the deficient practice. 3. Resident 39 was reassessed for [NJ Exec] [redacted] and [NJ Exec. Order 26:4.b.1] were put in place and the care plan updated. All residents are assessed for [NJ Exec. Order 26] on admission, quarterly, and as needed based on change of condition. The 11-7 nurse will conduct daily audits to ensure that the appropriate equipment ordered is in place. 4. All nursing staff will be educated on the importance of following a physician's order and implementing and documenting the physicians order as appropriate. The DON or designee will conduct an audit on the resident [NJ Exec. Order 26:4.b.1] ordered for 4 weeks, then monthly for 3 months, then quarterly 2 times. The QAPI committee will review the findings and determine if further intervention/monitoring is needed.	

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F 689	Continued From page 10	F 689		

resident's prior MDS was completed.

Review of Resident #39's [NJ Exec. Order 26 4.b.1] report dated 09/29/22 indicated that, the resident got up from their bed to pick up an item from the floor when they [NJ Exec. Order 26:4.b.1] on the floor. The incident report indicated that the [NJ Exec] resulted in a [NJ Exec. Order 26:4.b.1] to the resident's [NJ Exec]

Review of Resident #39's [NJ Exec. Order 26 4.b.1] report dated 11/06/22 indicated that the staff member found the resident in the room in a sitting position between their [EX Order 26 § 4b1] and the bed. Further review of Resident #39's incident reports indicated that the resident also [EX Order 26 § 4b1]

Review of the January 2023 Physician Order Sheet revealed a 03/18/22 physician order (PO) for [NJ Exec. Order 26:4.b.1] along the bed while in bed, for [NJ Exec. Order 26]

Review of the January 2023 Treatment Administration Record (TAR) revealed the aforementioned PO with administration times of day, evening, and night. The TAR further revealed that nurses signed daily that the [NJ Exec. Order 26:4.b] was in place while the resident was in bed.

Review of the fall risk care plan (CP) initiated on 03/29/22 indicated that the aide would put a [NJ Exec. Or] on the floor alongside the resident's bed at night, for [NJ Exec. Order 26].

On 01/05/23 at 10:35 AM, the surveyor observed Resident #39 sitting in a [NJ Exec. Order 26 4.b.1] in their room. The surveyor did not observe a [NJ Exec. Order 26:4.b] in the resident's room. During an interview with the surveyor at this time, Resident #39 stated that

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F 689	Continued From page 11	F 689		

they had NJ Exec. Order 26 4.b.1 and that they never had a NJ Exec. Order 26:4.b. Resident #39 added that the NJ Exec. Order 26:4.b.1 "might be a good idea".

On 01/06/23 at 8:14 AM, the surveyor observed Resident #39 in bed with their eyes closed. The surveyor observed that there was no NJ Exec. Order 26:4.b beside the resident's bed.

During an interview with the surveyor on 01/06/23 at 12:03 PM, the Certified Nursing Assistant (CNA) stated that the resident did not have a NJ Exec. Or in their room.

During an interview with the surveyor on 01/06/23 at 12:17 PM, the Licensed Practical Nurse (LPN) stated that Resident #39 has had a history of NJ Exec. Or The LPN further stated that the resident had an order for a NJ Exec. Order 26:4.b.1 and that it was put in place in the evening before the resident went to sleep. The LPN and the surveyor entered the resident's room, and the surveyor asked the LPN to show her the resident's NJ Exec. Order 26:4.b.1. The LPN stated that there was no NJ Exec. Order 26:4.b.1 in the resident's room.

On 01/06/23 at 12:33 PM, the LPN approached the surveyor and stated that all the staff were responsible to check for placement of the NJ Exec. Orc and that it was not in place that morning.

During an interview with the surveyor on 01/06/23 at 12:37 PM, the Registered Nurse (RN) Supervisor stated that Resident #39 NJ Exec. Order 26:4.b times getting out of bed to their EX Order 26 9 4b1. The RN Supervisor stated that she thinks that the resident had a NJ Exec. Order 26:4.b.1 in their room. The RN supervisor further stated that a NJ Exec. Order 26:4.b.1 should be in place at NJ Exec. Order 26:4.b.1 and that the

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F 689	Continued From page 12 importance of having a [NJ Exec. Order 26:4.b.1] was so the resident did not ge[t] [NJ Exec. Orde] On 01/09/23 at 2:19 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). The LNHA stated the importance of having a [NJ Exec. Order 26:4.b.1] in place while Resident #39 was to follow the PO and CP, and to avoid potentially "[EX Order 26 § 4b1] y" for the resident. During an interview with the survey team on 01/10/23 at 1:23 PM, the Regional Nurse Consultant stated that the resident's [NJ Exec. Order 26:4.b.1] had spillage on it and that it went out to be cleaned but acknowledged that a replacement [NJ Exec.O] should have been in place per the PO. The facility policy, "Medication and Treatment Orders" with a revised date of 02/2018 failed to indicate how PO should be administered or documented. NJAC 8:39-27.1 (a)	F 689		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to evaluate the	F 730	1.How the Corrective Action will be accomplished.	2/3/23

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F 730	Continued From page 13 performance of Certified Nursing Assistants (CNA) on an annual basis. This deficient practice was identified for 4 of 5 randomly sampled CNAs whose personnel records were reviewed and was evidenced by the following: On 01/09/23 at 08:47 AM, a review of the personnel records for the selected CNAs that were provided by the facility revealed the following: CNA #1 was hired on 12/12/05. A "Performance Enhancement Program for Staff" dated 05/03/21. CNA #2 was hired on 09/28/87. A "Performance Enhancement Program for Staff" dated 12/20/17. CNA #3 was hired on 12/27/17. A "Performance Enhancement Program for Staff" dated 05/03/21. CNA #4 was hired on 10/08/10. A "Performance Enhancement Program for Staff" dated 05/03/21. On 01/09/23 at 09:08 AM, the surveyor requested the most recent employee evaluations. During an interview with the surveyor on 01/09/23 at 10:48 AM, the Director of Human Resources (DHR) stated that CNA performance evaluations should be done yearly but "due to the many recent changes at the facility, the evaluations may not have been completed." During a follow-up interview with the surveyor on 01/09/23 at 12:19 PM, the DHR confirmed the employee evaluations that had been provided were the most recent evaluations. He then stated that evaluations should be done yearly but they had not been completed until surveyor inquiry. He	F 730	There were no residents affected by this deficient practice. 2. How will the facility identify other residents having the potential to be affected. All residents have the potential affected by this deficient practice. 3. What measure will be put in place to make sure practice does not recur Human Resources conducted an audit of every healthcare staff member to assure compliance of conducting a performance review every 12 months. All reviews currently meet the requirement. 4. How will the facility monitor that the deficient practice will not reoccur. The Human Resource Director will provide supervisors a list at the beginning of each month of performance evaluations due. Evaluations are conducted on the start date anniversary basis for each employee. The Human Resource Director will alert the Administrator if any evaluations are not completed on a timely basis. Results will be shared with the Quality Assurance Committee monthly.	

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F 730	Continued From page 14 further stated that the Director of Nursing (DON) and the administrator were responsible for completing them. The DHR added that the evaluations should be done yearly "so employees know where they stand and what needs to be improved on." During an interview with the surveyor on 01/09/23 at 12:42 PM, and in the presence of the DON, the administrator stated that evaluations should be done annually and that she "realized some of the evaluations were overdue". She then stated that evaluations were important for "feedback and to keep open dialogue especially if there were areas of improvement needed." Review of the facility's "Performance Management" policy, revised on 03/01/12, indicated it is the policy of Springpoint Senior Living, Inc. (SSL) to review the job performance of each employee ...at least every 12 months thereafter The policy revealed that the purpose of the Performance Management process was to review the employee's competencies or performance criteria, completion of goals and objectives and the implementation of a step by step development plan. NJAC 8:39-43.17(b)	F 730		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 756		2/3/23

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F 756	Continued From page 15 §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to ensure recommendations made by the Consultant Pharmacist were acted upon in a timely manner and documented for 4 of	F 756	1. Resident's 11,14,39 pharmacy consultant recommendations were reviewed by the DON and the designee on 1/4/23 to 1/11/23 and the physician was informed about the	

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F 756	Continued From page 16 5 residents (Residents #11, #14, and #39) reviewed for unnecessary medications. This deficient practice was evidenced by: 1. According to the Face Sheet, Resident #11 had diagnoses that included, but were not limited to: EX Order 26 § 4b1 [redacted] Review of Resident #11's Electronic Pharmacist Information report (EPIC) revealed a Consultant Pharmacist (CP) recommendation, dated 12/01/22, to EX Order 26 § 4b1 [redacted] Review of Resident #11's Resident Medication Profile Physician Order Sheets (POS) revealed a 09/22/22 physician order (PO) for EX Order 26 § 4b1 [redacted] Review of Resident #11's Medication Administration Record (MAR) for 12/22 and 01/23 revealed that both the EX Order 26 § 4b1 and the EX Order 26 § 4b1 was scheduled to be administered at 9:00 AM. The EPIC revealed a second CP recommendation, dated 12/01/22, that "The	F 756	recommendations. The issues indicated in the report were immediately addressed in each resident's medical record. The three residents were monitored and did not show any adverse effects from the medication. The DON, designee, reviewed the consultant pharmacist review recommendations from October 2022 to December 2022, informed the physicians regarding the recommendations and addressed the concerns individually. 2. All residents had the potential to be affected by the deficient practice. Residents identified were not negatively affected by the deficient practice. 3. To assure that the deficient practice does not recur, the policy on Medication Regimen Reviews was reviewed and amended to assure that the recommendations are addressed within 28 days of receipt. The DON educated the staff on importance on ensuring that the recommendations are addressed and completed in a timely manner. The administrator met with the pharmacy consultant and asked that the consultant report immediately to the DON, or designee, any issue that has not been addressed from the last months previous findings. 4. In order to monitor the recommendations are addressed in a timely manner, the DON, or designee, will complete a monthly audit on the documents and report the findings to the QAPI committee for 4 weeks, then monthly for 3 months, then quarterly x2.	

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F 756	Continued From page 17 recommended dose of EX Order 26 § 4b1 EX Order 26 § 4b1 If continuing the present dosage, document the rationale." Review of Resident #11's CP recommendation, dated 12/29/22, revealed that the CP repeated the 12/01/22 recommendation that "The recommended dose of EX Order 26 § 4b1 If continuing the present dosage, document the rationale." The 12/29/22 CP recommendation further revealed that the physician reviewed and accepted the CP recommendation on 01/05/23. Review of Resident #11's POS revealed a 09/22/22 PO for EX Order 26 § 4b1 and to administer every 12 hours. Review of Resident #11's 12/22 and 01/23 MAR on 01/09/22 revealed the aforementioned PO with the administration times of 9:00 AM and 9:00 PM. The resident's MARs reflected that the EX Order 26 § 4b1 continued at the same dosage despite the physician accepting the CP recommendation on 01/05/23. 2. According to the Face Sheet, Resident #14 had diagnoses that included, but were not limited to: EX Order 26 § 4b1 Review of the Resident #14's "Consultant Pharmacist's Monthly Report" (CPMR), dated 11/29/22, revealed that the CP made a recommendation that "EX Order 26 § 4b1	F 756		

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EX Order 26 § 4b1 is recommended to be scheduled and given with or immediately following a meal. However, if the prescriber wants to give every 6, 8, or 12 hours despite manufacturer recommendation, then clarify with prescriber and update order to read without regard to meals." The CP made the same recommendation on 12/28/22.

Review of Resident #14's POS revealed an 11/05/22 PO for EX Order 26 § 4b1 every 12 hours and included instructions to EX Order 26 § 4b1 [redacted].

Review of Resident #14's 11/22 MAR on 01/06/23 revealed a 11/05/22 PO for EX Order 26 § 4b1 EX Orde every 12 hours with the administration times of 9:00 AM and 9:00 PM. The PO included the following under the instructions, NJ Exec. Order 26:4.b.1 [redacted]. However, per provider NJ Exec. Order 26:4.b.1 [redacted] The PO was discontinued on 11/05/22. Review of Resident #14's POS did not include the aforementioned PO.

Further reviewed of the 11/22 MAR revealed a second PO, dated 11/05/22, for EX Order 26 § 4b1 [redacted]. The PO included the following under the instructions, 'EX Order 26 § 4b1 [redacted]

The PO did not include the notation of that per the provider, give NJ Exec. Order 26:4.b.1 [redacted].

Review of the 12/22 and 01/23 MAR revealed the

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aforementioned 11/05/22 PO which did not include the notation of that per the provider, give NJ Exec. Order 26:4.b.1

During an interview with the surveyor on 01/11/23 at 1:56 PM, the Regional Nurse Consultant (RNC) stated they were unable to locate documentation of Resident #14's 08/22 and 09/22 CP Medication Regimen Reviews reports.

3. According to the Admission Record, Resident #39 had diagnoses that included, but were not limited to: EX Order 26 § 4b1 [redacted]

Review of Resident #39's CPMR revealed a CP recommendation, dated 09/28/22, EX Order 26 § 4b1 [redacted] preferably 1 hour before or 2 hours after meals. The CPMR reflected that the CP made the same recommendation on 10/31/22, 11/29/22, and 12/28/22.

Review of Resident #39's Physician Order Sheets (POSs) for 10/22, 11/22, 12/22, and 01/23 all revealed a 03/21/22 PO for EX Order 26 § 4b1 [redacted]

Review of Resident #39's MARs for 10/22, 11/22, 12/22, and 10/23 all revealed that EX Order 26 § 4b1 [redacted] was scheduled for 9:00 AM and 5:00 PM.

Review of the facility document, "Meal Times for

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Healthcare Unit" indicated that breakfast was served on the resident's unit between 7:35 AM and 7:45 AM and that dinner was served between 4:35 PM and 4:45 PM.

The CPMR revealed another recommendation, dated 10/31/22, "Please separate the administration of EX Order 26 § 4b1 [redacted] by at least 2 hours. Simultaneous administration of these medications may reduce absorption." The CPMR reflected that the CP made the same recommendation on 11/29/22 and 12/28/22.

Review of Resident #39's POS for 11/22, 12/22, and 01/23 all revealed a 06/08/22 PO for EX Order 26 § 4b1 [redacted]

Review of Resident #39's MARs for 11/22, 12/22, and 01/23 all revealed that EX Order 26 § 4b1 [redacted]

The CPMR revealed another recommendation, dated 10/31/22, "EX Order 26 § 4b1 [redacted]" The CPMR reflected that the CP made the same recommendation on 11/29/22 and 12/28/22.

Review of Resident #39's POS for 11/22, 12/22, and 01/23 all revealed a 04/20/22 PO for EX Order 26 § 4b [redacted] The PO did not indicate a frequency for the EX Order 26 to be

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given.

Review of Resident #39's MARs for 11/22, 12/22, and 01/23 all revealed that EX Order 26 § 4b1 [redacted] were ordered as needed and failed to reveal an indication for how frequently the EX Order 26 [redacted] could be given.

The CPMR revealed another recommendation, dated 11/29/22, "Please separate the administration of EX Order 26 § 4b1 from EX Order 26 [redacted] by at least 2 hours. Simultaneous administration of these medications may reduce absorption. The CPMR reflected that the CP made the same recommendation on 12/28/22.

Review of Resident #39's POS for 12/22 and 01/23 both revealed a 06/08/22 PO for EX Order 26 § 4b1 [redacted]

Review of Resident #39's MARs for 12/22 and 01/23 both revealed that EX Order 26 § 4b1 [redacted]

The CPMR revealed a final recommendation, "Please clarify the order for EX Order 26 § 4b1 [redacted]. Please indicate in the order, NJ Exe [redacted] and remove NJ Exec. Order 26 4.b.1 [redacted]

Review of Resident #39's POS for 01/23 revealed a 06/22/22 PO, EX Order 26 § 4b1 [redacted] be given one time a day.

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Review of Resident #39's MAR for 01/23 revealed that EX Order 26 § 4b1 had instructions to administer NJ Exec. Order 26:4.b.1 EX Order 26 § 4b in the morning.

On 01/10/23 at 10:40 AM, the surveyor reviewed Resident #39's progress notes (PN) from 09/11/22- 01/3/23. The PN revealed no documentation that the CP recommendations were discussed or addressed with the physician. The PN further revealed no documented rationale or response to the CP's recommendation.

During an interview with the surveyor on 01/10/23 at 10:13 AM, the VP of Health Services (VPHS) state the CP sends the recommendations via email to the Director of Nursing, the Licensed Nursing Home Administrator (LNHA), and the Unit Manager (UM). The VPHS added that it was the responsibility of the UM to follow up with the CP recommendations. The VPHS further stated they recently had a lot of changes in staff and that they were trying to find the CP recommendations now.

During an interview with the surveyor on 01/10/23 at 10:48 AM, the Licensed Practical Nurse (LPN) stated that the nursing supervisors and Director of Nursing (DON) were responsible to make sure that CP recommendations were addressed with the physician. The LPN stated that the nurses on the unit do not look at the CP recommendations.

During an interview with the survey team on 01/10/23 at 1:23 PM, the RNC stated the CP recommendations should be addressed by the responsible party to see if the medical director

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F 756	Continued From page 23 agrees and there should be documentation of when the recommendations are accepted or rejected. The facility policy, "Consultant Pharmacist Services-Requirements" dated 2020 indicated, "Upon receipt of the consultant's recommendations, the facility utilizes the information to complete the Resident Care Plan, takes any action to remedy problems identified, and places required reports in the resident's medical record." The facility policy also indicated, "Communicating to the responsible physician potential or actual problems detected relating to medication therapy orders or found within the resident's medical record."	F 756		
F 812 SS=E	NJAC 8:39-29.3(a)(1) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		1/31/23

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F 812	Continued From page 24 §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 documentation provided by the facility, it was determined that the facility failed to maintain proper kitchen sanitation practices to prevent the development of food borne illness. The deficient practice was evidenced by the following: On 01/04/23 between 09:57 AM and 10:42 AM, the initial tour of the kitchen was completed in the presence of the Director of Dining Services (DDS), the surveyor observed the following: 1. Cook #1 was observed leaning over to observe the contents inside the tilt skillet. The surveyor observed that Cook #1 had a tall white hat on top of his head with exposed hair on the side and back of his head. He was not wearing a hair net. During an interview with the surveyor at that time, Cook #1 stated, "I thought because I had a hat on I did not need to wear a hair net." He further stated that the "purpose of a hair net was to keep hair from falling in food". The DDS identified the contents of the tilt skillet as the "soup of the day." He then confirmed that Cook #1 should have had a hair net on. 2. Dishwasher #1 was observed on the clean side of the dishwasher wearing a baseball hat with exposed hair on the sides and back of his head. The surveyor did not see a hair net. During an interview with the surveyor at that time, Dishwasher #1 stated he had a hair net on, he lifted his hat and showed the surveyor the hair net that had slipped up under his hat leaving his hair	F 812	1. How the Corrective Action will be Accomplished. Uniform and dress code. The community updated the policy on hair restraints 1/22 to include wearing an approved hair restraint regardless of length of hair. All dining service staff received an in-service education regarding the policy. Food Supply and Storage The facility immediately addressed the issue and purchased the necessary emergency supplies and placed it in a secure location. A surveyor was taken to the site to show compliance. The facility updated its food supply and storage policy. All emergency supply will be secured in a separate and secure location. Hand and Hygiene The Infection Preventionist and Dining Service Managers will provide in-service education upon hire on handwashing and hygiene. The Infection Preventionist and/or Dining Service Mangers have provided immediate in-servicing on all areas related to infection control and food handling. 2. All residents have the potential to be affected.	

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	315022	A. BUILDING _____ B. WING _____	C 01/11/2023

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F 812	Continued From page 25 exposed. The DDS confirmed Dishwasher #1's hair was uncontained, and it should be contained in the hair net to keep hair from falling onto the dishes. 3. During review of the emergency supply storage the surveyor observed the following: -1 case of 12 cans of 50 ounces of minestrone soup with 02/22/22 stamped on the top of the cans. -1 case of 12 cans of 50 ounces of chicken noodle soup with 03/04/22 stamped on the top of the cans. -1 case of 12 cans of 50 ounces of chicken noodle soup with 02/02/22 stamped on the top of the cans. -3 cases of 12 cans of 50 ounces of cream of mushroom soup with 01/09/22 stamped on the top of the cans. -1 case of 12 cans of 50 ounces of tomato soup with 02/02/22 stamped on the top of the cans. During an interview with the surveyor at that time, the DDS confirmed that the date stamped on the top of the cans, were the expiration dates. On 01/10/23 from 11:15 AM to 11:36 AM, the surveyor observed the following during a revisit in the kitchen: 1. Cook #2 was observed by the ovens wearing a hat with exposed hair around the sides and back of his head and exposed facial hair around his mask. Cook # 2 walked past the surveyor, exited the kitchen and entered the DDS's office. The surveyor followed Cook #2 and observed him donning (putting on) a hair net. During an interview at that time, he stated he "realized I did	F 812	3. What measures will be put in place to ensure the practice does not recur, Hair Restraints Supervisors will conduct weekly audits x4, then monthly x3, then quarterly x2 to ensure compliance with the policy and document any findings through QAPI. Food Safety and Storage Dining Service staff will conduct monthly audits of the emergency supply area to review supply levels and expiration dates. They will also make sure that all storage is following the FIFO method. Dining managers will provide written documentation to the Administrator to indicate compliance with this policy through QAPI. Hand and Hygiene The Dining Service Team will continue to educate and conduct weekly audits x4, then monthly x3 then quarterly x2 audits as part of a QAPI project. 4. How will the facility monitor its corrective actions. Dining Service Supervisor will provide written documentation weekly x4, monthly x3 and quarterly x2 as part of QAPI.	

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F 812	Continued From page 26	F 812		

not have a hair net on and came out to get one." The surveyor asked about his facial hair, he stated "it has to be covered at all times."

2. Salad Prep #1 was observed stocking salad, she was wearing a hat with exposed hair around the side and back of her head. During an interview at that time she stated, "I forget to put the hair net on, it was a woopsie on my part." She further stated the purpose of the hair net was to keep everything clean.

3. Cook #3 was observed wearing gloves, cutting meat. He had a black mask tucked under his chin. Cook # 3 had a significant amount of exposed facial hair on and around his chin. He reached up to pull his mask up with visibly soiled gloves. He pulled his mask up over his nose and mouth, removed the gloves, and donned another pair. During an interview at that time, Cook #3 stated he was told that if facial hair was short enough "they didn't have to worry about it" and that "surgical masks are encouraged to be worn." When the surveyor asked him about handwashing, he stated it should be performed "upon entering and exiting kitchen and before and after donning gloves." He confirmed that he did not wash his hands after removing the visibly soiled gloves and donning new gloves.

On 01/10/23 at 11:22 AM, the surveyor reviewed the above observations with the DDS. He stated that surgical masks should be worn all day long and facial hair should not be exposed, it should be covered. He stated he would have to check the facility's policy on the length of the facial hair that should be covered.

During a follow up interview with the surveyor on

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F 812	Continued From page 27 01/10/23 at 11:30 AM, the DDS stated he was responsible for maintaining the emergency food supplies and ensuring it was up to date. On 01/10/23 at 12:08 PM, the DDS provided the surveyor with the facility's policy on Hand Hygiene and stated that he was unable to find a policy on the length of facial hair. The surveyor reviewed the previously provided policy "E006, Uniform Dress Code" with the DDS. The DDS reviewed the policy and confirmed that all facial hair should be covered and that it was not done. Review of the facility's policy "E006, Uniform and dress Code" revised 1/22, revealed Associates working with food should wear the approved hair restraint when on duty regardless of the length of presence of hair and to restrain all facial hair with a beard net/restraint. Review of the facility's policy "B003, Food and Supply Storage" revised 1/22, revealed that most, but not all, products contain an expiration date. The policy further revealed that foods past the "use by", "sell-by", or "enjoy by" date should be discarded, date and rotate items first in, first out (FIFO), and discard food past the use-by or expiration date. Review of the facility's policy "E007, Hand Hygiene" revised 1/22, indicated to wash hands with soap and water at the following times: ...before putting on gloves; after touching hair, skin, beard or clothing; after handling soiled silverware/utensils; after removing gloves, after any other activity that may contaminate the hands.	F 812		

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F 812	Continued From page 28 NJAC 8:39-17.1(a);17.2(g)	F 812		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing:	F 886		2/3/23

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F 886	Continued From page 29 (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and other pertinent facility documentation, it was determined that the facility failed to perform new admission COVID-19 testing per facility policy and in accordance with the Centers for Disease Control and Prevention guidelines (CDC) for infection control to mitigate the spread of COVID-19 for 7 out of 10 residents reviewed that had been admitted in the last 30 days. According to the U.S. CDC Interim Infection Prevention and Control Recommendations for	F 886	1. Residents #49, 37, 8, 38, 149, 152 and 13 were monitored by the nursing staff none showed signs and symptoms of NJ Exec. Order 26:4.b.1 . 2. All residents had the potenttial to be affected. Residents newly admitted, readmitted, or residents out of the facility for more than 24 hours will be NJ Exec. Order 26:4.b.1 [redacted] on day of admission, 48 hours after the 1st negative, and test again after 48 hours after the 2nd negative. 3. In order to assure that the deficient	

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F 886	Continued From page 30 Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated September 23, 2022 ...3. Setting-specific consideration ...Nursing Homes " Managing admissions and residents who leave the facility: o Testing is recommended at admission and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. In general, admissions in counties where Community Transmission levels are high should be tested upon admission; admission testing at lower levels of Community Transmission is at the discretion of the facility. o They should also be advised to wear source control for the 10 days following their admission. Residents who leave the facility for 24 hours or longer should generally be managed as an admission." This deficient practice was evidenced by the following: During an interview with the survey team on 01/06/23 at 10:27 AM, the Infection Preventionist (IP) stated that the Community Transmission level was high. She stated new admissions were COVID-19 rapid antigen tested regardless of their vaccination status on day 1 of admission and then again on day 5 through 7. When asked what guidance the facility was following, the IP stated the facility's policy. On 01/09/23 at 11:30 AM, the surveyor requested the COVID-19 testing for the new admissions from the last 30 days from the IP. Review of the facility provided 30-day new admission testing revealed the following:	F 886	practice does not recur, staff will be in-serviced by the DON and/or Infection Preventionist on the policy, NJ Exec. Order 26:4.b.1 [redacted] or Residents (Skilled Nursing and Assisted Living) to reflect CDC guidance from 9/23/22 and NJDOH guidance from 12/22/22, which highlighted the change in testing cadence to include testing residents who are new admissions, readmissions, and residents who leave the facility for 24 hours or longer, will be tested on day of admission, 48 hours after the first negative, then test again after 48 hours after the second negative. 4. In order to monitor that the testing cadence is followed, the Infection Preventionist will report the testing on a weekly basis x4, then monthly x3 to the Administrator. The QAPI committee will review the findings and will determine if further intervention/monitoring is needed.	

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F 886	Continued From page 31 -Resident #49 was admitted to the facility on EX Order 26 § 4b1. Review of the EX Order 26 § 4b1 Physician Order Sheet (POS) revealed a EX Order 26 § 4b1 physician order (PO) for EX Order 26 § 4b1 Test as needed, starting 12/20/22. Review of the nursing note dated EX Order 26 § 4b1, revealed the resident had a rapid EX Order 26 § 4b1 on admission. Review of the "December 2022 Non-PRN Medication Notes" the resident received a EX Order 26 § 4b1 on EX Order 26 § 4b1. -Resident #149 was admitted to the facility on EX Order 26 § 4b1. Review of the EX Order 26 § 4b1 POS revealed a EX Order 26 § 4b1 PO for EX Order 26 § 4b1 on Admission one time daily for one day starting EX Order 26 § 4b1 and PO for EX Order 26 § 4b1 5 days after Admission one time daily for one day starting EX Order 26 § 4b1 Review of the "EX Order 26 § 4b1 Non-PRN Medication Notes" revealed the resident received a EX Order 26 § 4b1 on EX Order 26 § 4b1 -Resident #37 was admitted to the facility on EX Order 26 § 4b1. Review of the EX Order 26 § 4b1 POS revealed a EX Order 26 § 4b1 PO for EX Order 26 § 4b1 on Admission one time daily for one day starting EX Order 26 § 4b1 and a PO for EX Order 26 § 4b1 5 days after Admission one time daily for one day starting EX Order 26 § 4b1. Review of the EX Order 26 § 4b1 revealed the resident received a EX Order 26 § 4b1 on EX Order 26 § 4b1. -Resident #8 was admitted to the facility on EX Order 26 § 4b1 Review of the EX Order 26 § 4b1 POS revealed a EX Order 26 § 4b1 PO for EX Order 26 § 4b1 on Admission one time daily for one day starting EX Order 26 § 4b1 and a PO for EX Order 26 § 4b1 EX O days after	F 886		

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Admission one time daily for one day starting [redacted]. Review of the "[redacted] Non-PRN Medication Notes" revealed the resident received a [redacted] on [redacted]

-Resident #152 was admitted to the facility on [redacted]. Review of the [redacted] POS revealed a [redacted] PO for [redacted] Admission one time daily for one day starting [redacted] and a PO for [redacted] days after Admission one time daily for one day starting [redacted]. Review of the [redacted] Non-PRN Medication Notes" revealed the resident received a [redacted]

-Resident #38 was admitted to the facility on [redacted]. Review of the [redacted] POS revealed a [redacted] PO for [redacted] on Admission one time daily for one day starting [redacted] and a PO for [redacted] days after Admission one time daily for one day starting [redacted]. Review of the "[redacted] Non-PRN Medication Notes" revealed the resident received a [redacted] on [redacted]

-Resident #13 was admitted to the facility on [redacted]. Review of the [redacted] POS revealed a [redacted] PO for [redacted] on Admission one time daily for one day starting [redacted] days after Admission one time daily for one day starting [redacted]. Review of the [redacted] revealed the resident received a [redacted] on [redacted]

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F 886	Continued From page 33 During a meeting with the survey team and the administrative staff on 01/10/23 at 01:22 PM, the Regional Nurse Consultant (RNC) stated the facility followed the New Jersey Department of Health, Local Health Department and the CDC guidelines, which was to test the resident on day of admission and then preferably day 5 and 7. The surveyor requested a copy of the guidance they were following. During a meeting with the survey team on 01/11/23 at 01:52 PM, the IP stated there was no additional information to present for the new admission testing and that she submitted the Medication Administration Records (to the survey team) that reflected testing on Day 1 and Day 5. Review of the facility's policy "COVID-19 Universal Testing for Residents (Skilled Nursing and Assistant Living)" revised 1/4/2023 revealed the Purpose: To mitigate the spread of COVID-19 in Springpoint communities; 5. All new admissions, readmissions, and residents who leave the facility for 24 hours or longer: a) testing immediately on admission; b) Test after 48 hours after 1st negative; c) Test again after 48 hours after the 2nd negative; 9. Follow all current CDC guidance pertaining to COVID-19 Management.	F 886		
F 922 SS=E	NJAC 8:39-19.4 (a) Procedures to Ensure Water Availability CFR(s): 483.90(i)(1) The facility must-- §483.90(i)(1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply;	F 922		1/31/23

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F 922	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain the designated emergency supply of water needed for residents in the event of a loss of normal water supply. This deficient practice was evidenced by the following: On 01/04/22 at 10:30 AM, the surveyor observed the emergency water storage area in the presence of the Director of Dining Services (DDS). The resident census on the day of observation was 44. The surveyor observed 2 cases that contained six (6) 1-gallon bottles each, plus an additional one (1) gallon of water for a total of 13 gallons. The DDS stated that they should have "3 gallons of water per resident for 3 days in storage." He further stated it was important to have the water in storage because "you never know what mother nature will do." The DDS then confirmed that this was the only water stored for the facility. Review of the facility's policy, "Recommendations for safe practices during water supply disruption and/or Contamination in Health Care Facilities" effective date 04/01/01, revealed A. Procurement of Water from Alternate Sources/Use of Well Water: 1. Bottled Water: a. Determine amount of water needed for patients and personnel (1 to 2 Liters per person per day, depending on patient population);...d. An emergency supply of bottled water should be maintained on premises. NJAC 8:39-31.6 (n)	F 922	1. How will the corrective action be accomplished. Additional water was immediately purchased to meet the requirements and stored in a secure location. Surveyor was shown this and provided invoices for the purchase. 2. All residents have the potential to be affected. 3. What measures will be put in place. Dining Service team will conduct audits of all emergency food and water storage to assure adequate supply and expiration dates. 4. How will facility monitor. The Director of Dining Services/Designee will audit the compliance of the maintenance of an adequate water supply on site weekly x4 weeks. Then, the audit will be completed monthly for 2 months. The audit results will be reviewed on a weekly basis with the Administrator and then monthly. Any deficiency will be corrected on the spot. The Director of Dining Services/Designee will document our compliance and report at the monthly QAPI meeting.	

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	031102	A. BUILDING: _____ B. WING _____	C 01/11/2023

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for 2 of 14 day shifts and 1 of 14 evening shifts reviewed. This deficient practice was identified, and the findings were as followed: 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	S 560	The facility is submitting this Plan of Correction in compliance with the law. Nothing in this Plan of Correction shall be construed as an admission that the facility has failed to comply with any statutory or regulatory standard. 1. How the corrective action is being accomplished. The staffing scheduler/Administrator/ DON will review direct care staff to resident ratios for compliance with the mandatory staffing requirements. The Administrator, DON, Staffing Scheduler, and HR will conduct a weekly	2/3/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/03/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	031102	A. BUILDING: _____ B. WING _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
MEADOW LAKES	300 MEADOW LAKES EAST WINDSOR, NJ 08520

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D 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 1 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. Staffing was requested for the weeks of 12/18/22 to 12/24/22 and 12/25/22 to 12/31/22. Review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing for residents on 2 of 14 day shifts and 1 of 14 evening shifts as follows: -12/23/22 had 5 CNAs for 48 residents on the day shift, required 6 CNAs. -12/24/22 had 4 total staff for 48 residents on the evening shift, required 5 total staff. -12/31/22 had 4 CNAs for 44 residents on the day shift, required 5 CNAs. During an interview with the surveyor on 01/09/23 at 12:55 PM, the Unit Coordinator/Staffing Coordinator (UCSC) and the Administrator stated they were aware of the staffing ratios. The Administrator further stated, "we are not meeting	S 560	recruitment meeting to review direct care staffing needs and open positions. They will also review resumes, applications and advertising. Advertisements will be done through various venues, but not limited to, Our company website, online recruitment companies, flyers to local agencies, and social media. Agency contracts will be utilized to supplement Direct Care Staff to meet compliance with staffing levels. 2. How the facility will identify other residents affected by the same deficient practice. All residents have the potential to be affected. 3. What measure will be put in place or systematic changes made to ensure that the deficient practice will not recur. When a staff to resident ratio inequity is identified, the facility will contact all available staff to come to work for an additional shift, offer incentive pay to those volunteering to work additional shifts, and/or contact staffing agencies to assist with the mandatory staffing levels. The facility will conduct weekly Recruitment Meetings to recruit staff and review efforts/status (refer to #1 above). Administrative staff will review wages/benefits to remain competitive, offer sign-on referral bonuses to new hires and current staff. Daily staffing levels will be reviewed by	

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S 560	Continued From page 2 the staffing ratios all of the time."	S 560	Administrator, DON/Designee to ensure compliance with the regulation and direct care staff to resident ratio. Our policy is that when we place opening on our job board it is advertised in several ways. Our job Board will typically run ads no longer than 45-60 days. For 2022 CNA positions ads were placed on 1/11, 2/24. 4/29. 6/21,7/25, 9/19, and 12/6. For 2022 LPN positions ads were placed on 7/25, 9/8, and 12/6. For 2022 RN positions ads were placed on 3/1. 5/10, 8/18, and 10/25. 4. How the facility will monitor its corrective action to ensure the deficient practice is being corrected and not recur. Results of the daily staffing levels will be reported by the DON/Designee monthly to the QAPI Committee for a period of 3 months. Any staffing level inequities that are identified will be addressed immediately with appropriate corrective action. Results of the weekly Recruitment Meetings will be reported by the HR/Designee monthly to the QAPI Committee for a period of 3 months.	

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
315022 Y1	A. Building B. Wing Y2	2/14/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LAKES	300 MEADOW LAKES EAST WINDSOR, NJ 08520

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 F0637	Correction	ID Prefix F0658	Correction	ID Prefix F0689	Correction
Reg. # 483.20(b)(2)(ii)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	02/03/2023	LSC	02/06/2023	LSC	02/03/2023
ID Prefix F0730	Correction	ID Prefix F0756	Correction	ID Prefix F0812	Correction
Reg. # 483.35(d)(7)	Completed	Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	02/03/2023	LSC	02/03/2023	LSC	01/31/2023
ID Prefix F0886	Correction	ID Prefix F0922	Correction	ID Prefix	Correction
Reg. # 483.80 (h)(1)-(6)	Completed	Reg. # 483.90(i)(1)	Completed	Reg. #	Completed
LSC	02/03/2023	LSC	01/31/2023	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	

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?
1/11/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
031102 (Y1)	(Y2)	2/14/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LAKES	300 MEADOW LAKES EAST WINDSOR, NJ 08520

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 02/03/2023	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 1/11/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ YES ☐ NO

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315022	A. BUILDING **01** B. WING _____	C **01/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
MEADOW LAKES	**300 MEADOW LAKES** **EAST WINDSOR, NJ 08520**

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E 000	Initial Comments . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 01/11/23. The facility was found to be in compliance with 42 CFR 483.73. .	E 000		
K 000	INITIAL COMMENTS . A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 01/11/23 and was found not to be in compliance with requirements for participation in Medicare/Medicaid at 42 CFR 483.90 (A) Life Safety from fire and the 2012 edition of the National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), chapter 19 EXISTING health care occupancy. The facility is one story first occupied in 1965. The facility has concrete flooring, multiple roofing materials including fiberglass and wood sheathing and block bearing walls. The facility is noted to be a type III (211) with complete sprinkler system and complete fire alarm system with smoke detection in all corridors and bedrooms. The facility has two generators. One 2250 KW (kilowatt) diesel generator generates power for the entire campus and back up 60 KW for the health center. The facility has three smoke compartments in the certified area. The facility has a census of 44. .	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101	K 222		2/3/23

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 222	Continued From page 1 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and	K 222		

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K 222	Continued From page 2 ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: . Based on observation and interview with facility staff, the facility failed to ensure that exit doors were not equipped with a latch or lock that requires the use of a tool or key or special knowledge from the egress side for one exit door in accordance with NFPA 101 Life Safety Code (2012 edition) section 7.2.1.6.1. This deficient practice had the potential to affect 10 residents. Findings include: An observation of the main dining room exit door, located between the C and B units, on 01/11/23 at 10:35 AM revealed the exit door, equipped with a wander guard, opened with a delay of 15 seconds. The door lacked a sign indicating	K 222	Observation noted the main dining room exit door was equipped with a Wanderguard system The door lacked a sign indicating, PUSH UNTIL ALARM SOUNDS. DOOR WILL OPEN IN 15 SECONDS. 1.How Corrective Action will be accomplished. Signage was purchased and immediately installed on the Healthcare Center Dining Room exit door to meet compliance. 2.All residents have the potential to be affected. 3.What measures will be put in place to	

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K 222	Continued From page 3 "PUSH UNTIL ALARM SOUNDS. DOOR WILL OPEN IN 15 SECONDS." An interview with the Maintenance Director at the time of the observation verified the door did not have a sign as indicated above. Additionally, the facility had no testing documentation. NJAC 8:39-31.1(c), 31.2(e) .	K 222	ensure the the deficient practice will not recur. Extra signs were purchased to have on hand in case of any new doors are assigned or replaced. 4.How will the facility monitor its corrective action. Security Director/Designee will document preventive maintenance weekly x4, then monthly x3 then quarterly x2 through QAPI.	
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: .	K 341	Observations identified two smoke	2/14/23

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K 341	Continued From page 4 Based on observations and interviews, the facility failed to ensure that smoke detectors were greater than 36 inches from air supply diffusers in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 edition) section 29.8.3.4.(6). This deficient practice had the potential to affect all 44 residents. Findings include: An observation of a corridor smoke detector near bedroom C-14 on 01/11/23 at 9:45 AM revealed the smoke detector was eight inches from a supply air diffuser. An observation of the smoke detector in the corridor near the MDS (minimum data set) office on the B-unit on 01/11/23 at 10:35 AM revealed the smoke detector was 24 inches from a supply air diffuser. An interview with the Maintenance Director at the time of each observation verified the measurements of the smoke detectors to the supply air diffusers. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72 .	K 341	detectors that were located within 36 inches of air supply diffusers in accordance with NFPA 72 National Fire Alarm and Signaling Code. 1.How Corrective Action will be accomplished. The detector near bedroom C-14 and in the corridor near the MDS office on B-unit will be relocated in accordance with the code by an outside vendor, who is our company maintaining the fire alarm system, on February 14. Security will be responsible to make sure the work is complete. 2. All residents have the potential to be affected. 3. What measures will be put in place to ensure practice does not happen again. Any relocation of smoke detectors will be reviewed by the Director of Security. 4. How will the facility monitor its corrective action. Director of Security will provide written document of completion and report all results through QAPI. Director of Security will conduct weekly walks x4, monthly x3, and quarterly x2 to make sure all smoke heads meet the requirements.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance	K 345		2/14/23

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K 345	Continued From page 5 A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: . Based on document review and interview, the facility failed to complete a smoke detection sensitivity test for all 98 photo electric smoke detectors in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 edition) section 14.4.5.3.2. This deficient practice had the potential to affect all 44 residents. A review of fire safety records from the "Fire Alarm" folder revealed the most recent two fire alarm inspections on 03/30/22 and 08/22/22 did not include a smoke detection sensitivity test. An interview with the Maintenance Director on 01/11/23 at 1:00 PM revealed he did not have the test from the past two years and did not have a smoke detection sensitivity test for all 98 photo electric smoke detectors. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72 .	K 345	Fire alarm inspections follow code except for a smoke alarm sensitivity test. 1. How the Corrective Action will be accomplished. Our contracted company maintaining the fire alarm system, will conduct the tests on February 13 and 14, 2023 and provide written documentation per NJDOH guidelines. Security will be responsible to make sure the work is complete. 2. All residents have the potential to be affected. 3.What measures will be put in place to make sure it will not recur. An outside vendor will conduct regular testing and document in accordance with the regulation. Any findings will be immediately corrected. 4. How will facility monitor. Security Director/Designee will keep written documentation of all testing according to regulations. Results will be	

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K 345	Continued From page 6	K 345	reported to QAPI x3 months.	
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: . Based on document review and interview, the facility failed to ensure the fire plan referenced moving residents beyond the smoke compartment affected by fire to an unaffected smoke compartment and preparing the unit for evacuation in accordance with NFPA 101 Life Safety Code (2012 edition) section 19.7.2.2. This deficient practice had the potential to affect all 44 residents. Findings include: A review of the fire plan located in the "Disaster Manual" revealed the fire plan lacked reference to moving residents beyond the smoke compartment affected by fire to an unaffected	K 711	The findings indicated the fire plan in the Disaster Manual lacked a written reference to moving residents beyond the smoke compartment affected to an unaffected smoke compartment. 1. How Corrective Action will be accomplished. The Disaster manual was immediately updated by Security with the instructions indicating unaffected areas for resident evacuation. 2. All residents have the potential to be affected. 3. What measures will be put in place.	2/3/23

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K 711	Continued From page 7 smoke compartment and preparing the unit for evacuation. An interview with the Maintenance Director on 01/11/23 at 1:45 PM verified the plan did not address the above areas. NJAC 8:39-31.2(e) .	K 711	Staff will be in-serviced February 2023 to educate them on possible scenarios. A contracted licensed fire dill company who provides monthly in-service training to staff regarding fire drills and emergency response. 4. How the facility will monitor. Security Director/Designee will monitor and conduct a monthly review of disaster manual to include this information. The Administrator will review and sign off on the manual annually. All results will be reported through QAPI x3 months.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in	K 918		2/10/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315022	A. BUILDING **01** B. WING _____	C **01/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
MEADOW LAKES	**300 MEADOW LAKES** **EAST WINDSOR, NJ 08520**

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K 918	Continued From page 8 accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: . Based on observation, document reviews and interview, the facility failed to ensure that two of two generators were maintained in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 edition) sections 7.3.1 and 7.3.2. and 8.4.1 This deficient practice had the potential to affect all 44 residents. Findings include: An observation of the boiler room housing the two generator transfer switches on 01/11/23 at 11:00 AM revealed the area did not have battery operated emergency lighting for the two transfer switches. An interview with the Maintenance Director at the time of the observation verified the lack of battery powered emergency lighting. A review of the facility generator log for the 2250 KW (kilowatt) diesel generator revealed there	K 918	1. How the Corrective Action will be Accomplished. Maintenance Director has ordered battery operated lighting for the areas where generator transfer switches are located and will be installed by 2/1/23. All generator tests and inspections will be conducted per NJDOH guidelines. 2. All residents have the potential to be affected. 3. What changes will be put in place do deficient practice will not recur. Maintenance Director/Designee will perform weekly testing of generators and monthly load tests and document findings. Maintenance Director will conduct weekly testing of emergency lighting where generator switches are located.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315022	A. BUILDING **01** B. WING _____	C **01/11/2023**

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MEADOW LAKES	**300 MEADOW LAKES** **EAST WINDSOR, NJ 08520**

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K 918	Continued From page 9 were no weekly generator checks after June 28, 2022. In addition, there was no record of a monthly load test in October 2022 and December 2022. A review of the facility generator log for the 60 KW generator revealed there were no weekly generator inspections on 10/18/22, 10/25/22, 09/13/22, 09/06/22, 08/31/22, 08/24/22, 08/17/22, 08/03/22, 07/27/22, 07/11/22, 06/01/22, 04/14/22 and 01/28/22. An interview with the Maintenance Director on 01/11/23 at 12:45 PM indicated he would check with the previous Maintenance Director for additional documents related to weekly and monthly generator testing. At 1:45 PM on 01/11/23 he indicated there was no additional information. NJAC 8:39-31.2(e), 31.2(g) .	K 918	The Administrator will be immediately notified of any delay in testing. 4. How will the facility monitor. Maintenance Director will provide written documentation of all testing to Administrator weekly x4 monthly x3 then quarterly x2 through QAPI.	
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: .	K 926	1.How the Corrective Action will be	2/3/23

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	315022	A. BUILDING **01** B. WING _____	C **01/11/2023**

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MEADOW LAKES	**300 MEADOW LAKES** **EAST WINDSOR, NJ 08520**

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K 926	Continued From page 10 Based on document review and interview, the facility failed to ensure safety training for staff who handle oxygen cylinders was provided in the past 12 months in accordance with NFPA 99 Health Care Facilities Code (2012 edition) section 11.5.2.1. This deficient practice had the potential to affect all 44 residents. Findings include: A review of the facility training information on 01/11/23 at 3:00 PM revealed training had not been provided in the past 12 months related to safety when handling oxygen cylinders for relevant staff, including nurse aides, nurses, and maintenance staff. An interview with the facility Administrator on 01/11/23 at 3:00 PM revealed there were no in-services for safety for staff handling oxygen cylinders. NJAC 8:39-31.2(e) NFPA 99 .	K 926	accomplished. The Respiratory Therapist along with the Director of Security conducted in-service training with the nursing, housekeeping and maintenance department starting on 1/31/23. Training will be conducted at various times and dates to ensure all staff are educated. 2. All residents have the potential to be affected. 3. What measures will be put in place to make sure it does not recur. Training on safe handling of oxygen cylinders will be part of our mandatory in-service training for staff. The staff will receive training upon hire and annually as part of the mandatory requirements and for NJDOH review. 4. How will the facility monitor its progress. The Director of Security will provide written in-service documentation to the Administrator weekly x4, then monthly x3 , then quarterly x2 and report all results through QAPI.	

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
315022 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/14/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LAKES	300 MEADOW LAKES EAST WINDSOR, NJ 08520

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	02/03/2023	LSC K0341	02/14/2023	LSC K0345	02/14/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0711	02/03/2023	LSC K0918	02/10/2023	LSC K0926	02/03/2023
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	
1/11/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO