STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315010	A. BUILDING _____ B. WING _____	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORA HILLS HEALTH & REHABILITATION CENTER	225 W JERSEY STREET ELIZABETH, NJ 07202

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F 000	INITIAL COMMENTS Standard Survey: 4/8/22 Census: 176 Sample Size: 38 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities. Deficiencies were cited for this survey.	F 000		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623		5/4/22

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

Electronically Signed | 04/26/2022

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F 623	Continued From page 1	F 623		

before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with

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F 623	Continued From page 2 developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to notify resident families or resident representatives (RR), and the Ombudsman's office in writing for a facility-initiated transfer to the hospital for 8 of 8 residents (Resident #69, #15, #41, #607, #99, #144, #57 and #21) reviewed for hospitalization.	F 623	F-623 SS=C 1) Late written notice has been provided to the residents and their responsible parties. 2) All residents may potentially be	

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F 623	Continued From page 3 The deficient practice was evidenced by the following: The surveyors reviewed the hybrid medical records (paper and electronic) that revealed facility-initiated hospital transfers had occurred without written notification to the families and Ombudsman's office for the following residents: 1. According to the Discharge Minimum Data Set (MDS) an assessment tool dated [redacted] Resident #69 was transferred to the hospital with anticipated return to the facility. There was no documentation that the facility had notified the resident's family or [redacted] in writing regarding the reason for transfer and bed hold policy. On 3/29/22 at 12:45 PM, the surveyor interviewed the Social Worker (SW) who stated she was not aware of the Emergency Transfer Notification form. The SW stated "nursing does it." On 3/29/22 at 1:05 PM, the surveyor interviewed the Licensed Practical Nurse Charge Nurse (LPN#1/CN) who stated that they only call the resident's family when they are transferred to the emergency room, they don't send the letters. On 3/29/22 at 1:47 PM, the surveyor interviewed the Director of Nursing (DON)who stated nursing does it, the surveyor informed the DON that LPN#1/CN stated they do not send the letters to families. The DON then stated the SW does it, again the surveyor informed the DON that the SW stated they do not send the letters to families. The DON then said "I don't know, "I don't think we do it." 2. According to the Discharge MDS dated	F 623	affected. 3) Admissions and Nursing staff have been in-serviced on providing written notice to residents and the residents representative upon a discharge. 4) Administrator or designee will audit charts randomly, weekly x 4 weeks then monthly x 3 months to ensure Transfer notices are given to residents and resident representatives. Administrator or designee will report outcomes of all audits to the Quality Assurance team at the Quarterly Quality Assurance Improvement Meeting.	

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EX. Order 26.(4), Resident #15 was transferred to the hospital with anticipated return to the facility. There was no documentation that the facility had notified the residents family or Resident Representative in writing regarding the reason for transfer.

3. According to the Discharge MDS dated EX. Order 26.(4), Resident #41 was transferred to the hospital with anticipated return to the facility. There was no documentation that the facility had notified the resident's family or Resident Representative in writing regarding the reason for transfer.

On 3/29/22 at 1:55 PM, the surveyor asked the Two South LPN #2 the process of notification when a resident is transferred to the hospital. LPN #2 said, "the doctor is called, then transport or 911 is called and the family called". The surveyor asked if anything was sent in writing to the Resident Representative or family and LPN #2 said, "no".

On 3/29/22 at 1:58 PM, the surveyor interviewed the LPN #3 Unit Manager (LPN#3/UM) regarding the process of notification when a resident was transferred to the hospital. LPN#3/UM told the surveyor that the family was called. When the surveyor asked if a notification went to the Resident Representative or family in writing, the LPN#3/UM said, "no, just a phone call".

4. According to the Discharge MDS dated EX. Order 26.(4) Resident #607 was transferred to the hospital with anticipated return to the facility. There was no documentation that the facility had notified the resident's family EX. Order 26 in writing regarding the reason for transfer and bed hold policy.

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5. According to the Discharge MDS dated [redacted] Resident #99 was transferred to the hospital with anticipated return to the facility. There was no documentation that the facility had notified the resident's family or [redacted] in writing regarding the reason for transfer and bed hold policy.

6. A review of Resident #144's hybrid medical record revealed the following:

The [redacted] MDS indicated the resident was discharged from the facility on [redacted] and anticipated to return to the facility. The Census tab in the electronic record indicated the resident was readmitted to the facility on [redacted].

On 3/31/22 at 10:42 AM the Social Services Director stated the resident or responsible party was not provided with written notification of the reason for an emergency transfer. She stated facility staff notified the responsible party by phone, however, no written notification was provided to the resident or responsible party.

7. According to the Discharge MDS dated [redacted] and [redacted], Resident #57 was transferred to the hospital with an anticipated return to the facility. There was no documentation that the facility had notified the resident's family or [redacted] in writing regarding the reason for transfer and bed hold policy.

On 3/31/22 at 9:20 AM, the surveyor interviewed LPN#1/CN who stated the resident was "usually" hospitalized due to [redacted] and the most recent one was because the [redacted] was dislodged. LPN#1/CN stated that there was no

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documentation that the facility had notified the resident's family in writing regarding the reason for transfer and bed hold policy, "we don't do that here, it was my first time to see the forms when they showed it to me the other day."

8. According to the Discharge MDS dated [redacted], Resident #21 was transferred to the hospital with anticipated return to the facility. There was no documentation that the facility had notified the resident's family or RR in writing regarding the reason for transfer and bed hold policy.

On 4/4/22 at 1:38 PM, the survey team discussed the above hospitalization notification concern with the Administrator and DON. The Administrator informed the surveyors that only the office of the Ombudsman was notified monthly.

A review of the facility's policy titled Discharge Services dated January 2022 revealed the following: Under Procedure A-1 and 2, "Notice Before Transfer When a resident is temporarily transferred on an emergency basis to an acute care facility, it is considered to be facility-initiated transfer. Before a nursing facility transfers to the ER - or the resident goes on therapeutic leave or has a planned hospital admission - the nursing facility will provided written information to the resident and resident representative that specifies:
1. The duration of the state bed-hold policy for hospital transfers, during which the resident is permitted to return and resume residence in the nursing facility (NOTE: At the time of this writing , it is the policy of the State of New Jersey that a [redacted] recipient's bed is to be held for a maximum of ten days.)

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F 623	Continued From page 7 2. For residents over age 60, send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman monthly." NJAC 8:39-5.3	F 623		
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 observation, interview, and record review, it was determined that the facility failed to medications were administered in a timely manner in accordance with professional standards of nursing practice for 1 of 38 residents reviewed (Resident # 103). This deficient practice 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 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."	F 658	F658 D 1. Corrective action(s)accomplished for resident(s)affected: The identified Licensed Nurse was re-educated on administration of medication in a timely manner in accordance with professional standards of nursing practice. Resident #103's physician was notified, and this resident had no negative outcomes related to this deficient practice. 2. Residents identified having the potential to be affected and corrective action taken: Residents currently residing in the facility have the potential to be affected. Licensed Nurses were re-educated by the Assistant Director of Nursing (ADON)/Designee regarding Medication Pass and on the administration of	5/4/22

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F 658	Continued From page 8 On 3/31/22 at 9:33 AM, during the medication observation pass, the surveyor observed a 2 South Licensed Practical Nurse (LPN #1) starting to prepare medications for Resident #103. The surveyor observed two medications on the electronic Medication Administration Record (eMAR) that were shaded pink with an administration time of 8 AM. The eMAR revealed that pink shaded medications were overdue. The two medications were EX. Order 26.(4) B1 (a medication used to reduce EX. Order 26.(4) B1 mg tablet and EX. Ot, Order 26.(4) B1 (a medication used to EX. Order 26.(4) B1 EX. Order 26.(4) B1 EXEX mg tablets. At that time, the surveyor interviewed LPN #1, who stated that she was aware that EX. Order 26.(4EX. O and EX. Order 26.(4) B1 were both overdue for medication administration, but she wanted to give all the medications after Resident #103 ate breakfast. LPN #2 confirmed that both EX. Order 26.(4) B1 and EX. Order 26.(4) B1 had an administration time of 8 AM. On 3/31/22 at 10:00 AM, the surveyor observed LPN #1 administer medications, including EX. Order 26.(4) B1 mg and EX. Order 26.(4) B1 mg to Resident #103. On 3/31/22 at 10:45 AM, the surveyor reviewed the Admission Record for Resident #103 which indicated that the resident had diagnoses which included EX. Order 26.(4) B1 EX. Order 26.(4) B and EX. Order 26.(4) B1. A review of the EX. Order 26.(4) B1 Order Summary Report (OSR) revealed a physician's order dated EX. Order 26.(4) for EX. Order 26.(4) B1 mg tablet, give 1 tablet by mouth every EX. Or hours related to EX. Order 26.(4) B1 and hold for EX. Order 26.(4) B1 or EX. Order 26.(4) B1. The OSR also revealed a physician's order dated EX. Order 26.(4) B1 for EX. Order 26.(4) B1	F 658	medication in a timely manner in accordance with professional standards of nursing practice. 3. Measures will be put into place to ensure the deficient practice will not recur: ADON/designee will review the Medication Administration Audit Report each shift to ensure all medications have been administered on time. The Pharmacy consultant will review medication regimes monthly and make recommendations on improving medication administration efficiency by decreasing the number of medications passes per resident. 4. Corrective actions will be monitored to ensure the deficient practice will not recur: ADON/Designee will conduct a weekly audit times 4 weeks, then monthly times 3 months to validate medications are administered in a timely manner. Discrepancies will be reported to the Director of Nursing (DON) with follow up actions as necessary. The DON will analyze and trend the Medication Administration Audit Reports findings and report outcomes to the QA Committee quarterly for recommendations as necessary.	

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F 658	Continued From page 9 EX. O mg tablet, give 1 tablet by mouth three times daily for EX. Order 26.(4) B1 and hold for EX. Order EX. Order 26.(4) B1 The above corresponding physician's order was transcribed onto the EX. Order 26.(4) B1 electronic eMAR. The eMAR also revealed that EX. Order 26.(4) B1 administration time was 8 AM and 8 PM (0800 and 2000) and that the EX. Order 26.(4) B1 mg tablets, administration time was 12 AM, 8AM and 4 PM (0000, 0800 and 1600). A review of Manufacturer's Specifications revealed that both EX. Order 26.(4) B1 and EX. Order 26.(4) B1 could be administered with or without food. On 3/31/22 at 2:00 PM, the surveyor discussed the above concerns with the Administrator and Director of Nursing (DON). No additional information was provided. A review of the facility's policy titled "Medication Dispensing System" provided by the DON with a revised date of 1/31/22, indicated the following under Medication Administration. "Medications are administered in a timely fashion as specified by policy." And "Follow appropriate medication administration guidelines (e.g., rotating insulin injection sites, providing food and fluid with medications, shaking medications before pouring, etc.)." NJAC: 8-39-27.1(a); 11.2(b)	F 658		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a	F 688		5/4/22

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F 688	Continued From page 10 resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) ensure that the applications of assistive devices were provided as ordered and b.) provide an appropriate Restorative Nursing Program (RNP) for 2 of 6 residents (Resident #20 and #115) reviewed for EX. Order 26.(4) B1) according to the facility's policy and procedures and standards of clinical practice. This deficient practice was evidenced by the following: 1. On 3/28/22 at 10:20 AM, the surveyor observed that Resident #20 was not in their room. At that time, the Licensed Practical Nurse #1/Charge Nurse (LPN #1/CN) informed the surveyor that Resident #20 was "probably" self-propelling in the unit. LPN #1/CN stated that the resident was EX. Order 26.(4) B1 , did not speak EX. Order 26.(4) B1 , and had EX. Order 26.(4) B1	F 688	F688 SS-D 1. Corrective action(s)accomplished for resident(s)affected: The identified Licensed Nurses were re-educated on following physician orders. The attending physicians for residents #20 and #115 were notified. Resident #20 had no negative outcomes related to not wearing the EX. Order 26.(4) B1 as ordered by the physician. Resident #115 had no negative outcomes related the omission of documentation of how long the EX. Order 26.(4) B1 EX. Order 26.(4) B1 was applied. 2. Residents identified having the potential to be affected and corrective action taken:	

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F 688	Continued From page 11 EX. Order 26.(4) B1 due to a previous history of EX. Order 26.(4) B1 Furthermore, LPN #1/CN informed the surveyor that the resident was on EX. Order for EX. Order 26.(4) B1 ROM (range of motion), and EX. Order 26.(4) to the EX. Order EX. Order 26 On 3/30/22 at 9:10 AM, the surveyor observed the resident seated in a wheelchair in front of their room. The resident was not wearing the EX. Order 26.(4) B1. The resident informed the surveyor that he/she was waiting for the nurse to administer their medication. The resident's hybrid medical record (paper and electronic) revealed the following. The Admission Record indicated the resident was admitted to the facility with diagnoses which included but were not limited to EX. Order 26.(4) B1 and EX. Order 26.(4) B1 , and EX. Order 26.(4) B1 EX. Order 26.(4) B1 that causes the EX. Order 26.(4) B1 . The EX. Order 26.(4) B1 Annual Minimum Data Set (MDS), an assessment tool used to facilitate care management, indicated a Brief Interview for Mental Status (BIMS) score of EX. Order 26.(4) B1, which reflected that the resident's EX. Order 26.(4) B1 The MDS indicated that the resident had limited EX. Order 26.(4) B1 to EX. Order 26.(4) B1 for both EX. Order 26.(4) and EX. Order 26.(4) B1. A review of the EX. Order 26.(4) B1 Order Summary Report included a physician order dated EX. Order 26.(4) for an RNP Task to apply a EX. Order 26.(4) B1	F 688	Residents receiving applications of assistive devices have the potential to be affected. Residents with assistive device orders were reviewed and orders were placed on the Treatment Administration Record (TAR) to include the total time the assistive devices were applied. 3. Measures will be put into place to ensure the deficient practice will not recur: Licensed Nurses were re-educated by the Assistant Director of Nursing (ADON) regarding Following Physician Orders and Principles of Documentation. A new process is in place to include assistive device orders are entered in the Treatment Administration Record (TAR) to include the total time the assistive devices was applied. 4. Corrective actions will be monitored to ensure the deficient practice will not recur: The ADON/Designee will conduct a weekly audit times 4 weeks, then monthly times 3 months to validate that assistive device orders were carried out and documented as ordered. Discrepancies will be reported to the Director of Nursing (DON) with follow up actions as necessary. The DON will analyze and trend assistive device audit findings report outcomes to the QA Committee quarterly for recommendations as necessary.	

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	315010	A. BUILDING _____ B. WING _____	04/08/2022

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EX. Order 2 to the EX. Order 26.(4) B1 with EX. Order 26.(4) B1 for EX. Order 26.(4) B1 (hrs) or as tolerated when out to bed (OOB) during AM shift with skin checks.

The order for splinting was transcribed to the Certified Nursing Assistant (CNA) Task section of the electronic medical records. Further review of the EX. Order 26.(4) B1 Task showed that the CNA was signing the application for a EX. Order 26.(4) B1 for EX.O minutes twice a day during the morning and evening shifts. According to the EX. Order 26.(4) B1 Task documentation the resident's EX. Order 2 order to apply the EX. Order 26.(4) B1 for EX. Order 26 hours during AM shift was not followed.

A review of the EX. Order 26.(4) B1, and EX. Order 26.(EX. Order 2 RNP Nursing Monthly Reevaluation (NMR) showed that Restorative Goal #2 included "Assistance with EX. Order 26.(4) B1 ." The RNP NMR also included "Continue current goal."

Further review of the EX. Order 26.(4) B1 RNP NMR did not reflect the above actual order for left/wrist splint. There was no further documentation that indicated how long the resident was able to tolerate the EX. Order 26 or if the resident was receiving the EEX. Order hours of EX. Order 2 application as ordered and as part of the licensed nurse evaluation and assessment of the use of an assistive device.

On 3/30/22 at 9:43 AM, the surveyor interviewed LPN #1/CN who informed the surveyor that RNP for EX. Order 26.(4) B1, and EX. Order 26.(4) B should have a physician order and be transcribed to the Task of the CNA. LPN #1/CN stated that there was no restorative aide in the facility and it was the

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responsibility of the assigned aide to follow the physician's order, perform the RNP, and document it to the Task.

On that same date and time, the surveyor asked LPN #1/CN to review the splinting Task of the resident. LPN #1/CN and surveyor reviewed the Task together. LPN #1/CN confirmed that the CNA was documenting [redacted] and [redacted] minutes during morning and evening shifts in the Task for the [redacted] EX. Order 26.(4) B1 when the order was [redacted] hours application during AM shift. When asked why the task was documented that way, LPN #1/CN stated, "I don't know." The surveyor asked LPN#1/CN how does the nurse know if the resident was tolerating the [redacted] for [redacted] hours and LPN #1/CN had no answer.

Furthermore, LPN #1/CN stated that the resident's [redacted] limitation was not something new to the resident and there was no significant decline in the resident. She further stated that the CNA was aware that the [redacted] should be applied for three hours.

On 3/30/22 at 10:19 AM, the surveyor interviewed CNA #1 who informed the surveyor that she was the regular CNA of Resident #20. CNA #1 stated that the resident was EX. Order 26.(4) B1 with some EX. Order 26.(4) B1 that required limited to extensive assistance with ADL (activities of daily living). She further stated that the resident had a EX. Order 26.(4) B1 which was not something new to the resident. She indicated that she applied a EX. Order 26.(4) B1 daily for three hours and the [redacted] was well tolerated.

At that time, CNA #1 showed the documentation on the kiosk (a small stand-alone device

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providing information and services on a computer screen) to the surveyor. She stated she uses the kiosk for documenting the RNP. The surveyor asked CNA #1 why [redacted] minutes was documented in the Task for the EX. Order 26.(4) B1 when the order was to apply for [redacted] hours. CNA #1 had no answer.

On 3/30/22 at 11:32 AM, the surveyors observed the resident seated in a wheelchair in front of their room with no [redacted] in use.

At that same time, the surveyor asked LPN #1/CN to check the resident if the EX. Order 26.(4) B1 was in use. LPN #1/CN checked the resident's [redacted] and confirmed the [redacted] was not in place. She stated CNA #1 applied the [redacted] at 9:30 AM and removed it because it was [redacted] hours had passed. The surveyor explained to LPN #1/CN that the [redacted] was observed placed on at 9:30 AM and removed at 11:30 AM for a total of [redacted] hours. LPN #1/CN stated that the resident "probably removed it." The surveyor asked LPN #1/CN if it was documented that the [redacted] was in place for [redacted] hours instead of [redacted] hours. LPN #1/CN did not respond.

On 3/30/22 at 1:10 PM, the surveyors interviewed the resident in their room. A [redacted]-speaking surveyor asked the resident who applied and removed the EX. Order 26.(4) B1 and how long it was being applied. The resident stated in [redacted] that it was the CNA who applied and remove the splint. The resident stated occasionally they take it off. The resident further stated that the CNA put on the [redacted] for [redacted] hours and was not being applied daily. The resident stated to the surveyors that the [redacted] was applied today "only for [redacted] hours," and it was the therapist who

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removed the [redacted] today. The resident was not sure why the [redacted] was removed today.

On 3/30/22 at 2:09 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) They were made aware of the surveyor's concerns. The DON informed the surveyors that the [redacted] minutes that was documented in the Task for the CNA and it was the time the CNA applied the [redacted] and did not refer to how long the resident had the [redacted] on.

The surveyor further asked the DON how the resident's tolerance to the [redacted] was monitored and where was it documented the resident's record. The surveyor asked to review documentation for the accountability of the application of the EX. Order 26.(4) B1. The DON stated that "we have not been doing that." The DON acknowledged that the order for [redacted] hours of application should have been followed, documented, and monitored for tolerance and compliance of the resident according to the standard of practice.

2. On 3/29/22 at 10:06 AM, the surveyor observed Resident #115 lying in bed, awake with EX. Order 26.(4) B1.

A review of the Admission Record reflected that the resident had diagnoses which included, but not limited to EX. Order 26.(4) B1 [redacted].

A review of the [redacted], Quarterly MDS indicated a BIMs score of [redacted] which reflected that the resident's EX. Order 26.(4) B1. The

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MDS also reflected that the resident was totally dependent on staff to complete his/her activities of daily living (e.g., bed mobility and transfer).

A review of "PT [physical therapy] Evaluation & Plan of Treatment" notes dated EX. Order 26.(4) reflected that the resident was referred to PT due to EX. Order EX. Order 26.(4) B1 to EX. Order 26.(4) B1. It was indicated in the PT evaluation notes that the resident's baseline was totally dependent with EX. Order 26.(4) B1 of EX. Order 26.(4) B1, developing of EX. Order 26.(4) B1." It also indicated the PT goal was "Trial and issuance of EX. Order 26.(4) B1 schedule EX. Order 26.(4) B1 to prevent further EX. Order 26.(4) B1." The resident was discharged from PT on EX. Order 26.(4) B with recommendations for RNP: Application of EX. Order 2 EX. Order 26.(4) B1 hours daily, either in bed or EX. Order 26.(4) B1, skin check for skin irritation before and after application.

A review of the Order Summary Report (OSR) for EX. Order 26.(4) B1 reflected physician's orders dated EX. Order 26.(4) B1 or "RNP TASK 2: APPLICATION OF EX. Order 26.(4) B1 OURS DAILY, EITHER IN BED OR IN EX. Order 26.(4) B1, SKIN CHECK FOR SKIN IRRITATION BEFORE AND AFTER EACH APPLICATION."

On 3/30/22 at 1:15 PM, CNA #2 informed the surveyor that the resident was dependent with care from staff. She also stated that the resident was on RNP where an EX. Order 26.(4) B1 to EX. Orde EX. Order was applied in the evening by CNAs and removed by morning CNAs at 7:30 AM. She stated that she recorded 15 minutes in Point of Care or PoC (an electronic device that enables staff to record the care they provided to the

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residents) for the total amount she spent removing the EX. Order 26.(4) B1 off the resident.

The LPN #2/CN acknowledged to the surveyor that the CNA documentation in the PoC did not appropriately reflect the physician's order for EX. Order 26.(4) B1 application. She also acknowledged that the CNA documentation in PoC did not specify that the EX. Order 26.(4) B1 was applied for EX. hours daily, per physician's order. She stated to the surveyor that the CNA only recorded the amount of minutes spent providing EX. Order 26 assistance (application and removal) for the resident in the PoC.

On 3/31/22 at 10:38 AM, the DON informed the surveyor that the CNA was responsible for implementation of prescribed RNP and documentation of the task in the PoC. The DON acknowledged to the surveyor that the physician's RNP order indicated the application of EX. Order 26.(4) B1 to EX. Order 26.(4) B1 hours daily. The DON also stated that the CNA documented the minutes spent for application and removal of the EX. Order 26. in PoC. The surveyor and the DON reviewed the CNA documentation, which indicated the date, time, and EX. Order minutes spent provided for the EX. Order 26 assistance. However, it showed no evidence of its EX.-hour application daily, per physician's order. The surveyor asked the DON if the CNA's documentation in PoC reflected the physician's order and the DON answered, "no." The DON also acknowledged to the surveyor that there was no accountability that the EX. Order 26.(4) B1 was applied on the resident for EX. hours daily.

A review of the facility Restorative Nursing

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F 688	Continued From page 18 Program Policy and Procedures, revised 1/2022, provided by the DON included "Purpose: It is the policy of [name redacted] to maintain up to date and accurate documentation for all residents on Restorative Nursing Program (RNP). Procedure: The following elements will be in place for all residents on RNP: A licensed nurse will supervise the activities of the restorative nursing program. Although therapists may participate, members of the nursing staff are still responsible for overall coordination and implementation of the restorative nursing program.....Duration of time spent practicing goals, applying and removing [redacted], performing skin check before and after [redacted] application/removal, and maintaining proper [redacted] positioning will be recorded by the CNA, in a format designated by the facility." NJAC 8:39-27.2(m)	F 688		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;	F 692		5/4/22

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F 692	Continued From page 19 §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) ensure that weekly weights were done, and b.) re-evaluate and modify the care plan goal to reflect the current condition of the resident for 1 of 5 residents reviewed for nutrition (Resident #57). This deficient practice was evidenced by the following: On 3/28/22 at 10:27 AM, the surveyor observed Resident#57 seated in a EX. Order 26.(4) B1 [redacted] with a EX. Order 26.(4) B1 [redacted]) EX. Order 26.(4) B1 ml/hr (milliliters/hour) with EX. Order 26.(4) B1 infused. Review of the resident's admission record reflected that the resident was admitted to the facility with diagnoses that included EX. Order 26.(4) B1 [redacted] A review of the EX. Order 26.(4) B1 Quarterly Minimum Data Set (QMDS), an assessment tool used to	F 692	F692 SS-D 1. Corrective action(s)accomplished for resident(s)affected: Resident # 57 attending physician was notified and an order was given for monthly weights. Resident was immediately weighed, and the resident's weight is currently stable. Resident #57 care plan goal was updated to reflect the status of resident. 2. Residents identified having the potential to be affected and corrective action taken: Residents currently residing in the facility have the potential to be affected. 3. Measures will be put into place to ensure the deficient practice will not recur: The Registered Dietician was re-educated by the Regional Dietician regarding following up to obtain physician orders and reviewing and updating Nutrition care plan goals quarterly and/or as needed. The Weight Policy was revised to include admission weights are ordered by	

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F 692	Continued From page 20 facilitate the management of care, indicated a Brief Interview for Mental Status (BIMS) score of [redacted], which reflected that the resident's cognition was [redacted] d. The QMDS indicated that the resident had a [redacted]). Further review of the MDS showed that the resident was readmitted on [redacted] as shown on the Entry MDS from an acute hospitalization. A review of the Comprehensive Nutrition Assessment dated [redacted] revealed that Resident #57 was readmitted from the hospital with a recommendation from the Registered Dietitian (RD) to monitor weekly weights. A review of the Order Summary Report for [redacted] revealed that there was no order for weekly weights. A review of the individualized care plan reflected a care plan goal for Resident #57 to encourage [redacted] with a goal weight range of [redacted] pounds (lbs) with a revision date of [redacted]. A review of the electronic weight record showed that the resident's weight was not being checked weekly as evidenced by the following weights recorded in the medical record since the re-admission on [redacted]: 3/3/22=[redacted] lbs 3/2/22=[redacted] lbs On 3/30/22 at 12:13 PM, the surveyors interviewed the RD. The RD acknowledged that she should have obtained a physician's order for weekly weights following her recommendation on [redacted] The RD stated that it was the facility's	F 692	the physician specifically for each resident. 4. Corrective actions will be monitored to ensure the deficient practice will not recur: The Registered Dietician/Designee will conduct a weekly audit times 4 weeks, then monthly times 3 months to validate weekly weights are completed and nutritional care plan goals are updated to reflect the status of resident Discrepancies will be reported to the Director of Nursing (DON) with follow up actions as necessary. The DON will analyze, and trend audit findings report outcomes to the QA Committee quarterly for recommendations as necessary.	

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procedure to monitor weekly weights of residents who are readmitted from the hospital.

On that same date and time, the surveyor interviewed the RD who stated that Resident#57 had a [redacted] and was stable at [redacted] lbs. She further stated that the care plan goal should have been revised to reflect the current status of the resident whose goal weight was [redacted] lbs.

At that time, the Licensed Practical Nurse/Charge Nurse (LPN/CN) informed the surveyors that the physician was aware of the [redacted] which was why the physician ordered to [redacted] the [redacted]. The LPN/CN stated that it was facility policy to obtain a physician's order or the RD could give an order for weekly weights for four weeks upon admission and readmission to the facility. The LPN/CN could not speak to why Resident#57 had no physician's order for weekly weights.

On 3/30/22 at 2:09 PM, the survey team discussed the above observations and concerns with the Licensed Nursing Home Administration (LNHA) and Director of Nursing (DON).

On 4/4/22 at 9:41 AM, the survey team met with the LNHA and the DON. The DON stated that it was the facility policy to weigh residents upon admission and readmission and then weekly for four weeks. The DON further stated that when Resident#57 was readmitted to the facility on [redacted], the physician ordered a monthly weight which was why the weekly weight was not followed.

On 4/4/22 at 10:38 AM, the surveyors met with the DON. The DON provided a copy of the care plan that included the revised goal dated [redacted]

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where the goal weight of [redacted] lbs was removed. The DON informed both surveyors that the goal was revised and pointed to the [redacted] date. The surveyor asked the DON if the care plan goal was revised after the surveyor's inquiry and the DON stated "oh no, I can not answer for the RD, you have to ask her that." The surveyor then asked the DON to have the RD talk to the surveyors and the DON stated that she will get back to the surveyors.

On 4/5/22 at 9:46 AM, the surveyors met with the RD. The surveyor asked the RD if she was aware of the [redacted] readmission order of the physician for monthly weight and the RD stated "I might not have seen the doctor's order for monthly weight." The RD further stated that when she recommended weekly weights on [redacted] she thought the resident was on weekly weight "already" as per facility protocol.

On that same date and time, the surveyor asked the RD if she would look back after a month, check the weekly weight she recommended, and document. The RD stated "I should have gone back and checked," to make sure that her recommendations were acted upon.

Furthermore, the RD informed the surveyors that the resident was stable for three months at [redacted] lbs, skin intact, and laboratory results were good. The RD stated that the resident had a history of [redacted] was [redacted] "probably" causing [redacted] continued [redacted] She acknowledged that the care plan goals should have been revised according to the current condition of the resident, according to the resident's assessment, and that the resident would still benefit from [redacted] and that it

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ELMORA HILLS HEALTH & REHABILITATION CENTER	225 W JERSEY STREET ELIZABETH, NJ 07202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 23	F 692		

should have been reflected in the care plan.

A review of the undated facility Weight Policy that was provided by the RD included "Policy: It is the policy of [name redacted] to weigh each resident upon admission and readmission followed by (4) weekly weights, to prevent significant weight loss/gain or any weight discrepancies. Procedure:..The RD will review the medical record of residents with weight changes and make necessary dietary recommendations and interventions as needed ...Intervention initiated by the RD in response to weight changes shall be reflected in the care plan. Residents with significant weight changes shall be further reviewed by the IDCP team weight meetings."

A review of the facility Nutritional Assessment Policy with a revised date of February 2022 that was provided by the DON included "Policy: A nutritional assessment, including current nutritional status and risk factors for impaired nutrition, shall be conducted for each resident. Procedure: 1. The Dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission and as indicated by a change in condition that places the resident at risk for impaired nutrition. 2. The nutritional assessment will be a systematic, multidisciplinary process that includes gathering and interpreting data and using that data to help define meaningful interventions for the resident at risk for or with impaired nutrition ..."

A review of the facility Care Plan Development Policy with a revised date of January 2022 that was provided by the DON included "It is the policy of the Facility to develop plans of care to address

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F 692	Continued From page 24 the needs and strengths, as well as personal and cultural preferences of our residents that aligns with the resident's goals and wishes for treatment during their stay with us." NJAC 8:39-27.2 (a)	F 692		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to obtain a physician's order for the administration of EX. Order 26.(4) B1. This was found with 1 of 1 residents reviewed for EX. Order 26.(4) B1 treatment, Resident # 121. The deficient practice was evidenced by the following: On 3/28/22 11:39 AM, the surveyor observed Resident #121 seated in a wheelchair in the dining room during an activity. The resident had EX. Order 26.(4) B1 going EX. Order 26.(4) B1) by way of (EX. Order 26.(4) B1. On 3/30/22 at 10:49 AM, the surveyor observed the resident in the dining room seated in a	F 695	F695 SS-E 1. Corrective action(s)accomplished for resident(s)affected: Resident #121's physician was notified, and an order was obtained for EX. O, Order 26.(4) B1 EX. Order 26.(4) B1. The identified licensed nurse was re-educated regarding reviewing the physician order prior to administering EX. Order 26.(4) B1. 2. Residents identified having the potential to be affected and corrective action taken: All residents utilizing EXEX. Order 26 have the potential to be affected by this deficient	5/4/22

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F 695	Continued From page 25 wheelchair with EX. Ord being delivered at EX. Order 26.(4) B1 EX. Order 26.(4) B1. At 11:29 AM, the surveyor asked the activity aide (AA) who was assigned to the area if Resident #121 always used EX. Or. The AA stated, "yes, [the resident] always has EX. Or on." The surveyor reviewed Resident #121's hybrid (paper and electronic) medical records that revealed the following: According to the Admission Record, Resident #121 was admitted with diagnoses that included EX. Order 26.(4) B1 and history of EX. Order 26.(4) B1 The Quarterly Minimum Data Set, an assessment tool dated EX. Order 26.(4) B revealed that the facility performed a Brief Interview for Mental Status which the resident scored a EX. Order 26.(4) B1 that indicated the resident had EX. Order 26.(4) B1 EX. Order 26.(4) B1 On this MDS the facility had indicated the resident was receiving EX. Ord The EX. Order 26.(4) B1 Order Summary Report revealed a physician's order for EX. Order 26.(4) B1 EX. Order 26.(4) B at EX. Order 2 as needed for EX. Order 26.(4) B1 EX. Order 26.(that was initiated on EX. Order 26.(4) B The EX. Order 26.(4) B1 electronic Treatment Administration Record (eTAR) revealed the order for EX. Order 26.(4) B1 at EX. Order 2 as needed for EX. Order 26.(4) B1. There was no nurses documentation that the resident was receiving EX. Ord The nurses documented in the Progress Notes on EX. Order 26.(that the resident was receiving EX. Or EX. Order 26.(4) B1 The care plan titled "[the resident] has the potential for EX. Order 26.(4) B1 EX. Order 26.(4) B1 EX. O	F 695	practice. Residents utilizing EX. Order 26.(4 were reviewed by the (Assistant Director of Nursing) ADON/Designee to validate that the EX. Order 26.(4) was being administered per physician order. 3. Measures will be put into place to ensure the deficient practice will not recur: Licensed Nurses were educated by the ADON/designee on reviewing the physician order prior to administer EX. Order 26.(4) B1. A new process has been implemented to include all EX. Order 26.(4) orders as needed will have a specific timeframe to evaluate the need for EX. C. Order 26.(4) B1 EX. Order 2 4. Corrective actions will be monitored to ensure the deficient practice will not recur: The ADON/Designee will conduct EX. Order 26.(4) as needed audits weekly times 4 weeks, then monthly times three months Discrepancies will be reported to the Director of Nursing (DON), with follow up actions as necessary. The DON will analyze and trend report outcomes to the QA Committee quarterly, with follow up recommendations as necessary.	

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F 695	Continued From page 26 [EX. Order 26.(4) B1] device due to history of [EX. Order 26.(4) B1]." The interventions included "provide [EX. Order 26.(4)] as ordered." On 3/30/22 at 1:09 PM, the surveyor interviewed the certified nursing assistant (CNA) who was assigned to Resident #121. The CNA stated that the resident used [EX. Or] everyday. On 3/31/22 at 10:14 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to the resident. The LPN stated that the resident received [EX. Order 26.(4) B1] The surveyor asked the LPN where she signed for the [EX. Or]. The LPN and surveyor looked at the eTAR which revealed the [EX. Or] as needed order. She could not find a physician's order for [EX. Order 26.(4) B1] The LPN confirmed that there was no physician's order for [EX. Order 26.(4) B1] and she had not been signing the eTAR that the resident needed [EX. Orde] On 3/31/22 at 1:25 PM, the surveyor discussed the above concern with the Administrator and Director of Nursing. No additional information was provided. The surveyor reviewed the facility's policy titled [EX. Order 26.(4)] Administration, the first instruction on the policy under Procedure #1 reads, "Check MD order."	F 695		
F 698 SS=D	NJAC 8:39-27.1(a) Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent	F 698		5/4/22

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F 698	Continued From page 27 with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to 1.) consistently ensure the EX. Order 26.(4) B1 Progress Note was completed by both the facility and EX. Order 26.(4) center and 2.) failed to monitor residents returning from the EX. Order 26.(4) center for EX. Order 26.(4) B1 and vital signs. The deficient practice was observed for 4 of 4 residents (Resident #69, #71, #15 and #99) reviewed. The deficient practice was evidenced by the following: 1. On 3/28/22 at 11:23 AM, the surveyor observed Resident #69 lying in bed, awake and alert and able to be interviewed. Resident #69 stated that he/she goes to EX. Order 26.(4) EX. Order 2 days a week, on EX. Order 26.(4) B1 and EX. Order 26.(4) The resident stated that he/she usually returns to the facility approximately 6 PM. The resident further stated that the nurses heat up the dinner meal upon returning from the EX. Order 26.(4) B1 center. The surveyor reviewed Resident #69's hybrid (paper and electronic) medical records that revealed the following: According to the Admission Record, Resident #69 was admitted to the facility with diagnoses that include EX. Order 26.(4) B1 times a week. The Annual Minimum Data Set (MDS) an assessment tool dated EX. Order 26.(4) B1 revealed that the	F 698	F698 D 1. Corrective action(s)accomplished for resident(s)affected: Residents #69, #71, #15 and #99 attending Physicians' were notified and orders were obtained to monitor the access site and obtain vital signs EX. Order 2 EX. Order 26.(4). Residents #69, #71, #15 and #99 immediately had a physical assessment to include vital signs and assessment of the EX. Order 26.(4) B1. There were no negative findings. 2. Residents identified having the potential to be affected and corrective action taken: • All residents receiving EX. Order 26.(4) have the potential to be affected by this deficient practice. 3. Measures will be put into place to ensure the deficient practice will not recur: All Medication Administrator Records (MAR) and Treatment Administration Records (TAR)were audited on all residents receiving EX. Order 26.(4) to ensure that residents had physician orders to include EX. Order 26.(4) B1 vital signs and assessment of the EX. Order 26.(4) B1 All dialysis communication books were audited to ensure that both the facility and the EX. Order 26.(4) center completed	

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F 698	Continued From page 28 facility performed a Brief Interview for Mental Status (BIMS) which indicated that the resident had a score of EX. Order 26.(4) B1. The resident was assessed to be EX. Order 26.(4) B1. The EX. Order 26.(4) B1 Order Summary Report revealed a physician's order for EX. Order 26.(4) B1 every EX. Order 26.(4) B1 and EX. Order 26.. The was another physician's order to check the EX. Order 26 EX. Order 26.(4) B1 and EX. Order 26 prior to leaving for EX. Order 26.(4). The EX. Order 26.(4) B1 electronic Medication Administration Record (eMAR) revealed an order for the EX. Order 26.(4) B1 and EX. Order 2 to be taken prior to leaving for EX. Order 26.(4) B1. There was no physician's order to check the EX. Order 26.(4) B1 and EX. Order 26 when the resident returned from EX. Order 26.(4). The Dialysis Progress Note inside the dialysis communication binder showed vital signs assessment prior to EX. Order 26.(4) treatment and a section completed by the EX. Order 26.(4)B facility. There was no section for vital signs assessment to monitor for EX. Order 26.(4) B1 when the resident returned to facility. The Progress Notes dated from EX. Order 26.(4) to EX. Order 26.(4) revealed that the nurses documented the resident had returned from EX. Order 26.(4) B. However, there were no EX. Order 26.(4) B1 documented and the nurses did not consistently document the assessment of the EX. Order 26.(4) B1 There were no nurses notes documenting the return and assessment of the resident on the following dates: EX. Order 26.(4) B1 - EX. Order 26.(4) B1 and EX. Order 26.(4). The Dialysis Progress Note forms that go with the resident to the EX. Order 26 center and return with the	F 698	the EX. Order 26 progress note. Licensed nurses were re-educated by the Assistant Director of Nursing (ADON)/designee regarding resident assessment and monitoring EX. Order 26.(4) B1. Licensed nurses were re-educated by the Assistant Director of Nursing (ADON)/designee regarding completion of the EX. Order 26.(4) B progress note by the facility and EX. Order 26.(4) center. A new process has been implemented to include obtaining physician order for EX. Order 26.(4) B1 vital signs and monitoring of the EX. Order 26.(4) B1. In addition, the EX. Order 26.(4) progress note will be reviewed each time the resident returns to the facility. If found incomplete the Licensed Nurse will contact the EX. Order 26.(4) center for completion. 4. Corrective actions will be monitored to ensure the deficient practice will not recur: Assistant Director of Nursing (ADON), or designee, will perform MAR and TAR audits on residents receiving EX. Order 26.(4) weekly times 4 weeks then monthly times 3 months to ensure that residents have physician orders to include EX. Order 26.(4) B1 vital signs and assessment of the EX. Order 26.(4) B EX. Ord. Assistant Director of Nursing (ADON), or designee, will perform EX. Order 26.(4) progress note audits weekly times 4 weeks then monthly times 3 months to ensure that both the facility and the EX. Order 26.(4) center have completed the EX. Order 26.(4) progress note. Discrepancies will be reported to the Director of Nursing (DON) with follow up actions as necessary.	

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F 698	Continued From page 29 resident to the facility included two sections. The top of the page was completed by the facility and the remaining information was completed by the EX. Order 26.(4) center. There were four EX. Order 26.(4) Progress Note forms that were not completed by the facility or EX. Order 26.(4) center. The dates are as follows: EX. Order 26.(4) B1 and EX. Order 26.(4) The care plan titled "Dx [diagnosis] EX. Order 26.(4) receiving EX. Order 26.(4), potential for complication initiated on EX. Order 26.(4) B1 included an intervention to "maintain open communication with EX. Order 26.(4) B staff via book or consult form to accompany resident with each visit to EX. Order 26.(4). Communication should include: diet changes, fluid & pertinent medication changes, labs or diagnostic reports pertinent to resident's care, any changes to access site, wt [weight] changes, & any other pertinent changes in status." The care plan does not include an intervention to monitor the resident's EX. Order 26.(4) B1 and EX. Order 26.(4) B1 EX. Order 26.(4) B 2. On 3/28/22 at 11:25 AM, the surveyor observed Resident #71 out of bed seated in a wheelchair. The resident informed the surveyor that she/he goes out to EX. Order 26.(4) on EX. Order 26.(4) B, EX. Order 26.(4) B1 and EX. Order 26.(4) and usually returns to the facility approximately 7:30 PM. The surveyor reviewed Resident #71's hybrid medical records that revealed the following: According to the Admission Record, Resident #71 was admitted to the facility with diagnoses which included EX. Order 26.(4). The resident required EX. Order 26.(4) B1 is a treatment EX. Order 26.(4) and EX. Order 26.(4) B1, as the EX. Order 26.(4) B did when they were healthy. EX. Order 26.(4) B1 helps	F 698	The DON will analyze and trend audits and report outcomes to the QA Committee quarterly, with follow up recommendations as necessary.	

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EX. Order 26.(4) B1 and balance important EX. Order 26.(4) B1, such as EX. Order 26.(4) B1, and EX. Order 26.(4) B1) EX. Order 2 times a week on EX. Order 26.(4) B1 and EX. Order 26.

The Quarterly MDS dated EX. Order 26.(4), revealed that the facility performed a EX. Order 2 which indicated that the resident had a score of EX. Order 26.(4) B1. The resident was assessed to be EX. Order 26.(4) B1.

The EX. Order 26.(4) B1 Order Summary Report revealed a physician's order for EX. Order 26.(4) B1 every EX. Order 26.(4) B1 and EX. Order 26.(4) The was another physician's order to check the EX. Order 2 EX. Order 26.(4) B1 and EX. Order 2 prior to leaving for EX. Order 26.(4).

The EX. Order 26.(4) B1 eMAR revealed an order for the EX. Order 26.(4) B1 and EX. Order 2 to be taken prior to leaving for EX. Order 26.s. There was no physician's order to check the EX. Order 26.(4) B1 and EX. Order 2 when the resident returned from EX. Order 26.(4).

The EX. Order 26.(4) Progress Note inside the EX. Order 26.(4) communication binder showed vital signs assessment prior to EX. Order 26.(4) treatment and a section completed by the EX. Order 26.(4) facility. There was no section for vital signs assessment to monitor for EX. Order 26.(4) B1 when the resident returned to facility.

The Progress Notes dated from EX. Order 26. to EX. Order 26.(4) revealed that the nurses documented the resident had returned from EX. Order 26.(4). However, there were no EX. Order 26.(4) B1 documented, and on EX. Order 26.(4) there was no documentation of the resident's return to the facility.

The care plan titled "Dx [diagnosis] EX. Order 26.(receiving EX. Order 26.(4), potential for EX. Order 26.(4) B1

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initiated on EX. Order 26.(4) does not include an intervention to monitor the resident's EX. Order 26.(4) B1 and EX. Order 26.(4) B1.

On 3/30/22 at 10:11 AM, the surveyor interviewed the Licensed Practical Nurse #1 Charge Nurse (LPN#1/CN) what do the nurses do when the resident returns from EX. Order 26.(4) and the EX. Order 26.(4) B1 Progress Note is blank. LPN#1/CN stated that the 3-11 nurse was responsible to make the EX. Order 26.(4) B1 Progress Note was completed by the center and to contact the center to have the form faxed to the facility.

3. On 03/28/22 at 9:42 AM, during the initial tour of the facility Resident #15 was in bed with eyes open. Resident #15 family member told the surveyor that the resident went to EX. Order 26.(4) B1 times per week, on EX. Order 26.(4) B1, and EX. Order 26.(4

Review of the MDS dated EXEX. Order 26.(4) indicated that Resident #15 had a BIMS of EX. O, meaning the resident was EX. Order 26.(4) B1 Special Procedures and Treatments, of the MDS indicated the resident was receiving EX. Order 26.(4) B1. Medical diagnosis included, but not limited to EX. Order 26.(

On 3/29/22 at 10:19 AM, the surveyor reviewed the physician orders which showed the following order: EX. Order 26.(4) B1 every EX. Order 26.(4) B1 and EX. Order 26.(, and no EX. Order 26.(4) B1 or EX. Order 26.(4) B1 to EX. Order 26.(4) B1, monitor EX. Order 26.(4) B1) to EX. Order 26.(4) B1 and EX. Order 26.(4) B1 to EX. Order 26.(4) B1), signs and symptoms EX. Order 26.(4) B1, and for signs of EX. Order 26.(4) B1

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The EX. Order 26.(4) B1 Progress Note inside the EX. Order 26.(4) communication binder showed vital signs assessment prior to EX. Order 26.(4) treatment and a section completed by the EX. Order 26.(4) B1 facility. There was no section for vital signs assessment to monitor for EX. Order 26.(4) B1 when the resident returned to facility.

The surveyor then reviewed the vitals signs section of the Electronic Medical Record (EMR) which indicated the facility was not checking Resident #15 vital signs after returning to the facility from EX. Order 26.(4) B treatments. Vital signs were missing for EX. Order 2 of the EX. Order 26.(4) B1 days for EX. Order 26.(4) B1

The surveyor reviewed the residents care plan which included the following focus: diagnosis of EX. Order 26.(4) B1), receiving EX. Order 26.(4) B and EX. Order 26.(4) B1 . The care plan interventions did not include monitor the EX. Order 26.(4) B1 .

On 3/30/22 at 9:54 AM, the surveyor observed the resident in bed. LPN #2 was in the room and told the surveyor that the resident had EX. Order 26.(4) "today, soon". The surveyor asked LPN #2 the process prior to going to EX. Order 26.(4) and on return from EX. Order 26.(4) B to the facility. LPN #2 told the surveyor residents were checked for EX. Order 26.(4) B1 and vital signs were done prior to sending the resident. When the resident returns LPN #2 told surveyor she or "whoever is working" will check for EX. Order 26.(4) B1 of the EX. Order 26.(4) B1 and check the vital signs. The surveyor clarified if vital signs included EX. Order 26.(4) B1 and EX. Order 26.(4) B1 and LPN #2 said, "of course".

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORA HILLS HEALTH & REHABILITATION CENTER	225 W JERSEY STREET ELIZABETH, NJ 07202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 33	F 698		

On 4/4/22 at 11:10 AM, the surveyor interviewed the LPN #3/Unit Manager (LPN #3/UM), LPN#3/UM told the surveyor, some of the vitals for EX. Order 26.(4) B1 to facility are missing. LPN #3/UM said, "maybe we should have orders to do EX. Order 26.(4) B1 when the residents return".

4. On 3/31/22 at 10:36 AM, the surveyor interviewed Resident #99 who stated that he/she receives EX. Order 26.(4) treatment EX. Order 2 times a week.

A review of the hybrid (paper and electronic) medical record revealed the following information:

The Admission Record revealed diagnoses that included EX. Order 26.(4) B1 EX. Order 26.(4) B1

The EX. Order 26.(4) B1 Physician's Order Summary sheet indicated an order for EX. Order 26.(4) on EX. Order 26.(4) B1, and EX. Order 26.(at 10:15 AM and to check for EX. Order 26.(4) B1 and EX. Order 2 prior to leaving for EX. Order 26.(4) B

The Significant Change in Status Assessment MDS dated EX. Order 26.(revealed that Resident #99's EX. Order 26.(4) B1. EX. Order 26.(4) B1 of the MDS, titled special procedures and treatments included EX. Order 26.(4) B

On 3/28/22 at 10:30 AM, the surveyor reviewed the EX. Order 26.(4) communication binder for the month of EX. Order 26.(4) B1. The communication forms showed EX. Order 26.(4) B1 assessment prior to EX. Order 26.(4) treatment and a section completed by the EX. Order 26.(4) facility. There was no section for vital signs assessment to monitor for EX. Order 26.(4) B1 when the resident returned to facility.

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F 698	Continued From page 34	F 698		

The surveyor reviewed the nurse's progress notes in EMR from EX. Order 26.(to EX. Order 26.(4) which revealed that the nurses failed to assess and monitor Resident #99's vital signs upon return from EX. Order 26.(4) B for the following dates: EX. Order 26.(4) EX. Order 26.(4) EX. Order 26.(4) B1, and EX. Order 26.(4).

On 4/4/22 AT 11:00 AM, the surveyor interviewed the Licensed Practical Nurse #4 (LPN) who stated that she assesses the EX. Order 26.(4) B1 and obtain the vital signs upon resident's return from EX. Order 26.(4). However, the resident usually returns from EX. OrOrder 26.(in the afternoon which is after her shift.

On 4/4/22 AT 11:10 AM, the surveyor interviewed the Unit Manager (UM) who stated that nurses are responsible for assessing the EX. Order 26.(4) B1 EX. Or, obtain vital signs, and document their findings in the EMR. The surveyor reviewed the nurse's assessment EX. Order 26.(4) B1 treatment with the UM for the month of EX. Order 26.(The surveyor asked why the vital signs were not documented in EMR when the resident returned from EX. Order 26.(4) B The UM stated that the best practice is to monitor the resident, assess the EX. Order 26.(4) B1 and obtain the vital signs upon return from EX. Order 26.(4) B However, the vital signs were not assessed and documented because there was no Physician's order for it.

On 4/4/22 at 1:38 PM, the surveyors discussed the above concern with the Administrator and Director of Nursing (DON). The DON stated they never document the vital signs when the resident returns from EX. Order 26.(4) center.

A review of the facility's policy titled EX. Order 26.(4) B Care

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F 698	Continued From page 35 dated February 2022 Under Policy indicated the following; "The facility will ensure residents receiving dialysis treatments are appropriately assessed and cared for EX. Order 26.(4) B1 treatment. Under Procedures revealed "Monitor vital signs as ordered."	F 698		
F 812 SS=F	NAACP 8:39-11.2(d) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review it was determined that the facility failed to a.) store potentially hazardous foods in a manner to prevent food borne illness, b.) failed to sanitize and air-dry dishware, steam table pans and silverware in a manner to prevent microbial	F 812	F812 SS- F 1) Handwashing sink was immediately put out of service. The plastic container was immediately	5/4/22

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F 812	Continued From page 36	F 812		

growth and c.) failed to maintain the kitchen environment and equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development of a food borne illness. This deficient practice was evidenced by the following:

On 3/28/22 at 9:48 AM, in the presence of the Food Service Director (FSD), the surveyor observed the following:

1. The surveyor observed a handwashing sink next to a food preparation area and there was no barrier between them to prevent cross-contamination.

2. On a shelf under the coffee dispenser, the surveyor observed a clear plastic container stored upside down with water on the inside surface. The FSD acknowledged the plastic container should be placed on a drying rack for adequate ventilation.

3. In the food preparation area, the surveyor observed five sheet pan lids stored on the top of the steam table, which were soiled with white particles.

4. On a shelf inside a metal storage cabinet, the surveyor observed a yellow-colored debris on its surface which was sticky to the touch. There was clean dishware stored on the shelf.

5. In the food preparation area on a storage rack for clean dishware, the surveyor observed four storage cups with an off-white colored, crusted debris on each cup. In the same storage area, in a silverware rack, the surveyor observed a metal spoon with white colored debris on it.

removed from the shelf.
The five food pan lids were removed from on top of the steam table and cleaned.
The entire metal storage cabinet was cleaned out.
The four storage cups with debris on them and the metal spoon with debris were removed.
The bowls from the food preparation table were removed and cleaned.
The 2 four inch pans stacked with water between them were removed and rewashed. The pound cake pan was removed and washed.
The blade of the can opener was washed and clean of dirt or sticky substances.
The four convection oven knobs and the stove handle were removed and cleaned properly.
The cottage cheese was immediately thrown out.
The container with the expired mixed chopped vegetables were immediately thrown out.
The cracked lid was immediately removed.
The 10 hot dogs were immediately thrown out.
2) All residents have the potential to be affected.

3) Staff cleaning matrix was updated to reflect identified areas.
Staff in-serviced on updated cleaning matrix.
Staff in-serviced on Properly dating and labeling.

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F 812	Continued From page 37 6. In the food preparation area, the surveyor observed a cream-colored debris between each of the bowls which were stacked on a food preparation table. 7. On a storage shelf for pans, the surveyor observed two 4-inch half pans which were stacked with water between them. A pound cake pan was also observed soiled with grey and beige colored particles. 8. In the food preparation area, the surveyor observed red and white plastic material stuck on the blade of the can opener. 9. The surveyor observed four convection oven knobs and one of nine stove handles which were soiled with a black grease-like substance. 10. The surveyor observed a drying rack for storage of clean insulated lids. Many of the insulated lids were soiled with a white colored, crusted debris and one of the lids had a visible crack on it. 11. On a shelf in refrigerator number 4, the surveyor observed a container of cottage cheese which had a stamped manufacturer expiration date of 3/24/22. 12. On a shelf in refrigerator number 1, the surveyor observed a container of mixed chopped vegetables with a use by date of 3/27/22. 13. On a shelf in refrigerator number 6, the surveyor observed 10 undated and wrapped hot dogs.	F 812	Staff in-serviced on proper storage of equipment. Staff in-serviced on cross contamination. 4) FSD/Designee will conduct weekly audits x 4 weeks, then monthly x 3 months to ensure staff are following the updated cleaning matrix, dating and labeling correctly, cross contamination and properly storing equipment. FSD or designee will report outcomes of all audits to the Quality Assurnace team at the Quarterly Quality Assurance Improvement Meeting.	

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F 812	Continued From page 38	F 812		

On 3/28/22 at 1:47 PM, the surveyor informed the Administrator and Director of Nursing of the above concerns.

The surveyor reviewed the facility's policy referring to Sufficient Storage of Food with a revised date of January 2022. The policy indicated that all foods should be covered, labeled and dated and should be consumed within their use by dates.

The surveyor reviewed the facility's policy titled "Cabinets, Tables and Drawers" with a revised date of January 2022. The policy indicated that cabinets, tables and drawers will be free of food particles and dirt.

The surveyor reviewed the facility's policy referring to Food Preparation and Equipment with a revised date of January 2022. The policy indicated that food service equipment should be washed, rinsed, sanitized and air-dried after each use. The policy also indicated that plastic-ware or dishware that is cracked should be disposed of.

NJAC 8:39-17.2(g)

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	32003	A. BUILDING: _____ B. WING _____	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORA HILLS HEALTH & REHABILITATION CENTEF	225 W JERSEY STREET ELIZABETH, NJ 07202

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	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 facility provided documentation, the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18	S 560	S-560 1) No residents were identified. 2) The deficient practice has the potential to affect all residents residing in the facility. 3) The facility currently has multiple Nursing Agency Contracts. Referral and sign-on bonuses are offered. The facility is recruiting on multiple employment search engines and multiple social media	5/4/22

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

Electronically Signed | 04/26/22

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S 560	Continued From page 1 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the	S 560	platforms. Rates have been increased in order to attract new staff. 4) Administrator or designee will conduct weekly staffing schedule audits. The Administrator or designee will report findings to the Quality Assurance team at the Quarterly Quality Assurance Performance improvement Meeting.	

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S 560	Continued From page 2 midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of the facility-provided Nursing Home Resident Care Staffing Reports from 3/13/22 to 3/26/22 which included the following staff to resident ratio for each shift: The facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows: -03/13/22 had 19 CNAs for 172 residents on the day shift, required 22 CNAs. -03/20/22 had 20 CNAs for 170 residents on the day shift, required 22 CNAs. -03/21/22 had 21 CNAs for 171 residents on the day shift, required 22 CNAs. -03/22/22 had 21 CNAs for 171 residents on the day shift, required 22 CNAs. -03/24/22 had 21 CNAs for 171 residents on the day shift, required 22 CNAs. During an interview on 4/5/22 at 12:31 PM the Administrator stated the facility utilized temporary staff through agencies, advertising on social media, sign on bonuses to new hires, and incentives for employee referrals.	S 560		