STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315485	A. BUILDING _____ B. WING _____	C 06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WALL	**2621 HIGHWAY 138 WALL, NJ 07719**

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F 000	INITIAL COMMENTS Survey Date: 6/02/2022 Census: 111 Sample: 26 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 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		6/24/22

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

Electronically Signed | 06/19/2022

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F 656	Continued From page 1 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan for each resident for 6 of 13 residents reviewed for transmission-based precautions (used for patients infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission) (Resident #11, #54, #83, #105, #358, and #359). This deficient practice was evidenced by the following: 1. On 5/18/22 at 10:12 AM, the surveyor interviewed the Registered Nurse (RN) assigned to the resident who stated that Resident #11 was placed on Person Under Investigation (PUI) due to being exposed to another [redacted] resident on 5/18/22.	F 656	1. Resident # 11. Resident # 54, Resident # 83, Resident # 105, Resident # 358 and resident # 359 were in the person under investigation unit (PUI) with signage posted by the door under quarantine, droplet/contact precaution because of [redacted]. 2. Residents have the potential to be affected by this practice. 3. The ADON immediately provided education to nursing staff on care planning specific to residents need and condition. The care plans of residents #11, # 54, # 83, # 105, #358 and # 359 were updated to reflect person-centered place.	

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F 656	Continued From page 2 On 5/18/22 at 10:47 AM, the surveyor observed Resident #11's room door was closed. The room was also observed to be in a PUI unit. There was a sign posted on Resident #11's door indicating, "Under quarantine. Droplet/Contact Precaution." The surveyor further observed a personal protective equipment (PPE) caddy equipment hanged by the resident's room door. The surveyor reviewed Resident#11's medical records. The resident's Face Sheet (FS), an admission summary, revealed that the resident was admitted to the facility with a diagnosis that included but was not limited to EX Order 26 § 4b1 [redacted] The Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate care management dated 2/25/22, indicated a Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted], which indicated that the resident's cognition [redacted] According to the individualized care plan for Resident #11 which was initiated on 11/22/21, the care plan failed to address that the resident was placed on Transmission Based Precautions (TBP), which are special measures that are put in place to prevent the spread of infection, or that they were a PUI for [redacted] The care plan also failed to address the specific goal and intervention for Resident #11 while they were on TBP and were on PUI for [redacted] when the	F 656	4. The DON/designee will perform an audit of the care plan of 5 residents in the PUI area weekly x 2 weeks, then 3 residents in X 2 weeks and the 3 residents monthly. Results of the audit will be presented to the QAPI monthly for a period of three months. The committee will review the data and determine the need for further changes to the plan	

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F 656	Continued From page 3	F 656		

resident was exposed to a positive resident on 5/18/22.

On 5/26/22 at 10:17 AM, the above concern was discussed with the Director Of Nursing (DON) together with the survey team. There was no other information provided.

2. On 5/17/22 at 12:38 PM, the surveyor observed Resident #54 seated in a wheelchair in his/her room. Resident #54 was not on TBP, which are special measures that are put in place to prevent the spread of infection.

During the interview of the surveyor on 5/19/22 at 10:31 AM, the Unit Secretary for the first-floor unit stated that the hall which contained rooms [redacted] was now considered a "yellow zone" and that the residents, that resided in that hall, were placed on TBP from potential exposure to COVID-19.

On 5/19/22 at 10:35 AM, during the surveyor interview, the Unit Manager stated that since there were so many residents that tested positive for COVID-19 in that hall, they decided to treat all the remaining residents in that hall as being exposed to COVID-19 and placed them on TBP.

On 5/19/22 at 10:38 AM, the surveyor observed a sign on Resident #54's door that indicated the resident was on TBP.

The surveyor reviewed the medical record of Resident #54.

The FS indicated that Resident #54 had diagnoses that included but were not limited to [redacted]

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EX Order 26 § 4b1 [redacted]

The resident's most recent admission Minimum Data Set (MDS) dated 4/3/22 indicated that the resident had a BIMS score of [redacted] out of [redacted], indicating that the resident's cognition was [redacted].

The individualized care plan for Resident #54 was initiated on 3/29/22. The care plan did not address that the resident was placed on TBP or that they were a PUI for [redacted].

3. On 5/17/22 at 11:14 AM, the surveyor observed Resident #83 in bed.

On 5/19/22 at 9:43 AM, the surveyor observed a Droplet/Contact Precaution Stop Sign on Resident #83's door. The sign indicated that a gown, N95 respirator, eye protection, and gloves should be worn in the resident's room.

On 5/20/22 at 10:40 AM, the surveyor interviewed the DON. The DON stated that Resident #83 developed symptoms including [redacted] and was placed in the PUI Unit for [redacted] on [redacted].

The surveyor reviewed the medical record of Resident #83.

The FS indicated that Resident #83 had diagnoses that included but were not limited to EX Order 26 § 4b1 [redacted].

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F 656	Continued From page 5 The resident's most recent admission MDS dated 4/18/22 indicated that the resident had a BIMS score of [redacted] out of [redacted], indicating that the resident's cognition was [redacted]. According to the individualized care plan for Resident #83 which was initiated on 4/14/22. The care plan failed to address that the resident was placed on TBP or that they were a PUI for [redacted] The care plan also failed to address the specific goal and intervention for Resident #83 while they were on TBP and were a PUI for [redacted] On 5/24/22 at 8:57 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) working in the PUI unit. The LPN stated that she was not sure if PUI residents should have a specific care plan in place because they are PUI for [redacted] or because they are on TBP. The LPN stated that she has never seen a specific care plan in place for any PUI residents at the facility. On 5/28/22 at 9:13 AM, the surveyor interviewed the Registered Nurse (RN) who stated that she was the "desk nurse" for the PUI unit. The RN stated that no specific care plan was initiated for PUI residents. The surveyor asked the RN how the facility ensured that the care plan was person-centered, addressed the resident's needs, and drove the type of care and services that the resident received. The RN did not respond. At that same date and time, the RN stated that a TBP care plan was only initiated for residents who tested [redacted] not for PUI residents.	F 656		

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F 656	Continued From page 6 4. On 5/17/22 at 11:16 AM, the surveyor observed Resident #105 seated in a wheelchair in their room. Resident #105 was not on TBP. On 5/19/22 at 10:39 AM, the surveyor observed a sign on Resident #105's door that indicated the resident was on TBP. The surveyor reviewed the medical record of Resident #105. The FS indicated that Resident #105 had diagnoses that included but were not limited to [redacted] The resident's most recent admission MDS dated 5/2/22 indicated that the resident had a BIMS score of [redacted] of [redacted], indicating that the resident's cognition [redacted] According to the individualized care plan for Resident #105 which was initiated on 4/26/22. The care plan did not address that the resident was placed on TBP or that they were a PUI for [redacted] 5. On 5/17/22 at 10:26 AM, the surveyor observed Resident #358 seated in a wheelchair in his/her room. Resident #358 was not on TBP. On 5/19/22 at 10:37 AM, the surveyor observed a sign on Resident #358's door that indicated the resident was on TBP.	F 656		

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F 656	Continued From page 7 The surveyor reviewed the medical record of Resident #358. The FS indicated that Resident #358 had diagnoses that included but were not limited to [redacted]. The resident's most recent admission MDS dated 5/11/22 indicated that the resident had a BIMS score of [redacted] indicating that the resident's [redacted]. According to the individualized care plan for Resident #358 which was initiated on 5/5/22. The care plan did not address that the resident was placed on TBP or that they were a PUI for [redacted]. 6. On 5/17/22 at 11:08 AM, the surveyor observed Resident #359 lying in bed in his/her room. Resident #359 was not on TBP. On 5/19/22 at 10:37 AM, the surveyor observed a sign on Resident #359's door that indicated the resident was on TBP. The surveyor reviewed the medical record of Resident #359. The FS indicated that Resident #359 had diagnoses that included but were not limited to [redacted]	F 656		

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F 656	Continued From page 8 EX Order 26 § 4b1 [redacted] The resident's most recent admission MDS dated 5/13/22 indicated that the resident had a BIMS score of [redacted] out of [redacted] indicating that the resident's cognition [redacted]. According to the individualized care plan for Resident #359 which was initiated on 5/6/22. The care plan did not address that the resident was placed on TBP or that they were a PUI for [redacted] On 5/24/22 at 12:50 PM, The surveyor presented the above concerns to the DON and Licensed Nursing Home Administrator (LNHA). On 5/25/22 at 12:31 PM, the surveyor interviewed the DON and the LNHA. The DON stated that the care plan should be person-centered. The surveyor asked if a care plan should be in place for residents who were identified as PUI. The DON did not respond. During the surveyor interview on 5/27/22 at 9:38 AM, the DON stated that after the facility had so many residents that tested positive for COVID-19 on 5/18/22, they decided to place the remaining residents in that hall on TBP because they could not "pinpoint" which residents were exposed or were not exposed to a resident or staff that tested positive. Furthermore, the DON stated that if they could not identify the direct exposures, at that point, she	F 656		

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would consider all the residents in the area to be PUI.

A review of the facility policy, "Care Plans, Comprehensive Person-Centered" with an edited date of 4/25/22 reflected that the care plan should incorporate identified problem areas, should describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, and should be revised as information about the resident and the residents' conditions change.

A review of the facility policy, "[name redacted] Cohort Plan (All)" with a revised date of 3/1/22 indicated that PUI residents should be placed on TBP with their doors closed, that staff should wear a gown, gloves, N95 respirator and eye protection while in the PUI resident rooms, and that PUI residents should be COVID-19 tested per protocol.

A review of the facility provided policy titled, "Care Plans, Comprehensive Person-Centered" with an edited date of 4/25/22, included the following:
8. The comprehensive, person-centered care plan will:
a. Include measurable objectives and timeframes;
b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; ...
h. Incorporate identified problem areas;
i. Incorporate risk factors associated with identified problems; ...
l. Reflect treatment goals, timetables and objectives in measurable outcomes;
m. Identify the professional services that are

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F 656	Continued From page 10 responsible for each element of care; n. Aid in preventing or reducing decline in the resident's functional status and/or functional levels; p. Reflect currently recognized standards of practice for problem areas and conditions ... 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. N.J.A.C. 8:39-11.2(e)(2)	F 656		
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 follow a physician's order for a resident who is on daily weight in accordance with professional standards of nursing practice for 1 of 5 residents (Resident #79). 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 and 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,	F 658	Element 1: Resident #79 was assessed by the primary physician and the nurse practitioner, new orders were required or changes to the plan of care. The patient was discharged Element 2: Resident who receives orders from a physician have the potential to be affected Element 3: The Director of Nursing or Designee will re-educated the licensed staff on following physician prescribed orders and documentation of an administered order.	6/24/22

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F 658	Continued From page 11 and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." 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." This deficient practice was evidenced by the following: On 5/17/2022 at 10:10 AM, the surveyor observed Resident #79 at the bedside alert and able to respond to the surveyor's question appropriately. The resident was [redacted], had no [redacted], and denied discomfort at that time. The resident stated he/she had weight fluctuations since admission due to cardiac issues with no negative effect. The surveyor reviewed the medical records of Resident #79. The Resident Face Sheet sheet revealed medical diagnoses including but not limited to: Encounter for surgical aftercare following surgery on the [redacted] EX Order 26 § 4b1	F 658	Element 4: The Director of Nursing or designee will audit up to five residents on daily weights weekly for four weeks, then twice monthly for two months. This will include the documentation of prescribe orders. Results of the audit will be presented to the Quality Assurance Performance Improvement Committee monthly for a period of three months. The committee will review for a period of three months. The committee will review data and determine the need for further changes to the plan.	

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EX Order 26 § 4b1

The most recent Admission Minimum Data Set (AMDS) an assessment tool used to facilitate care, dated 4/14/2022 with a Brief Interview for Mental Status (BIMS) score of [redacted], which means that the resident's cognition [redacted]. The AMDS showed that the resident had no [redacted].

The May 2022 order summary report revealed an order dated 4/12/2022 for daily weights and to call the medical doctor (MD) for a weight gain of 3 lbs/day or 5 lbs/week and the weight to be taken in the morning.

The electronic weight records revealed the following dates with 3 lbs/day or 5 lbs/day weight gain:

5/16/2022 05:29 [redacted]
5/15/2022 05:38 [redacted]
5/14/2022 06:17 [redacted]
5/13/2022 05:55 [redacted]
5/12/2022 06:46 [redacted]
5/1/2022 05:25 [redacted]
4/30/2022 05:54 [redacted]
4/29/2022 06:39 [redacted]
4/28/2022 05:11 [redacted]

During an interview of the surveyor on 5/19/22 at 11:10 AM, Licensed Practical Nurse (LPN) #1 stated "once we get the medical parameters for the patients and there is an order to alert the doctor; I will call or text the doctor to alert them of what is going on with the patient and write a

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skilled nursing note in [name redacted]." LPN#1 further stated that the daily weight is taken during the 11 PM- 7 AM shift.

On that same date and time, LPN#1 could not speak to why the doctor was not alerted of the resident's [redacted] on [redacted] and [redacted] when there was a [redacted] of a[redacted] and there was no documentation on the electronic medical records indicating that the doctor was alerted of the weight gain.

On 5/20/22 at 09:17 AM, the surveyor interviewed the 1st floor Unit Manager/Register Nurse#1 (UM/RN#1) regarding the above dates that the resident had [redacted] and the MD was not called. UM/RN #1 could not speak to why there was no documentation alerting the doctor of the weight gain but did acknowledge there should have been documentation.

On 5/23/22 at 10:27 AM, the surveyor conducted a phone interview with 11 PM-7 AM RN/Supervisor, (RN/S). The RN/S stated that he was familiar with all Resident # 79's orders and acknowledged the daily weight is taken on their shift. The RN/S further acknowledged that on April 29th, May 13, and 16th the resident had a [redacted] of at least [redacted] and the doctor was not contacted, and was unable to provide reasons why this occurred.

On 5/23/22 at 10:40 AM, the surveyor made multiple attempts to conduct phone interviews with LPN#2 and #3 who had been assigned to Resident # 79 during the 11 PM-7 AM shifts on 4/29, 5/13, and 5/16/22.

On 5/26/22 at 10:45 AM, the surveyor interviewed

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the Director of Nursing (DON). The DON stated that the patient's weights are discussed in the morning meeting daily, but could not recall resident #79 weight being discussed on April 29, May 13, and May 16. The DON further stated, that they were not sure why the weight gain was not documented. She further stated that the change in the resident's status, as well as all weight changes, should be documented in the nurses' notes.

A review of the facility's policy on Change on a Resident's Condition or Status revised in May 2017 and Weighing and Measuring the Resident edited February 18, 2022 that was provided by the DON included the following:
The Change in Resident's Condition or Status states under Policy Statement
Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes I the resident's medical/mental condition and/or status (e.g., changes on level of care, billing/payments, resident rights, etc.).
Policy Interpretation and Implementation
1. The nurse will notify the resident's Attending Physician or physician on call when there has been a(an):
i. Specific instruction to notify the Physician of changes in the resident's condition.
8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.
The Weighing and measuring the Resident states under Purpose
The purpose of the procedure is to determine the resident's weight and height, to provide a baseline and an on-going record of the resident's body weight as an indicator of the nutritional

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F 658	Continued From page 15 status and medical condition of the resident, and to provide a baseline to determine the ideal weight of the resident. Reporting 1. Report significant weight loss/weight gain to the nurse supervisor 4. Report other information in accordance with the facility policy and professional standards of practice. On 5/27/22 at 12:56 PM, the surveyors met with the DON. The facility did not provide additional information. NJAC 8:39-11.2(b)	F 658		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition	F 690		6/24/22

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F 690	Continued From page 16 demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and review of facility documents, the facility failed to provide appropriate [redacted] for 1 of 3 residents reviewed for [redacted] with [redacted] (UTI) (Resident #83). This deficient practice was evidenced as follows: A review of Resident #83's Admission Record reflected that the resident was admitted with diagnoses which included but were not limited to: EX Order 26 § 4b1 [redacted]. A review of Resident #83's Admission Minimum Data Set (MDS), a tool to facilitate the management of care, dated 4/18/22, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which reflected that he/she was EX Order 26 § 4b1 [redacted]. The MDS also reflected that the resident required EX Order 26 § 4b1 [redacted]	F 690	Element 1: Resident #83 has been discharged from facility and had no adverse effects. Element 2: Residents with [redacted] catheter have the potential to be affected. No other residents were identified upon review of residents with catheters. Element 3: Education of [redacted] catheter was provided to the nursing staff which included [redacted] bag to have [redacted] in place and positioning. Element 4: The Director of Nursing or designee will perform 5 audits on residents with catheter weekly for four weeks, the twice	

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F 690	Continued From page 17 EX Order 26 § 4b1 In addition, the MDS reflected that the resident had an EX Order 26 § 4b1 A review of Resident #83's Order Summary Report for May 2022 reflected a physician's order for [redacted] care every shift for "Retention/Failed voiding trial x 2", dated 4/16/22. A review of Resident #83's Care Plan initiated 04/14/22, reflected that the resident had "Use of EX Order 26 § 4b1 related to EX Order 26 § 4b1." The goal was for Resident #83 not to have acute complications due to EX Order 26 § 4b1 use. The interventions included to maintain the EX Order 26 § 4b1 below EX Order 26 § 4b1 level, secure the EX Order 26 § 4b1 with a securement device, and report signs of a EX Order to the physician. On 5/17/22 at 11:14 AM, the surveyor observed Resident #83 in bed. The residents EX Order 26 § 4b1 was noted to be on the left side of the bed, resting directly on the floor mat. The EX Order 26 § 4b1 was not in a [redacted] At 12:45 PM, the surveyor observed that the resident's EX Order 26 § 4b1 EX Order 26 § 4b1 was directly touching the floor and was not in a EX Order 26 § 4b1. On 05/18/22 at 09:15 AM, the surveyor observed the resident's EX Order 26 § 4b1 on the left side of the bed with the bottom of the EX Order resting directly on the floor. The EX Order 26 § 4b1 EX Order 26 § 4b1 was not in a EX Order 26 § 4b1. At 9:30 AM in the presence of the Unit Manager (UM), the surveyor observed the resident's EX Order 2 EX Order 26 § 4b1 directly on the floor. The	F 690	monthly for two months. Results of the audit will be presented to the Quality Assurance Performance Improvement Committee monthly for a period of three months. The committee will review the data and determine the need for further changes to plan.	

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F 690	Continued From page 18 UM stated that the Certified Nurse Aides (CNA) were responsible to ensure that the EX Order 26 § 4b1 EX Order 26 § 4b1 were in EX Order 26 § 4b1 and not on the floor. The UM attempted to run her finger underneath the EX Order 26 § 4b1 but was unable to do so. On 5/24/22 at 10:37 AM, the surveyor interviewed the UM who stated that she relayed the concern to the Assistant Director of Nursing (ADON) and spoke with the residents CNA #1. The UM stated that the CNA was supposed to know what to do. On 5/25/22 at 11:45 AM, the surveyor interviewed CNA #2. She stated that if a resident had a EX Order 2 [redacted] it should have been in a EX Order 26 § 4b1 and should not touch the floor to ensure appropriate EX Order 26 § 4b1 . A review of the facility policy "Catheter Care, Urinary" with a revised date of September 2014, indicated the following: "The purpose of this procedure is to prevent EX Order 26 § 4b1 -associated EX Order 26 § 4b1 ." Under Infection Control it is stated: "Use standard precautions when handling or manipulating the drainage system." "Be sure the EX Order 26 § 4b1 [redacted] are kept off the floor." And "The policy was not being followed." NJAC 8:39-19.4 (a)5	F 690		
F 756 SS=D	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	F 756		6/24/22

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F 756	Continued From page 19 licensed pharmacist. §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 observation, interview, and record review, it was determined that the facility failed to ensure that a Consultant Pharmacist (CP)	F 756	Element 1: Resident # 40 has updated [redacted] monitoring in place	

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F 756	Continued From page 20 reported irregularities in the drug regiment to the physician and facility. This deficient practice occurred for 1 of 5 residents (Resident #40) that were reviewed for Unnecessary Medication. This deficient practice was evidenced by the following: On 5/17/22 at 12:10 AM, the surveyor observed Resident #40 in their bed with their eyes closed. The surveyor reviewed Resident #40's medical record. The Face Sheet (FS), an admission summary indicated that the resident was admitted to the facility with diagnoses which included EX Order 26 § 4b1 [redacted] The May 2022 Order Summary Report (OSR) revealed an order dated 2/21/22 for EX Order 26 § 4b1 [redacted] The Significant Change Minimum Data Set (SMDS), an assessment tool used for management of care dated 3/24/22 showed a Brief Interview for Mental Status (BIMS) score of EX [redacted] of [redacted] which indicated that the resident's cognition was [redacted]. The SMDS revealed that the resident was on EX Order 26 § 4b1	F 756	Element 2: Residents receiving psychotropic medication have the potential to be affected. No other residents were identified. Element 3: Education provided to licensed staff on psychotropic medication use which included physician order review, [redacted] documentation and side effect documentation. Consultant Pharmacist sends out monthly Psychoactive Behavior Flow Sheet to DON & Medical Director. Attending MDs are made available of any resident irregularities Element 4: The DON/designee will audit 5 charts every week x 4 weeks then 3 charts every 2 weeks for 4 weeks and evaluate outcome of audits. Results of the audit will be presented to the QAPI Committee monthly for a period of 3 months. The committee will review the data and determine the need for further changes to the plan.	

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medication.

The resident's individualized care plan that was initiated on 02/22/22 had a focus area for "At risk for [redacted]." The care plan interventions included: "Attempt [redacted] drug reduction per physician orders and observe mental status [redacted] changes when new medication started or with changes in dosage.

Further review of medical records showed that there was no [redacted] monitoring notes with target [redacted] use of [redacted].

The Consultant Pharmacist Medication Regiment Review (CPMR) from March 2022 to May 2022 revealed that there was no recommendation for the facility to monitor target behaviors for use of [redacted]. The CPMR from March 2022 to May 2022 did not identify the irregularities with the use of [redacted] when there was no documented evidence that the [redacted] was being monitored with the use of [redacted].

On 5/24/22 at 10:15 AM, the surveyor interviewed a second floor, Licensed Practical Nurse (LPN) regarding behavioral monitoring notes for Resident #40. The LPN stated that all behavioral monitoring notes are in the computer under a section titled forms. The surveyor asked the LPN why there was no [redacted] monitoring documented for use of [redacted]. The LPN had no answer.

On 5/24/22 at 1:00 PM, the surveyor met with the Director of Nursing (DON) and the License Nursing Home Administrator (LNHA) and requested copies of Resident #40's behavioral monitoring notes.

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F 756	Continued From page 22 On 5/25/22 at 9:15 AM, the surveyor received no behavioral monitoring notes for Resident #40. On 5/25/22 at 12:30 PM, the survey team met with the DON. The DON informed the surveyor that as per facility protocol and practice, resident on psychoactive medications including [redacted] should have a physician order to monitor for targeted [redacted] and documented in the eMAR. The DON further stated that Resident #40 had no physician order to monitor for target behaviors for [redacted] that was the reason why no [redacted] monitoring was not done. At that same date and time, the DON acknowledge that the facility did not have any documentation showing that Resident #40's behaviors were being monitored. The DON further stated that there should have a [redacted] monitoring for Resident #40 and this should have been identified during the CPs monthly review. A review of the facility's policy for Psychopharmacologic Medication Policy that was dated 5/2018 and was provided by the DON indicated the following: Under Policy: "Residents who receive psychopharmacologic medications have been appropriately assessed and are monitored to evaluate the effectiveness of the medication (s) used, whether any side effects are present, and for reduction opportunities on an ongoing basis." Under Implementation: "2. The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms and risks to the resident and	F 756		

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F 756	Continued From page 23 others."	F 756		
F 761 SS=D	NJAC 8:39-29.3 (1) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to properly label, store, and dispose of medications in 3 of 7 medication carts and 1 of 2 medication	F 761	Element 1: Opened medications requiring a date that did not have a date were discarded immediately and order obtained to	6/24/22

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F 761	Continued From page 24 refrigerators inspected. This deficient practice was evidenced by the following: On 5/23/22 at 10:30 AM, the surveyor inspected the [redacted] medication cart [redacted] in the presence of a Licensed Practical Nurse (LPN#1). The surveyor observed a two opened bottle of [redacted] can help [redacted] in people who [redacted]) [redacted] and one bottle of [redacted] (is used to treat [redacted] inside the [redacted] or other [redacted] such as [redacted]) [redacted] that had no opened date and a pharmacy label date from [redacted] The surveyor interviewed LPN #1 who stated that once an [redacted] is opened that it should have an opened date since some [redacted] have a specific expiration date. On 5/23/22 at 10:40 AM, the surveyor inspected the [redacted] medication refrigerator in the presence of LPN #1. The surveyor observed an opened bottle of [redacted] (is used to [redacted]) [redacted]) solution that contained no opened date. The surveyor interviewed LPN #1 who stated that an opened bottle of [redacted] solution should have been dated. On 5/23/22 at 10:55 AM, the surveyor inspected the [redacted] medication cart [redacted] in the presence of a Registered Nurse (RN#1). The surveyor observed an opened bottle of [redacted] (used [redacted] to treat [redacted]) [redacted] with an opened date of 4/2/22 that was discontinued on 4/3/22. The surveyor also observed an opened [redacted] [redacted] that had an opened date of 10/21/21 and that was	F 761	replace. Discontinued and expired meds were also discarded and an order obtained to replace Element 2: Any resident that has a medication that requires dating upon use have the potential to be affected. Element 3: Education was provided to nursing staff on dating upon opening a medication that requires such documentation related to the manufactures recommendations (e.g.- medicated eye drops and liquid medication) Element 4: The DON/designee will preform an audit of four medications carts and two medication room refrigerators weekly x 4 weeks, then four med rooms and two med room refrigerators every 2 weeks. Results of the audit will be presented to QAPI committee monthly for a period of three months. The committee will review the data and determine the need for further changes to plan	

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F 761	Continued From page 25 expired. On that same date and time, the surveyor interviewed RN #1 who stated that a discontinued medication should have been removed from the medication cart. RN#1 also stated that the [redacted] help maintain your [redacted] was expired and should have been removed from the medication cart. On 5/23/22 at 11:05 AM, the surveyor inspected the [redacted] medication cart[redacted] in the presence of LPN #2. The surveyor observed an opened bottle of [redacted] (used to treat [redacted] inside the [redacted] or other [redacted] such as [redacted]) [redacted] with an opened date of [redacted], that was expired. The surveyor interviewed LPN #2 who stated that an expired bottle [redacted] should have been removed from the medication cart. A review of the Manufacturer's Specifications for the following medications revealed the following: 1. [redacted] once opened have an expiration date of 30-days. 2. [redacted] once opened have an expiration date of 30-days. 3. [redacted] once opened have an expiration date of 90-days. 4. [redacted] once opened have an expiration date of 42-days. On 5/24/22 at 12:30 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), and no further information was provided by the facility.	F 761		

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(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) COMPLETION DATE
F 761	Continued From page 26 A review of the facility's policy for Labeling of Medication Containers that was dated 4/2019 and was provided by the DON indicated the following: "3. Labels for individual resident medications include all necessary information, such as:" "h. The expiration date when applicable; and." A review of the facility's policy for Administration of Ophthalmic, Otic and Nasal Products that was dated 1/2015 and was provided by the DON indicated the following: "c. Always check expiration date on the product before administration. If product appearance has changed (change in color, odor, etc.) do not use the product." "d. Once a sterile, sealed container is opened, it is no longer sterile. These products should be discarded 30 days after opening." "8. Schedule II-V controlled medications are stored separately locked, permanently affixed compartments NJAC: 8:39-29.4 (a) (h) (d)	F 761		
F 812 SS=F	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.	F 812		6/24/22

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F 812	Continued From page 27 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices and properly store potentially hazardous foods in a safe and sanitary environment and in accordance with nationally recognized guidelines to prevent the development of food borne illness. This deficient practice was observed upon entering the facility, during kitchen tours and was evidenced by the following: On 5/17/22 at 9:00 AM, the survey team entered the facility and observed three stacked boxes of bread directly on the floor of the building entranceway. At 10:01 AM, the surveyor toured the kitchen with the Culinary Service Director (CSD) in the presence of two additional surveyors. The CSD had a ServSafe Certification (means a person possesses a ServSafe certificate and has proven her knowledge in food safety) with an expiration date of 6/25/2024. The entire top of a beige step on garbage near the handwashing sink was visibly soiled black	F 812	Element 1: Immediate actions by staff included discarding the peeling wire racks, cheese, health shakes, lactose free milk, bag of rice and lentil pasta, dented can and cases of water. Bread in box was removed from floor. The staff cleaned the trash can, replacing wire racks and wet glove box was discarded. The staff replaced the cutting board, cleaned green racks, restaurant pans were reprocessed in the dishwasher, coffee cups were processed in stain solution. Broom area wall was cleaned, fan covers were cleaned, water filter changed and hood cleaned. Employee lunch bags were removed. Element 2: Residents that have culinary services have the potential to be affected. No	

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F 812	Continued From page 28 substance. During an initial interview, the CSD acknowledged that the bread delivery was directly on the floor of the building entranceway and that it had been an ongoing concern that bread deliveries arrive between 4 and 5 AM, before the kitchen is open. The CSD further stated that part of the problem was that the bread company did not deliver the bread, rather the bread company hired a delivery service. There was a large white cutting board gouged and discolored on a wire rack upon entrance to the kitchen from the hallway. The CSD acknowledged the condition of the cutting board and stated it should not be used and needed to be replaced. There was also a medium sized yellow and red cutting board, each were worn and gouged. The CSD stated that they needed to be replaced. The wire rack that held the cutting boards upright had a black epoxy covering that was peeling off and the exposed metal was covered in a reddish substance. The CSD stated "looks like rust to me." There were multiple metal restaurant pan covers leaning on a box of red potatoes. The CSD stated that they were clean pan covers and should not be leaning on a box of potatoes. The following observations occurred in the walk-in refrigerator: There were two fan covers covered with a gray fuzzy substance. The CSD removed a piece with his fingers and acknowledged that it was "dust"	F 812	residents ere identified to be affected. Element 3: Education as provided by CSD and included following: Cleaning schedule which included surfaces, fans, hood, trash areas and water filter replacement. Cleaning products such as "Dip It" to decrease stains e.g. mugs Expiration of foods and storage, rotation of food items. Dating and Labeling System which correlates with USDA requirements. Validation process was reviewed as well as the process to change the date. Opening and closing checklist to assist with routine to maintain kitchen Dented can location and use of bin Food items placed on food tray placed on food truck must be covered Personal food not to be stored in kitchen walk in. Element 4: CSD or designee will complete kitchen open and closing checklist daily. The Registered Dietitian will perform sanitation checks monthly for six months. Results of the audits will be reported by CSD or Designee at monthly QAPI Committee for six months for compliance. QAPI Committee will review results for any additional recommendations.	

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and should be cleaned.

There was an opened package of sliced American cheese, which was labeled with an opened date of 5/16/22 and a use by date of 6/5/22. The CSD stated that the department had a labeling machine with preloaded data for best if used by information. He could not speak to the source or guidance these dates were predicated on.

There was an opened bag of shredded mozzarella cheese, which was labeled with an opened date of 5/17/22 and a use by date of 6/15/22.

There were two metal sheet pans with 4-ounce health shake containers, as well as one tray with 4-ounce strawberry and one tray with 4-ounce vanilla health shakes. The CSD stated that the date on the container from the manufacturer indicated the best if use by date if the shake remained frozen. He further stated that once they were defrosted the shakes were good for three days. He acknowledged that they were not dated and so he would not know when they were defrosted and thus how long they were good until. The CSD stated that the prep position usually dated the shakes and that it should have been done and could not speak to why it was not done.

There were four outdated (5/16/22) 8-ounce low-fat lactose free milks. These were mixed in a milk crate with other milks dated 5/25/22.

At approximately 10:15 AM, the Regional CSD (RCSD) joined the tour.

There was a personal fabric lunch bag not

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labeled and dated in the walk-in refrigerator. The RCSD stated that there was no facility policy that allowed for personal lunches to be stored in the kitchen refrigerator and that it belonged in the employee break room. The CSD stated that it belonged to the Registered Dietitian (RD) #1.

The four green epoxy covered racks in the walk-in refrigerator were observed with sticky buildup. The CSD stated that the racks were cleaned when the refrigerator emptied out and the product volume got low. He then stated that that rarely happened.

At 10:33 AM, the surveyor interviewed RD #1 in the presence of the CSD, the RCSD and two additional surveyors. She stated that she put her lunch bag in the walk-in refrigerator the night before because she did not want to bring it home and did not want anyone to eat her leftover food if she left it in the breakroom refrigerator. RD #1 acknowledged that it should not have been stored in the kitchen refrigerator and could not speak to why it was not labeled or dated.

At 10:37 AM, the surveyor observed a thick black smear on the tiled wall above the broom rack. The CSD was able to rub this off with his finger and stated that "it's probably from the broom; it's grease."

The two door reach in refrigerator had two fan covers with heavy buildup of a brownish-black debris, which the CSD acknowledged.

There was a water filter attached the ice machine dated 8/26/21. The CSD did not know how often the water filter should be changed.

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On the bottom shelf of a stainless-steel table next to a tabletop mixer, there was a box of small disposable gloves opened that was wet and soiled.

There was another large white cutting board that was gouged and soiled and appeared to have been recently used. The CSD acknowledged it was gouged and soiled and stated that "it's definitely soiled and will not be used again."

There were 26 gray coffee mugs that were heavily stained with a brown substance. They were stored in an upright position exposed. The CSD stated that they should have been inverted. He acknowledged that they were "stained."

The following observations occurred in the dry storage area at 10:46 AM,

There was a 50-pound (lb.) bag of rice and two 25 lb. bags of brown rice that were opened and exposed to the environment. The CSD acknowledged this and stated that they "should be sealed."

There was an opened wrapped bag of lentil penne pasta dated 12/19/21. The CSD could not state if that was the opened or use by date. He further stated that was before he started in January 2022, and he had never noticed it before.

There were two cases of water stored directly on floor.

There was a dented large #10 can of creamed corn. He stated he had seen it this am and should have discarded it. There was no designated dented can area. The CSD stated that their

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process was to discard dented cans and report the losses to the vendor.

The RCSD stated that an opened package of sliced American cheese had a shelf life of two days. She then stated it would be good up to 10 days.

At 12:53 PM, four surveyors observed lunch on the first floor. All observed lunch trays with fruit cups not covered and open to the environment in all three hallways during tray delivery.

On 5/19/22 at 9:30 AM, the surveyor conducted a second kitchen tour with the CSD.

The hood baffles were observed with caked on debris. The CSD stated that "the hood is cleaned quarterly, June 9th is the next scheduled cleaning." He further stated that "the hood is cleaned by us as needed, I will clean it today."

On 5/25/22 at 8:20 AM, the surveyor interviewed the CSD. He stated that he was often responsible for putting away deliveries and was ultimately responsible to ensure foods were rotated and removed when expired. He stated the cleaning policy was to clean as needed and that there was no actual written schedule for cleaning.

At 9:03 AM, the surveyor interviewed the Director of Environmental Services. He stated he was responsible for changing the water filter for the kitchen ice machine and it should be replaced every three to six months.

At 10:50 AM until 11:26 AM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) in the

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presence of another surveyor to discuss concerns.

At that time the surveyor requested multiple policies which included but were not limited to: water filter usage, receiving deliveries, dented cans, labeling and dating and the guidance followed for appropriate use by dates for opened food items, food storage cold and dry, shake usage, kitchen sanitation, preventing food borne illness, preventing cross contamination, and cutting board usage.

On 5/27/22 at 9:48 AM in the presence of the survey team, the DON acknowledged that the documents and the information provided in writing were the facility responses as a follow up to the meeting on 5/25/22 at 10:50 AM.

At 11:10 AM, the surveyor met with RD #2. She stated that if she observed an item in the refrigerator without a label or date, she would discard it. She also stated that if she observed an opened package of sliced American cheese, she would expect it to be good for 72 hours after opening. RD #2 stated that their labeling machine was preloaded with information about best if use by dates; however, she was not sure of their source or guidance.

At 1:30 PM, RD #2 provided the surveyor with a printout from the company that provided the facility with menus. It referenced best if used by dates for food items, however, she could not speak to the source or guidance this information was derived from.

Review of the facility policy "Food Preparation and Service" with a revised date of April 2019,

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reflected the policy statement "Food and nutrition services employees prepare and serve food in a manner that complies with safe food handling practices."

Review of the facility policy "Sanitization" with an edited date of 5/2/18, reflected a policy statement "The food service area shall be maintained in a clean and sanitary manner." It also reflected that "All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning." In addition, it also reflected that "All equipment ... shall be washed to remove or completely loosen soils by manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions." It further reflected that "Kitchen ... surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime." And that "The Food Services Manager will be responsible for scheduling staff for regular cleaning ..."

Review of the facility policy "Refrigerators and Freezers" with a revised date of December 2014, reflected a policy statement "This facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines." It also reflected that "Information regarding acceptable storage periods for perishable foods will be kept in the supervisors' office. A condensed version will be posted by each refrigerator and freezer for reference." In addition, it also reflected that "Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired or past perish dates." It further reflected

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that "Supervisors will inspect refrigerators and freezers monthly for ... fan condition ..." And that "Refrigerators and freezers will be kept clean, free of debris, and mopped with sanitizing solution on a scheduled basis and more often as necessary."

Review of an undated facility policy "Dented Can Policy" reflected that "All cans must be inspected, placed in the Culinary Directors office for a credit and then disposed of. We will not store any dented, bulging, or damaged cans in any other space."

Review of the facility policy "Food Receiving and Storage" with an edited date of 12/4/18, reflected a policy statement "Foods shall be received and stored in a manner that complies with safe food handling practices." It also reflected that "Other opened containers must be dated and sealed or covered during storage."

The DON provided the surveyor a paper with responses on 5/27/22 at 8:42 AM. Next to the question "When water filters are changed and how it is tracked", indicated a response "missed it" and "it is change with next due date to change."

An addition paper was provided to the surveyor at that same date and time. It reflected that the facility's procedure for safely handling shakes was to date each shake two weeks from the date it was pulled from the freezer to ensure proper use and rotation. It also reflected that the facility's practice to replace ice machine filters was every six months and that Maintenance writes the date it should be replaced on the new filter. In addition, it reflected that the facility's procedure for

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care/replacement of cutting boards included once cutting boards become visibly worn, they are to be replaced. It further reflected that the facility's procedure for dating and labeling was to utilize their labeling machine whereby dates are loaded into the system with the most stringent criteria based off ServSafe guidelines which are also accepted and followed by the USDA.

RD #2 provided the surveyor with a "Refrigerated Storage Quick Reference Guide" with a revised date of 1/9/20, on 5/27/22 at 1:30 PM. The document reflected that Cheese: Slices or Opened Packages had a recommended storage time at 35-41 degrees Fahrenheit or less for two weeks if unopened and did not reflect a recommended storage time once opened.

According to guidance from ServSafe the 7th Edition based on the U.S. Food and Drug Administration Food Code 2017 and the Centers for Disease Control and Prevention, last reviewed 3/4/22, foods that are considered time/temperature control for safety (TCS) should not be kept more than seven days. According to the NJ Department of Health Chapter 24 effective date 1/3/22, a "TCS food means a food that requires time and/or temperature control for safety to limit pathogenic microorganism growth or toxin formation." In addition, non-TCS foods include: Baked goods, including bread, rolls, biscuits, cakes, cupcakes, pastries, and cookies; Candy, including brittle and toffee; Chocolate-covered nuts and dried fruit; Dried fruit; Dried herbs, seasonings, and mixtures thereof; Dried pasta; Dry baking mix; Fruit jams, fruit jellies, and fruit preserves; Fruit pies, fruit empanadas, and fruit tamales (excluding pumpkin); Fudge; Granola, cereal, and trail mix;

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F 812	Continued From page 37 Honey and sweet sorghum syrup; Nuts and nut mixtures; Nut butters; Popcorn and caramel corn; Roasted coffee and dried tea; Vinegar and mustard; Waffle cones and pizzelles. NJAC 8:39-17.2(g), 19.7(d)	F 812		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to properly dispose and maintain waste in 2 of 3 garbage dumpster areas as evidenced by the following: On 5/17/22 at 11:05 AM, the surveyor inspected the three garbage dumpster areas with the Culinary Services Director (CSD) and the Regional CSD (RCSD) in the presence of two additional surveyors. Each dumpster area was separated by high barriers. The area where the compactor dumpster was located had a strong spoiled foul odor. The CSD acknowledged the odor and stated that Environmental Services (EVS) cleaned that area and was not sure how often it was cleaned. The area that had the dumpster for the discard of cardboard top was closed however there was extensive debris on both sides of the container such as soiled disposable gloves, supplement containers, cups, food wrappers, bottle caps, wood, and plastic. The CSD could not speak to why that type of debris was there when that	F 814	Element 1: No residents were affected by the practice. Element 2: Residents that reside in facility have the potential to be affected. Element 3: The staff immediately cleaned the dumpsters. The excessive odors were coming from a hole in the compactor, which was fixed by the vendor. Accountability schedule was implemented and reflect frequency of cleaning schedule. Element 4: The Maintenance Director or designee will perform daily rounds and inspect the dumpster area. Maintenance Director or designee will report compliance at the monthly QAPI Committee meeting for a period of 3	6/24/22

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F 814	Continued From page 38 dumpster was only meant for cardboard. He again stated that EVS was responsible to clean that area. At 11:26 AM, the surveyor interviewed the Regional Director of Maintenance in the presence of the CSD, RCSD and two additional surveyors. He stated that maintenance was responsible for cleaning the dumpster areas as needed, which included cleaning trash off the ground. On 5/25/22 at 9:03 AM, the surveyor interviewed the Director of EVS (DEVS). He stated that housekeeping was mostly responsible for cleaning and maintaining the dumpster areas. He also stated that maintenance helped out as well. The DEVS stated that compacter got picked up once a week and if there was an odor it should get power washed. He also stated that the cardboard dumpster area should only have cardboard, no other debris. 5/25/22 at 9:15 AM, the surveyor interviewed that Director of Housekeeping (DH). He stated that both housekeeping, and maintenance were responsible for cleaning and maintaining the dumpster areas. The DH also stated that the area was cleaned daily but could not speak to a specified time. He stated that there were sometimes spills by the compacter that could cause odors and it should be cleaned with bleach and then rinsed. He further stated that there should not have been debris on the floor near the dumpster designated for cardboard and that he would not expect to see gloves or food debris in that area. The DH stated that there was no schedule or written accountability for cleaning and maintaining those areas.	F 814	months. QAPI Committee will review results for any further recommendations.	

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F 814	Continued From page 39 At 10:50 AM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) in the presence of an additional surveyor to relay concerns regarding the dumpster areas. At that time, the surveyor requested any policies or documentation related to the cleaning and maintenance of those areas. On 5/27/22 at 9:48 AM, in the presence of the survey team the DON acknowledged that the documentation provided to the surveyor in response to the previous mentioned concerns and policy requests was all they could provide. The facility was unable to provide any policy or documentation related to the cleaning and maintenance of the dumpster areas. NJAC 8:39-19.7(a)(b)	F 814		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		8/17/22

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F 880	Continued From page 40 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 41 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to: a.) ensure that staff were wearing appropriate personal protective equipment (PPE) for 12 of 29 staff observations and identified on 2 of 2 isolation units., b.) perform hand hygiene for 3 of 29 staff observations, c.) ensure that staff performed daily COVID-19 screening and monitoring for 1 of 2 staff reviewed, d.) ensure that residents received daily COVID-19 Screening and Monitoring every shift for 4 out of 4 residents reviewed (Resident #83, #96, #75, #408), and e.) disinfect personal care items prior and after being used on residents according to manufacturer's recommendations before use to check the blood sugar of 1 of 2 residents observed (Resident #47) and in accordance with the Centers for Disease Control and Prevention (CDC) guidelines for infection control and facility policies. This deficient practice was evidenced by the following: 1. On 5/17/22 at 10:04 AM, two surveyors met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON, also the Infection Preventionist) for an entrance conference. The DON stated that the facility was in a COVID-19 outbreak which started on	F 880	Element 1 Staff that weren't in proper PPE, corrected wearing N95, goggles and other appropriate PPE in designated areas. LPN #1 in-serviced and competency and clinical practice referral CNA#1 in-serviced and competency CNA # 2 in-serviced and was sent home CNA #3 was in-serviced and competency. DC was in-serviced about proper screening Laundry staff will be in-serviced about folding linen and not touching floor Laundry area was immediately cleaned. Maintenance man in-serviced in regards to hand washing Element 2: Any resident residing in facility has the potential to be affected. Element 3: Staff education on the completion and documentation of COVID screening and assessment tool. Building wide education done for all staff to perform daily COVID screening.	

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F 880	Continued From page 42 3/31/22. The DON stated that the outbreak included 10 staff cases and 7 resident cases of COVID-19. The LNHA stated that COVID-19 positive staff members worked throughout the building and that some were staff who provided direct care to residents. The LNHA stated that all staff should be wearing a N95 (respirator) mask and a face shield while in the facility. The COVID ActNow Community Risk Level for [name redacted] provided by the LNHA and updated on 5/17/22 indicated that the community risk level for [name redacted], the county in which the facility was located, was high. On 5/18/22 at 10:20 AM, the surveyor observed the Unit Clerk (UC) wearing a surgical mask while sitting at the second-floor nurse's station. At this time the surveyor interviewed the UC. The surveyor asked if the UC was vaccinated against COVID-19. The UC stated that she had a religious exemption to vaccination and that she had not received any COVID-19 vaccinations. On that same date and time, the surveyor asked if the UC was fit tested (a series of steps used to determine the suitability of a respirator mask for a specific use) for a N95 mask. The UC stated that she was fit tested. The surveyor asked where the surgical mask that she was wearing came from. The UC stated that it came from the facility. The surveyor asked to see the box of surgical masks. The UC handed the surveyor the box, which was labeled, "Cone Style Procedure Face Mask with Headband". On 5/18/22 at 10:53 AM, the surveyor interviewed the UC again. The surveyor asked the UC if she was wearing an N95 mask. The UC looked at the	F 880	Staff education on hand hygiene and donning/doffing of personal protective equipment. Staff educated on disinfecting personal care items such as glucometer before and after being used on residents Staff educated on not using own personal items Staff educated on COVID screening tool for residents. Laundry/Washers will be disinfected between loads by laundry staff and monitored daily by Housekeeping Director or Designee for proper compliance of daily cleaning logs ALL staff viewed Module 6A, 6B, 7 and 11B. Add Infection Preventions viewing Modules 1, 4, 5, 6A, 6B, 7, 11A and 11B. Element 4: DON/designee will perform an audit of 5 residents and 5 staff members and their COVID screening weekly x four weeks. Then 3 residents and 3 staff members for every other week for four weeks and evaluate the outcomes. Results will be brought to monthly QAPI meeting DON/designee will conduct weekly audits related to observations proper PPE donning and doffing and hand washing for a period of 4 weeks. Results will be brought to monthly QAPI committee and will be re-evaluated for reporting	

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F 880	Continued From page 43 box of masks and stated, "these don't say N95". The surveyor asked why the UC was wearing a surgical mask and not the N95 mask that she was fit tested for. The UC stated that she was not aware that the masks were not N95 grade and stated that she was given the box of surgical masks by a nurse who works at the facility. The facility Staff Vaccination Matrix (also known as facility vaccination record) indicated that the UC had a religious exemption to all COVID-19 vaccinations. On 5/19/22 at 11:36 AM, two surveyors observed the Dietary Aide (DA) in the hallway near the kitchen with a thick beard and a N95 respirator mask. The N95 mask was not in contact with the DA's skin to create a seal and both straps of the mask were worn around the DA's neck. The DA was observed without eye protection. At this time the surveyors interviewed the DA. The surveyor asked if the DA was vaccinated for COVID-19. The DA stated that he did not receive any vaccinations for COVID-19 because he had a medical exemption. The surveyor asked what PPE the DA should wear while in the facility. The DA stated that he needed to wear a N95 mask and an "eye shield". The surveyor asked if his N95 mask was worn appropriately. The DA did not respond. The surveyor asked where the DA's eye protection was. The DA entered the kitchen and removed goggles from a shelf in the kitchen which stored kitchen supplies. The surveyor asked if it was his practice to store his goggles in this way. The DA said that this was where he usually stored his goggles. The facility Staff Vaccination Matrix indicated that	F 880	DON/Designee will conduct weekly audits of 3 staff members properly disinfecting personal care items for four weeks and then monthly for 2 months. Results will be reported at monthly QAPI meeting. Housekeeping Director/Designee will review laundry/washer disinfection with compliance and report result to Monthly QAPI Meeting for duration of 6 months. Laundry area will be monitored daily for proper cleaning logs and reported monthly to QAPI Committee for period of 3 months. Then will be re-evaluated by compliance for continued reporting. Addendum for DPOC: The following items were assigned and have been captured as part of F880. Below is Root Cause Analysis (RCA) *Staff not wearing proper PPE, staff were forgetful of proper PPE and nervous around surveyors. All staff were in serviced according with regular rounding and audits **Staff not following proper hygiene were aware of procedures but were quick on their counting **Daily Staff Covid Screening. Staff was aware of procedures but forgot on those given days to follow proper protocols. Education provided **Screening of Residents- staff was aware and didn't do. In servicing done accordingly **Disinfect personal care equipment- Staff	

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F 880	Continued From page 44 the DA had a medical exemption and did not receive any COVID-19 vaccinations. On 5/20/22 at 7:55 AM, the surveyor observed Licensed Practical Nurse (LPN) #1 take vital signs for and administer medications to a resident in the COVID-19 positive unit. LPN #1 removed her gloves prior to exiting the resident's room and proceeded to touch the vital signs monitor to wheel it into the hallway. Once in the hallways, LPN #1 touched the medication cart and the papers on the medication cart prior to performing hand hygiene with alcohol-based hand rub. At this time the surveyor interviewed LPN #1 and stated that she removed dirty gloves and touched equipment and papers prior to performing hand hygiene. LPN #1 did not respond. On 5/20/22 at 9:18 AM, the surveyor observed the Certified Nursing Assistant (CNA) #1 in the hallway of a 2nd floor resident care unit wearing a N95 mask with both straps worn around his neck and with goggles on top of his head. CNA #1 had no eye protection covering his eyes. At this time the surveyor interviewed CNA #1. The surveyor asked how the straps of a N95 mask should be worn. CNA #1 stated that the straps should be worn with one around the top of his head and with one around his neck. CNA #1 acknowledged that the mask was not worn properly and that it should have been. The surveyor asked how CNA #1 needed to wear his goggles. CNA #1 stated that he only needed to wear goggles in the resident rooms, not in the hallway. On 5/20/22 at 11:58 AM, the surveyor requested to speak with the Dietary Cook (DC) outside of the kitchen. The DC exited the kitchen, and the surveyor observed the DC wearing a surgical	F 880	member was unaware about proper use of personal equipment. New equipment order to elevated this issue along with education **Staff was aware of glucometer cleaning procedures and bringing in personal equipment. In-serviced according of proper procedures for both mentioned items **Laundry staff aware of cleaning machines but didn't follow procedures, in-serviced to proper methods Infection Preventionist completed Nursing Home Infection Preventionist Training Course through CDC Training: CDC Train Modules for Top Line Staff: 1- Infection Prevention & Control Programs 4- Infection Surveillance 5-Outbreaks 6A- Principles of Standard Precautions 6B- Principles of Transmission Based Precautions 7- Hand Hygiene 11A- Reprocessing Reusable Resident Care Equipment 11B- Environmental Cleaning & Disinfection Front Line Staff Education: Keep COVID-19 Out! Sparkling Surfaces Clean Hands Closely Monitor Residents Use PPE Correctly CDC Train- Module 7 Hand Hygiene	

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F 880	Continued From page 45 mask next to his skin and then a N95 mask over the surgical mask. The N95 mask was not in contact with the DC's skin to create a seal. The surveyor also observed that the DC was not wearing eye protection. On that same date and time, the surveyor asked the DC if he was vaccinated against COVID-19. The DC stated that he received two doses of a vaccination for COVID-19 but that he did not receive a booster dose yet. The surveyor asked why the DC was not wearing his masks appropriately. The DC stated that it was for, "protection". The surveyor asked if the DC was supposed to be wearing eye protection. The DC stated that he did not normally wear eye protection. The [name redacted] Digital COVID Certificate indicated that the DC received 2 doses of a COVID-19 vaccination but failed to indicate the DC received a booster or additional dose of the vaccine. The surveyor reviewed the timecard for the DC which indicated the days that the DC worked at the facility. The timecard indicated that the DC worked 5/1/22, 5/2/22, 5/3/22, 5/4/22, 5/5/22, 5/6/22, 5/9/22, 5/11/22, 5/12/22, 5/13/22, 5/14/22, 5/15/22, 5/16/22, 5/17/22, and 5/20/22. A review of the COVID-19 Screening Record for when the DC screened and monitored himself for COVID-19 failed to indicate that the DC screened and monitored for COVID-19 on 5/2/22, 5/5/22, 5/11/22, 5/13/22, and 5/14/22. 2. On 5/20/22 at 9:08 AM, the surveyor observed Resident#39's name outside a transmission base	F 880	Module 6A Principles of Standard Precautions Module 6B Principles of Transmission Based Precautions Module 11A Reprocessing Reusable Resident Care Equipment Intervention Prevention & Intervention Plan LTC Self Assessment was completed by Administrator, DON, IP and Infectious Disease Doctor Infection Preventionist completed Nursinh Home Infection Preventionist Training Course through CDC At door screening kiosk is currently at front door for all staff, vendors visitors and others upon before entering facility. Which takes temperatures and ask questions regarding symptoms. Kiosk with beep to deny entry is answered yes to any questions and/or high temperature. Rounds are done daily regarding prper PPE usuage by nursing leadership, audits are reviewed and kept in DON office. Result are reported monthly at monthly QAPI meeting	

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precaution (TBP) room. There was a PPE box hung outside the door that included a gown and gloves. The surveyor then observed CNA#2 wearing an N95 mask and goggles did not perform hand hygiene before getting towels from a linen cart parked near the TBP room. While walking toward the TBP room, CNA#2 held the towels towards her uniform and left the towels inside the TBP room. CNA#2 did not perform hand hygiene after exiting the TBP room.

During an interview with the surveyor on that same date and time, CNA#2 stated that the TBP room was on contact precaution. CNA#2 further stated that she left towels inside the room to be used later for morning care.

On 5/20/22 at 9:11 AM, the surveyor observed CNA#2 went back to the TBP room with an N95 mask and goggles without performing hand hygiene, donned (applied) gown and gloves, and closed the door.

On 5/20/22 at 9:16 AM, the surveyor observed the Maintenance Staff (MS) with an N95 mask did not perform hand hygiene before touching the doorknob of a TBP room while CNA#1 and Resident#39 were inside the room. Afterward, the MS went inside the bathroom of the TBP room and after 10 seconds the MS left the resident's bathroom.

During an interview of the surveyor with the MS outside the TBP room, the MS stated that he was not aware of the TBP precaution and why there was a PPE box hung outside the resident's room. He further stated that he was not sure if he should be performing hand hygiene before entering and after exiting the TBP room. The

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surveyor then asked the MS if he was not sure, would he ask the nurse first? The MS did not reply.

Later on, the MS stated, "I don't need to wash my hands before and after leaving the room because I did not touch anything inside the room, I just checked the thermostat (a temperature regulator) of the resident." Then, the surveyor asked the MS if he touched the resident's room doorknob before entering the TBP room and if he should have washed his hands. The MS did not respond.

During an interview of the surveyor on 5/20/22 at 9:21 AM, LPN#1 stated that Resident#39 was on contact precaution due to EX Order 26 § 4b1 [redacted] LPN#1 further stated that all staff must perform hand hygiene before entering the room, wear a full PPE (gown, gloves, N95 mask, and eye protection), remove PPE, and perform hand hygiene before exiting the room.

On 5/20/22 at 9:28 AM, two surveyors interviewed CNA#2. The surveyor asked CNA#2 if she should perform hand hygiene before getting clean towels and before donning and doffing (putting off) PPE. CNA#2 stated, "they (facility management) did not tell me that I have to do that."

On 5/20/22 at 9:28 AM, the surveyors interviewed the Assistant Director of Nursing (ADON). The ADON informed the surveyors that all staff was aware that as a standard of practice in the facility, staff must perform hand hygiene before and after exiting the resident's room.

On 5/20/22 at 9:47 AM, the surveyor in the presence of the survey team informed the LNHA

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and the DON about the above concerns. Both the LNHA and the DON acknowledge that both CNA#1 and MS should have performed hand hygiene.

3. On 5/23/22 at 9:49 AM, the surveyor entered the second floor and approached closed doors with signage indicating Yellow Zone. The signs further indicated PPE reminders such as gown prior to entering the room for any purpose, gloves, fit tested N95 (respirator mask) or KN95 respirator, and eye protection.

On 5/23/22 at 9:58 AM, the surveyor observed a nurse with a thick, long beard, an N95 mask, and eye protection. The nurse's beard covered his cheeks, chin, and neck. The surveyor observed that the N95 mask only covered a small portion of the nurse's mouth area. The N95 mask was not able to be worn down below the chin area and was not in contact with the nurse's face to create a seal.

On 5/23/22 at 9:59 AM, the nurse was identified as an agency LPN #2. LPN #2 stated he floats to units in the facility. LPN #2 stated all the residents in the Yellow Zone have had exposure to COVID-19 and were being monitored. LPN #2 stated staff limits contact with the residents, would wear PPE gowns into the resident room, remove the PPE gown when leaving the room, and change to a new N95 mask.

On 5/23/22 at 10:04 AM, the surveyor observed a CNA #2 wearing an N95 mask, eye protection, and no PPE gown. CNA #2 was carrying clean linens, did not don a PPE gown, and entered a two-resident room in the Yellow Zone.

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On 5/23/22 at 10:08 AM, during an interview with the surveyor, CNA #2 stated she had worked at the facility for 3 months but not usually in the Yellow Zone. CNA #2 stated the process would be to wear a PPE gown into the resident room but that it was "confusing on how to carry linen and put a gown on." CNA #2 stated she would bring the linen into the room, and "squeeze" the linen between her knees while she donned the PPE gown. CNA #2 acknowledged she should have donned the PPE gown prior to entering the resident room for infection control purposes. CNA #2 stated she had education on PPE and "thinks" she was fit tested for the N95.

On 5/23/22 at 10:16 AM, during an interview with the surveyor, the LPN acting Unit Manager#1 (LPN/UM#1) on the second floor stated all staff even agency staff would have received PPE and Infection Control education at facility. The LPN/UM#1 stated all education, and N95 respirator mask fit testing would be done at the facility. She further stated that all staff were expected to wear PPE into TBP rooms and that PPE was to be donned prior to entering the room for infection control purposes.

On 5/23/22 at 10:35 AM, during an interview with the surveyor, the DON stated she had worked at the facility about three months. She stated the facility had a Green Zone which was a non-ill unit, a Yellow Zone for Person Under Investigation (PUI) residents who were new admissions or had been exposed to COVID-19, and a Red Zone for the COVID-19 positive residents. The DON stated agency staff were fit tested to wear the N95 mask. She stated that all staff working on the Yellow Zone would be required to perform hand hygiene, wear an N95 respirator mask and full

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PPE prior to entering a resident room to prevent the spread of infection. The DON stated staff who needed to bring linens into the TBP room, should have PPE on prior to entering the room.

On 5/23/22 at 11:46 AM, during a follow up interview with the surveyor, LPN #2 stated he had been fit tested for the N95 mask at the facility twice with his beard. LPN #2 further stated it (the beard) "wasn't this big" and it was tough, but they finally got a seal.

On 5/23/22 at 11:50 AM, the surveyor observed a housekeeper in the non-ill hall on the second floor. The surveyor observed the housekeeper was wearing an N95 mask with one strap around the back of her head and the second strap in front of her face resting on the nose area of the N95 mask. The surveyor further observed the housekeepers face shield had been pushed up on the top of her head and not providing protection to the eye area.

During an interview with the surveyor at that time, the housekeeper stated she was in a Green Zone, and would change her mask in and out of rooms when she was in the PUI (Yellow Zone) unit. The housekeeper further stated she was required to wear an N95 mask and a face shield in all areas of the facility. The surveyor inquired if there was a reason the housekeep was not wearing her PPE as educated. The housekeeper could not provide a reason. The housekeeper acknowledged her N95 mask and face shield should have been worn properly to offer protection. The housekeeper further stated she had been educated on PPE.

On 5/23/22 at 12:06 PM, during a follow up

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interview with the surveyor, the DON stated CNA #2 "absolutely" should have had a (N95 respirator mask) fit test prior to working on the PUI unit.

On 5/24/22 at 10:38 AM, the DON provided the surveyor with an Occupational Safety and Health Administration (OSHA) Respirator Medical Evaluation Questionnaire Modified Form for Use with N95 Respirator Only, for CNA #1 dated 5/23/22. The DON acknowledged that CNA #1 had not had the medically cleared, N95 respirator fit test prior to working on the PUI Yellow Zone.

On 5/24/22 at 11:18 AM, during an interview with the surveyor, the facility Registered Nurse Educator (RNE) who administered the N95 respirator fit tests for the facility, stated a staff member would have to have a seal against their face where no air can get in. The RNE stated one staff was able to do a seal with his beard in a rubber band and the N95 respirator mask bottom flap tucked. The RNE further stated that on 5/23/22, she had the LPN#4 manipulate his beard the same way and the LPN#2 was annoyed. The RNE further stated the facility policy was to follow OSHA guidelines but could not speak to what the guideline referenced about beards.

Furthermore, the RNE stated a company trained her on 4/13/22 to do the N95 respirator mask fit testing. In the presence of the surveyor, the RNE reviewed the OSHA guideline and acknowledged a beard was contrary to passing a FIT test seal. The RNE stated that she became aware of the OSHA guideline and facility policy after administering the N95 fit test for LPN #2 on 5/23/22 and that had she been aware of the policy, LPN #2 would not have passed the fit test.

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On 5/25/22 at 9:10 AM, while on the second floor Yellow Zone, the surveyor observed CNA #2 gather linens from a covered cart. CNA #2 was observed holding linens in her left hand while donning a PPE gown on her right arm. Next the surveyor observed CNA #2 move the lines to her right hand to don the PPE gown on her left arm. The surveyor observed that CNA #2's PPE gown was not secured around the neck or waist in the back. CNA #2 entered the room of a resident on TBP.

On 5/25/22 at 9:12 AM, LPN #1 was present on the PUI Yellow Zone and stated the back of the PPE gown should be secured. LPN #1 knocked on the resident door and CNA #2 opened the door with the PPE gown visibly untied and loose around her body exposing her clothing. LPN #1 educated CNA #2 and CNA #2 secured her PPE gown.

On 5/25/22 at 9:15 AM, the surveyor observed the first floor Red Zone with signage to Stop, Quarantine, Droplet/Contact Precautions, only essential personnel should enter this room, everyone must clean hands, gown prior to entering the room for any purpose, N95 or KN95 respirator fit tested, eye protection, and gloves. The surveyor observed PPE bins with PPE gowns, N95 masks, surgical masks, eye protection, gloves, and alcohol-based hand rub throughout the unit.

On 5/25/22 at 9:17 AM, the surveyor observed CNA #3 wearing eye protection, and an N95 mask. CNA #3 was observed inside a TBP isolation room of a COVID-19 positive resident (Resident #49). CNA #3 was within six feet of Resident #49, was touching the resident's

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television set with his bare hands and was speaking to the resident. CNA #3 exited to the door of the room and the surveyor stopped to speak to him. CNA #3 stated he had worked at the facility for eight years and that residents in the Red Zone were there because they had COVID-19. CNA #3 further stated he had been educated on properly wearing PPE. CNA #3 could not offer any explanation as to why he had no PPE gown or gloves on while inside the room of COVID-19 positive resident.

On 5/25/22 at 9:22 AM, the DON was present on the Red Zone and escorted CNA #3 off the unit. The DON stated no staff should be in a COVID-19 positive resident room for any reason with PPE on.

A review of the facility provided, Disclosure Statement, dated 01/04/21 revealed that LPN #2 was contract or agency staff and had received education on topics which included but were not limited to respiratory protection program and 95 masks, and Infection Control.

A review of the facility provided education transcript revealed that CNA #3 had completed on-line education which included but was not limited to infection control prevention dated 03/29/22; introduction to Coronavirus 2019 dated 04/20/22, Keep COVID Out was dated 02/25/21, and using PPE correctly for COVID 19 dated 02/25/21.

A review of the facility provided email dated 05/24/22 at 3:10 PM, revealed the company who trained the facility RNE indicated "part of that training included that fit testing can't be done/is not reliable when individuals have beards."

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F 880	Continued From page 54 4. On 5/17/22 at 11:14 AM, the surveyor observed Resident #83 in bed. On 5/20/22 at 10:40 AM, the surveyor interviewed the DON. The DON stated that Resident #83 developed symptoms including lethargy and was placed on the PUI Unit for COVID-19 on 5/18/22. The surveyor reviewed the electronic medical record for Resident #83. The Face Sheet (FS), an admission record indicated that Resident #83 had diagnoses that included but were not limited to EX Order 26 § 4b1 [redacted] The resident's most recent admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 4/18/22 indicated that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted], indicating that the resident's EX Order 26 § 4b1 [redacted]. On 5/20/22 at 12:20 PM, the surveyor reviewed all the COVID-19 Patient Screening & Monitoring Tools for Resident #83 for April and May 2022. Resident #83 was screened and monitored for COVID-19 on 4/13/22 at 22:35, on 5/2/22 at 21:54, 5/4/22 at 22:02, 5/9/22 at 15:59, 5/10/22 at 12:57, 5/11/22 at 22:48, 5/13/22 at 15:23, 5/14/22 at 14:27, 5/15/22 at 14:34, and at 5/16/22 at 14:31.	F 880		

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The review of COVID-19 Patient Screening & Monitoring Tools failed to indicate that Resident #83 was screened and monitored for COVID-19 daily every shift.

On 5/17/22 at 10:58 AM, the surveyor observed Resident #96 sitting in a wheelchair in their room.

The surveyor reviewed the electronic medical record for Resident #96.

The FS indicated that Resident #96 had diagnoses that included but were not limited to EX Order 26 § 4b1 [redacted]

The resident's most recent admission MDS, dated 4/29/22 indicated that Resident #96 had a BIMS score of [redacted] out of [redacted] indicating that the resident's cognition [redacted].

The 5/18/22 Nursing/Clinical Progress Note Indicated that Resident #96's family and physician were made aware of their positive COVID-19 result on this date.

On 5/20/22 at 12:25 PM, the surveyor reviewed all the COVID-19 Patient Screening & Monitoring Tools completed for Resident #96 for April and May 2022. Resident #96 was screened and monitored for [redacted] on 4/23/22 at 15:05, on 4/30/22 at 15:18, on 5/2/22 at 16:03, on 5/4/22 at 00:08, on 5/5/22 at 16:53, on 5/6/22 at 15:05, on 5/9/22 at 16:31, on 5/10/22 at 13:17, on 5/11/22 at 23:05, on 5/13/22 at 15:39, on 5/14/22 at 14:19, on 5/15/22 at 14:10, and 5/19/22 at 18:47.

The review of COVID-19 Patient Screening & Monitoring Tools failed to indicate that Resident

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F 880	Continued From page 56 #96 was screened and monitored for [redacted] daily every shift. On 5/19/22 at 11:04 AM, the surveyor observed the Resident #75's room with a Contact/ Droplet Precaution Stop Sign on the door. The surveyor observed Resident #75 sitting in their wheelchair, awake and responsive to surveyor's questions. The surveyor reviewed the electronic medical record for Resident #75. The FS indicated that Resident #75 had diagnoses that included but were not limited to [redacted] The resident's most recent admission MDS, dated 4/8/22 indicated that the resident had a BIMS score of [redacted] out of [redacted], indicating that the resident's [redacted]. The "List of Residents in Yellow Zone" provided by the DON on 5/31/22 revealed that Resident #75 was designated a PUI for COVID-19 on 5/18/22. On 5/20/22 at 12:26 PM, the surveyor reviewed all the COVID-19 Patient Screening & Monitoring Tools completed for Resident #75 for May 2022. Resident #75 was screened and monitored on 5/3/22 at 1:17, on 5/3/22 at 14:27, on 5/4/22 at 22:59, on 5/6/22 at 14:27, on 5/9/22 at 19:26, on 5/10/22 at 11:23, on 5/11/22 at 13:00, on 5/12/22 at 14:00, on 5/12/22 at 22:14, on 5/13/22 at 19:10, on 5/16/22 at 14:19, on 5/17/22 at 13:31,	F 880		

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F 880	Continued From page 57 on 5/17/22 at 20:42, on 5/18/22 at 19:28. The review of COVID-19 Patient Screening & Monitoring Tools failed to indicate that Resident #75 was screened and monitored for COVID-19 daily every shift. On 5/23/22 at 10:03 AM, the surveyor observed Resident #408's door with a Contact/ Droplet Precaution Stop Sign on the door. The surveyor reviewed the electronic medical record for Resident #408. The FS indicated that Resident #408 had medical diagnoses that included but were not limited to EX Order 26 § 4b1 [redacted] The resident's most recent quarterly MDS, dated 5/24/22 indicated that the resident had a BIMS score of [redacted] out of [redacted] indicating that the resident's EX Order 26 § 4b1 [redacted]. The "List of Residents in Yellow Zone" provided by the DON on 5/31/22 indicated that Resident #408 was identified as a PUI for [redacted] on 5/18/22. On 5/23/22 at 12:40 PM, the surveyor reviewed all of Resident #408's [redacted] Patient Screening & Monitoring Tools for April and May 2022. Resident #408 was screened and monitored for [redacted] on 4/6/22 at 14:22, on 4/29/22 at 15:01, on 5/1/22 at 18:20, on 5/2/22 at 23:13, on 5/3/22 at 13:59, on 5/4/22 at 22:40, on 5/6/22 at 14:54, on 5/9/22 at 22:27, on 5/10/22 at 11:37, on 5/11/22 at 13:36, on 5/12/22 at 14:37,	F 880		

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F 880	Continued From page 58 on 5/12/22 at 22:28, on 5/13/22 at 19:57, on 5/16/22 at 21:47, on 5/18/22 at 22:37, on 5/19/22 at 15:50, on 5/21/22 at 12:39, and on 5/21/22 at 22:44. The review of [redacted] Patient Screening & Monitoring Tools failed to indicate that Resident #408 was screened and monitored for [redacted] daily every shift. On 5/23/22 at 12:42 PM, the surveyor interviewed the DON. The surveyor asked the DON what her expectation was of COVID-19 screening and monitoring for residents in the facility. The DON stated that her expectation was that residents were screened and monitored daily and every shift. On 5/24/22 at 8:57 AM, the surveyor interviewed LPN #5 about the expectation for COVID-19 screening and monitoring of residents. LPN #5 stated that at the end of every shift that she fills out the COVID-19 Screening & Monitoring Tool on an odds and evens basis according to an alternating, skilled nursing schedule. LPN #5 stated that COVID-19 screening and monitoring is not done every shift on every resident. On 5/24/22 at 9:13 AM, the surveyor interviewed the registered nurse (RN) who stated that she was the "desk nurse" for the first floor about the expectation for COVID-19 screening and monitoring. The RN stated that the expectation was that COVID-19 screening and monitoring would be completed daily and every shift for all unexposed and PUI residents. 5. On 5/24/22 at 10:30 AM, two surveyors entered the clean laundry folding area. The surveyors	F 880		

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observed the Porter folding linens. The surveyors also observed goggles and a N95 mask on a table near the clean folded linens and a clear plastic bag with an empty plastic water bottle inside hanging and touching the clean folded linen.

At this time the surveyors interviewed the Porter. The Porter stated that the linens that he is folding are clean, that the table is clean and that the linens are folded on the table. The Porter also stated that the goggles and N95 were his PPE and that he usually stored them on the table while he was folding linens. The Porter stated that the person who worked yesterday on the afternoon shift put up the plastic bag.

Furthermore, while the surveyors interviewing the Porter, part of the clean linen that he was folding touched the floor. The surveyor pointed to the Porter that part of the linen touched the floor. The Porter put the linen that he was folding back in the cart with the rest of the clean linen. The surveyor asked the Porter what should happen if clean linen touches or falls on the floor. The Porter stated that it needed to be washed again. The Porter did not remove the linen that touched the floor from the clean folded laundry.

On 5/24/22 at 10:40 AM, two surveyors entered the dryer room. The surveyors observed a desk with linens stacked upon it which also had a paper on it. The surveyors observed that above the desk that there were personal effects affixed to the wall and that a necklace hung down and touched the linens.

At this time, the surveyors interviewed Housekeeper #1 and the Laundry Aide (LA) who

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were in the dryer room. The LA stated that the papers were a resident census. The LA stated that the papers should be inside the desk and not on top of it with the clean linen.

On 5/24/22 at 10:50 AM, the surveyors and the LA entered the washing machine room. The surveyor asked about the LA's process for cleaning the washing machines and dryers between loads of laundry. The LA stated that for the COVID-19 and PUI resident's laundry that she washes the inside of the washing machine and the dryer with soap and water. She further stated that she washes the washing machine and dryer for non-COVID-19 resident's laundry with soap and water, "sometimes" but not between every load. The surveyor asked if there was a log to ensure accountability for the cleaning of the washing machines and dryers. The LA stated that there was not.

At that time, the surveyor asked how the LA disinfected her PPE including goggles and face shield. The LA stated that she washed her goggles with water. The surveyors asked where the LA stored her goggles. The LA stated that she stored her goggles inside of the desk in the room. The LA opened the desk drawer. Inside the drawer the surveyors observed goggles, pens, a marker, and lotion. The surveyors asked what the other items in the drawer were. The LA stated that these were her personal items.

On 5/24/22 at 11:08 AM, two surveyors interviewed the Director of Housekeeping and the Regional Director of Environmental Services. The Director of Housekeeping stated that PPE should not be stored on the clean table, that a plastic bag should not be hanging near and coming into

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contact with the clean linen, that clean linens should be rewashed if they come into contact with the floor, that PPE should not be stored in a desk drawer with personal items, that garbage should be covered, that staff's personal belongings should not be hanging down and coming into contact with resident clean linen, and that bleach sanitizer should be used to disinfect the washing machines and dryers after every load of laundry and should also be used to disinfect PPE including goggles, and that soap and water should not be used.

On 5/24/22 at 12:50 PM, The surveyor presented her concerns to the DON and LNHA.

On 5/25/22 at 12:31 PM, the DON and LNHA met with the survey team to present responses to their concerns. The DON stated that PPE such as a N95 and eye protection such as face shields or goggles needed to be worn by staff at all times while in the facility. The DON also stated that during outbreak it was her expectation that all residents be screened and monitored for COVID-19 every day and every shift. The DON continued to state that LPN #1 should have performed hand hygiene after removing gloves prior to touching anything else. The LNHA stated that all employees should be screened and monitored for COVID-19 every day.

On 5/27/22 at 11:42 AM, two surveyors observed CNA #4 on the 2nd floor resident care area wearing an eye shield on top of her head and not covering her eyes. The surveyors interviewed CNA #4. CNA #4 stated that she works on the PUI unit. The surveyors asked about the way that she was wearing her face shield. CNA #4 stated that she sanitized her eye shield after leaving the

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PUI unit and this is why it was worn on top of her head, because it was drying.

On 5/27/22 at 1:06 PM, the surveyor expressed her concern about CNA #4 to the DON. The DON stated that the eye shield should have been covering the CNA's eyes.

6. During the Medication Pass Administration on 05/20/22 at 08:10 AM, the surveyor observed LPN #3 entered Resident # 31's room to check the vital signs. LPN #3 informed Resident #31 of the procedure. LPN #3 reached in her jacket's pocket for a portable electronic thermometer (device that measures temperature) and returned the EX Order 26 § 4b1 in her pocket. Then she removed the EX Order 26 § 4b1 from her jacket's pocket, applied it to the resident's finger, checked the oxygen saturation and returned both items into her jacket's pocket without being disinfected.

On that same day at 08:22 AM, LPN #3 informed the surveyor that she would checked Resident #47 . LPN #3 used Alcohol Based Hand Rub (ABHR) to sanitize her hands, went to the medication cart, retrieved a small black bag and proceeded to enter Resident #47's room. LPN #3 had two EX Order 26 § 4b1 placed in the black bag,with no wrapping or barrier to prevent them from coming in contact with each other. She removed one EX Order 26 § 4b1 from the bag, placed it on a paper towel, donned gloves, and pierced Resident #47 's with a EX Order 26 § 4b1 and collected a drop of EX Order 26 to complete a EX Order 26 reading. After she finished checking, she returned the used lancet,the glucometer in the bag without being disinfected. LPN #3 then

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CAREONE AT WALL	2621 HIGHWAY 138 WALL, NJ 07719

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closed the bag, went to the sink, washed her hands with soap and water and exited the room.

At 08:25 AM, LPN #3 returned to the medication cart,opened the bag containing the EX Order 26 § 4b1, disposed of the used EX Order 26 § and the EX Order 26 § in the EX Order 26 container, closed the bag and returned it to the medication cart's drawer. LPN #3 did not disinfect the EX Order 26 § 4b1 before returning them to the medication cart.

On 05/20/22 at 08:40 AM, the surveyor interviewed LPN#3 who confirmed that the observed practice can cause EX Order 26 § 4b1. She added that she should have carried the soiled lancet on a paper towel and disposed of the used lancet in the EX Order 26 § 4b1. She could not provide the rationale for not disinfecting the EX Order 26 § 4b1 after exiting the resident room.

On 05/20/22 at 12:07 PM the surveyor interviewed LPN #3, in the presence of two other surveyors, regarding using her personal care items on residents and returning them in her pocket without being disinfected. LPN #3 confirmed that she was allowed to use her personal care items while providing care. LPN #3 added that she would disinfect them before using them on another resident.

On that same date and time, the surveyor observed LPN #3 retrieving the EX Order 26 § 4b1 EX Order 26 § 4b1 and the EX Order 26 § 4b1 within her pocket and did not disinfect them prior or after using them on Resident #31.

On 05/24/22 at 11:03 AM, the surveyor interviewed the RNE regarding any in-service education regarding resident care equipment and

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F 880	Continued From page 64 EX Order 26 § 4b1 care. The RNE indicated that she did not address any of the above topics recently. She further stated that she was made aware of the concerns with [redacted] and it was addressed by the ADON. Furthermore, when the surveyor asked the RNE if staff were allowed to use their personal care items such as a portable EX Order 26 § 4b1 [redacted] on residents she stated, "No" staff were not allowed to use personal care items on residents. She added that is problematic for infection control". On 5/24/22 at 12:45 PM, the surveyor met with the DON and the LNHA. The above concerns were discussed with the DON and the Administrator. On 05/25/22 at 12:24 PM, the DON provided in-services education regarding [redacted] catheter care. The DON added that the soiled [redacted] should be disposed in a sharp container. She also added that previous in-services education were done regarding glucometer, PPE and catheter care. The facility did not provide any further information regarding staff using their personal care items on Residents. On 05/27/2022 at 10:38 AM, the DON provided the in-service education dated 05/25/22 which reflected that staff should used facility's care equipment. A review of the facility policy titled, "Blood Glucose Monitoring dated 7-00 last revised 07/02/12 documented under policy: Blood glucose levels will be monitored according to physician orders in a manner that protects	F 880		

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residents from exposure to harmful pathogens.
The general Information reflected the following:
Blood glucose monitors will be disinfected per CDC and manufacturer's guidelines before and after each use, and when visibly soiled.
Procedure #4 revealed the following:
Disinfect the meter before and after each use, or when the monitor is visibly soiled as follows:
Use [name redacted] Germicidal Disposable Wipe (or other commercially prepared-moistened wipe which meets CDC guidelines) to wipe down the meter using caution not to get liquid in the test strip and key code ports of the meter. The procedure was not being followed.

A review of the facility policy, "Coronavirus Disease (COVID-19)-Vaccination of Staff" with an edited date of 4/18/22 reflected, "Staff who are not yet fully vaccinated, or who have a pending or been granted an exemption, or who have a temporary delay as recommended by the CDC are required to adhere to additional precautions intended to mitigate the spread of COVID-19 including: use of a NIOSH-approved N95 (or equivalent) respirator and eye shield for source control [...]".

A review of the facility policy, "The Coronavirus Disease (COVID-19)- Infection Prevention and Control Measures" dated 7/2020 indicated that, "Anyone entering the facility (including staff) is screened and triaged for signs and symptoms of and exposure to others with SARS-CoV-2 infection". The facility policy also indicated that, "If there is moderate to substantial COVID-19 transmission in the surrounding community [...] Staff wear all recommended PPE (i.e., gloves, gown, eye protection and respirator or facemask) for the care of all residents on the unit (or

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facility-wide based on the location of affected residents), regardless of symptoms."

A review of the facility policy, "Medication Administration Handwashing" dated 1/2015 indicated that facility staff will wash their hands before and after all resident contact.

A review of the facility policy, "Coronavirus Disease (COVID-19)-Identification and Management of Ill Residents" with an edited date of 1/27/21 reflected, "Residents are monitored twice daily (every shift in NJ) for signs of respiratory infection and/or symptoms of COVID-19 including fever or chills, cough, shortness or breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting and/ or diarrhea.

A review of the facility policy, "Departmental (Environmental Services)- Laundry and Linen", dated 3/4/2019 failed to indicate the proper process to disinfect washing machines and dryers.

A review of the facility policy, "Personal Protective Equipment", with an edited date of 9/16/21 failed to indicate the proper process to disinfect PPE.

A review of the facility provided, Respiratory Protection Program, undated, included but was not limited to Purpose: to ensure that employees required to wear respiratory protection .. are protected from respiratory hazards through the proper use of respirators. Medical Evaluation: employees must be medically evaluated and found eligible to wear the respirator selected for their use prior to fit testing or first time use of the

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respirator in the workplace. Fit Testing: will be conducted according to the rules and regulations outlined in OSHA Fit Testing Procedures (Appendix A to 1910.143). Fit testing: is required for tight-fitting respirators. Respirators that do not seal do not offer adequate protection. Supervisor: supervisors of employees with potential exposure to airborne infectious diseases are responsible for ensuring that the respiratory protection program is implemented in their particular units. Duties include but not limited to ensuring employees receive training and medical evaluations.

A review of the facility provided policy, "Use of N95 Respirator Masks", dated 10/20/09, included but was not limited to Purpose: intended to ensure the center meets the major requirements of OSHA's respiratory protection standard for the use of the N95 respirators. Use of Respirators: N95 respirators shall not be worn by employees who have facial hair or any other condition that interfere with the face to mask seal. Quantitative Fit Testing: 4. If you cannot achieve a proper seal, do not enter the contaminated area. This test should not be conducted if there is any hair growth between the skin and the face piece sealing surface, such as stubble beard grown, mustache or sideburns which cross the respirator sealing surface. Training and Information: all employees will be trained on the following information which included how to inspect, put on, and remove, use, and check the seal. N95 Mask Quantitative Fit Testing Application: 4. Fully open the top and bottom panels bending the nosepiece around your thumb, straps should separate when panels are open; 7. Pull top strap over your head and position it high on the back of the head; 8. Pull the bottom strap over your head and position

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it around your neck and below your ears.

A review of the facility provided, "1910.134-Respiratory protection" directive from OSHA, undated, included but was not limited to 1910.134(c)(1)(viii): training of employees in the proper use of respirators, including putting on and removing them, any limitations on their use, and their maintenance. 1910.134(e)(1): the employer shall provide a medical evaluation to determine the employee's ability to use a respirator, before the employee is fit tested or required to use the respirator in the workplace. 1910.134(g): these requirements prohibit conditions that may result in facepiece seal leakage, (1)(i)(A): facial hair that comes between the sealing surface of the facepiece and the face or that interferes with valve function.

A review of the Center for Disease Control and Prevention (CDC), US CDC's guidelines for Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 [COVID-19] Spread in Nursing Homes, for Nursing Homes & Long-Term Care Facilities, updated 9/10/21, included, "Key Points: Older adults living in congregate settings are at high risk of being affected by respiratory and other pathogens, such as SARS-CoV-2 ....Manage Residents with Suspected or Confirmed SARS-CoV-2 Infection: HCP [Health Care Professionals] caring for residents with suspected or confirmed SARS-CoV-2 infection should use full PPE (gowns, gloves, eye protection, and a NIOSH [National institute for Occupational Safety and Health]-approved N-95 or equivalent or higher-level respirator)....Manage Residents who had Close Contact with Someone with SARS-CoV-2 Infection: HCP caring for them

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F 880	Continued From page 69 should use full PPE (gowns, gloves, eye protection, and N-95 or higher-level respirator). A review of the CDC, PPE Sequence, undated, included but was not limited to the type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE 1. GOWN: Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back, and Fasten in back of neck and waist. 2. MASK OR RESPIRATOR Secure ties or elastic bands at middle of head and neck, Fit flexible band to nose bridge, Fit snug to face and below chin, and Fit-check respirator.	F 880		
F 886 SS=D	NJAC 8:39-19.4(a)(b)(c)(d) 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;	F 886		6/24/22

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F 886	Continued From page 70 (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: (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	F 886		

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F 886	Continued From page 71 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 observation, interview, and record review it was determined that the facility failed to appropriately use a COVID-19 rapid antigen test in accordance with manufacturer's instructions for 1 of 3 COVID-19 rapid antigen test observations (Resident #458). This deficient practice was evidenced by the following: On 5/17/22 at 10:04 AM, two surveyors met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) for an entrance conference. The DON stated that the facility was in a COVID-19 outbreak that started on 3/31/22 with 10 staff cases and 7 resident cases of COVID-19. The LNHA stated that COVID-19 positive staff members worked throughout the building and that some were direct care staff. The Resident Outbreak Line List indicated that by 5/20/22 there were 13 staff cases throughout departments and 11 facility acquired resident cases of COVID-19 on both floors of the building. On 5/20/22 at 9:05 AM, the surveyor observed the Licensed Practical Nurse (LPN) administer a rapid antigen test for COVID-19 to Resident #458 in their room. The LPN swabbed Resident #458's [redacted] for five seconds each to collect the specimen.	F 886	Element 1: Resident #458 was re-tested in accordance with manufacturer's instructions with negative test results and is discharged Element 2: Residents meeting the testing criteria to be tested for COVID 19, antigen test have the potential to be affected. No other residents were affected. Element 3: Education was provided to staff who may be performing COVID 19 antigen testing on residents, on proper technique in accordance to manufacturer's instructions. The Licensed Practical Nurse was immediately in serviced and demonstrated competency on performing COVID 19 antigen testing. Element 4: The DON/designee will perform an audit of COVID 19 antigen testing observations to 5 residents weekly x 4 weeks, then 5 residents every 2 weeks for 4 weeks and evaluate the outcomes of the audit. Results of the observations will be	

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F 886	Continued From page 72 The surveyor reviewed the electronic medical record for Resident #458. The Face Sheet (FS), an admission record summary indicated that Resident #458 had medical diagnoses that included but were not limited to EX Order 26 § 4b1 [redacted] The resident's most recent admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care of care, dated 5/22/22 indicated that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, indicating that the resident's EX Order 26 § 4b1 [redacted]. On 5/20/22 at 9:26 AM, the surveyor interviewed the LPN. The surveyor asked the LPN why she swabbed Resident#458's each nostril for five seconds if the manufacturer's instruction was to swab for 15 seconds. The LPN stated that she should have swabbed for 15 seconds in each nostril to ensure the accuracy of the COVID-19 test. On 5/20/22 at 12:08 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that she was the acting Unit Manager regarding the process for COVID-19 rapid antigen testing. The ADON stated that the swab should be kept in each nostril for, "at least 15 seconds" The surveyor asked what could happen if the person who performed the test failed to swab each nostril for 15 seconds. The ADON stated that you could get a "false negative" test result and that the "results would not be accurate".	F 886	presented to QAPI Committee monthly for a period of 3 months. The committee will review the data and determine the need for further changes to the plan	

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F 886	Continued From page 73 On 5/20/22 at 12:39 PM, the surveyor expressed her concern to the LNHA and the DON. The DON stated that testing should be done in accordance with testing specifications. A review of the facility policy, "Coronavirus Disease (COVID-19)-Specimen Collection, Reporting, and Documentation for COVID-19 Testing" dated 9/20 reflected that a specimen should be collected according to manufacturer or laboratory instructions. The [name redacted] COVID-19 Ag Card dated 12/2020 revealed that, "To collect a nasal swab sample [...] firmly sample the nasal wall by rotating the swab in a circular path against the nasal wall 5 times or more for a total of 15 seconds, then slowly remove from the nostril. Using the same swab, repeat sample collection in the other nostril." NJAC 8:39-5.1 (a)	F 886		

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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 the interview, and record review, it was determined that the facility failed to a.) ensure staffing ratios were met for 11 of the 14-day shifts reviewed and this deficient practice had the potential to affect all residents. b.) complies with applicable state rules and regulations with regard to the New Jersey Department of Health (NJDOH) by ensuring that the facility designated Infection Preventionist met the requirement to hire a full-time employee in the infection control prevention role with no other responsibilities. Reference: New Jersey Department of Health	S 560	Element 1: The facility leadership team has met on ongoing basis and continue to identify staffing challenges and areas of improvement for licensed and certified needs. Facility leadership met to discuss ideas to promote within for IP position Element 2: Any resident has potential to be affected. Element 3:	6/24/22

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

Electronically Signed | 06/19/22

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S 560	Continued From page 1 (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. According to the NJDOH Executive Directive No. 20-026 Directive for the Resumption of Services in all Long-Term Care Facilities licensed pursuant to N.J.A.C. 8:43, N.J.A.C. 8:39, N.J.A.C. 8:36 and N.J.A.C. 8:37 issued by the New Jersey Commissioner dated 1/6/21, included "II. Required Core Practices for Infection Prevention and Control. 1. Regardless of a facility's current reopening phase, core infection prevention and control practices must be in place at all times ... iv. Facilities with No Ventilator Beds. a. Facilities with 100 or more beds or on-site hemodialysis services must: 1. Hire a full-time employee in the infection prevention role, with no other responsibilities and must attest to the hiring no later than August 10,	S 560	The facility has implemented a significant above market rate for nurses and certified nurses aides. The facility has implemented an incentive program including sign-on bonuses for new hires, and referral bonuses for employees referring staff where appropriate. The facility implemented an expedited and robust onboarding process for new hires The facility will use agency staff as needed to meet staffing needs. The facility ill continue to offer free attendance at their CNA training program offered non-stop throughout the year The facility ill continue to utilize social media, recruitment events to hire new staff. Internal candidate is identified to assume position as Infection Preventions. Element 4: DON and/or designee meets with staffing coordinator daily to review facility census, call outs if any, and staffing needs. The DON and/or designee will monitor call outs and staffing ratios weekly until requirement is met. The results of the audits will be forwarded to the facility Administrator and Monthly QAPI committee for further review and recommendations as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	556213	A. BUILDING: _____ B. WING _____	C 06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
CAREONE AT WALL	2621 HIGHWAY 138 WALL, NJ 07719

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S 560	Continued From page 2 2021 ..." The deficient practice was evidenced by the following: 1. As per the "Nurse Staffing Report" completed by the facility for the weeks of 5/1/22 and 5/8/22, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts as follows: -05/01/22 had 13 CNAs for 114 residents on the day shift, required 15 CNAs. -05/02/22 had 14 CNAs for 114 residents on the day shift, required 15 CNAs. -05/03/22 had 10 CNAs for 114 residents on the day shift, required 15 CNAs. -05/05/22 had 13 CNAs for 114 residents on the day shift, required 15 CNAs. -05/07/22 had 12 CNAs for 117 residents on the day shift, required 15 CNAs. -05/08/22 had 12 CNAs for 117 residents on the day shift, required 15 CNAs. -05/09/22 had 12 CNAs for 119 residents on the day shift, required 15 CNAs. -05/10/22 had 12 CNAs for 117 residents on the day shift, required 15 CNAs. -05/11/22 had 13 CNAs for 114 residents on the day shift, required 15 CNAs. -05/12/22 had 12 CNAs for 114 residents on the day shift, required 15 CNAs. -05/13/22 had 13 CNAs for 114 residents on the day shift, required 15 CNAs. On 5/26/22 at 10:45 AM, the surveyor interviewed the Staffing Coordinator (SC) who stated that she was aware of the required minimum direct care staff to resident ratios. She further stated that the facility was meeting the ratios to the best of her ability but that she could not prevent staff callouts. The surveyor then asked the SC if she informed	S 560		

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S 560	Continued From page 3 anyone if she was unable to meet the required ratios. The SC stated that she met with the Director of Nursing (DON) every day and that the DON would be aware if the facility was not meeting the ratios. On 5/26/22 at 11:09 AM, the surveyor interviewed the DON who stated that she was aware of the required minimum direct care staff to resident ratios. The surveyor then asked the DON if the facility was meeting the required minimum direct care staff to resident ratios. She stated that the facility was meeting the required minimum direct care staff to resident ratios. A review of the facility provided policy titled, "Staffing", with a revised date of October 2017, included the following: Policy Statement: Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. Policy Interpretation and Implementation 1. Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services. 2. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care ... 4. Direct care staffing information per day (including agency and contract staff) is submitted to the CMS payroll-based journal system on the schedule specified by CMS, but no less than once a quarter ... The facility provided policy did not include the required minimum direct care staff to resident ratios.	S 560		

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S 560	Continued From page 4 2. On 5/17/22 at 10:01 AM, two surveyors conducted an entrance conference with the facility's Licensed Nursing Home Administrator (LNHA) and DON. At the start of the entrance conference, the LNHA identified the DON as the facility's Infection Preventionist (IP). At the same time, the LNHA and the DON both stated that they were aware of the NJDOH regulation about having a designated IP with no other responsibilities. They further stated that the facility requested a waiver for the DON to be the IP and will provide documentation about their request that was submitted to the NJDOH. On 5/17/22 at 11:41 AM, the LNHA provided a copy of the email that he sent to NJDOH Licensing with an attachment of the Application for Waiver form that was signed by the LNHA dated 3/31/22. The provided email and form did not have a return response and there was no notification for approval. On that same date and time, the surveyor asked the LNHA if the facility followed up and received approval for the waiver request, and the LNHA stated that he will get back to the surveyor. During an interview of the surveyor on 5/17/22 at 1:33 PM, the LNHA stated that they did not have an approval receipt from the waiver requested. On 5/25/22 at 12:23 PM, the survey team met with the LNHA and the DON. The DON informed the surveyors that "we've been actively hiring people, unfortunately, it scares people when they know it is for infection control position."	S 560		

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
315485 Y1	A. Building B. Wing Y2	9/6/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WALL	2621 HIGHWAY 138 WALL, NJ 07719

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 F0656	Correction	ID Prefix F0658	Correction	ID Prefix F0690	Correction
Reg. # 483.21(b)(1)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(e)(1)-(3)	Completed
LSC	06/24/2022	LSC	06/24/2022	LSC	06/24/2022
ID Prefix F0756	Correction	ID Prefix F0761	Correction	ID Prefix F0812	Correction
Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	06/24/2022	LSC	06/24/2022	LSC	06/24/2022
ID Prefix F0814	Correction	ID Prefix F0880	Correction	ID Prefix F0886	Correction
Reg. # 483.60(i)(4)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.80 (h)(1)-(6)	Completed
LSC	06/24/2022	LSC	08/17/2022	LSC	06/24/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
6/2/2022	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
556213 Y1	A. Building B. Wing Y2	9/6/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WALL	2621 HIGHWAY 138 WALL, NJ 07719

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 06/24/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
6/2/2022	☐ 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
	315485	A. BUILDING **01** B. WING _____	C **06/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WALL	**2621 HIGHWAY 138** **WALL, NJ 07719**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
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 6/1/22 and 6/2/22, was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy The facility is a 2- building that was built in 2002, It is composed of construction group classification:1-2 unprotected construction. The facility is divided into 10 smoke zones. The generator does approximately 70 % of the building. The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions.	K 000		

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

Electronically Signed | 06/19/2022

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 The facility has 138 certified beds. At the time of the survey the census was 111.	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on documentation review on 6/1/22, in the presence of the Maintenance Director and Regional Plant Operations Director, it was determined that the facility failed to inspect fire doors Annually in accordance with S&C 17-38-LSC. This deficient practice was evidenced for 9 of 9 fire doors observed by the following: At 10:00 AM, the surveyor reviewed all provided documentation from the Maintenance Director. The annual fire door inspection documentation was not provided for the facility's fire door assemblies. The Regional Plant Operations Director provided a monthly door check log, but it did not provide the specifics identified in the S&C 17-38-LSC documentation. An interview was conducted with the Maintenance Director and Regional Plant Operations Director, during the document review, where they stated that currently no further documentation could be	K 211	Element 1: Annual fire inspection of doors as will be requested. Element 2: Patients/Residents residing in facility have the potential to be affected, none were identified that were affected. Element 3: Administrator educated Director of Maintenance(DOM) that Fire Doors need to be inspected annually. DOM will coordinate a date of inspection for doors. The inspection date is anticipated to occur on or before 6/24/22 Element 4: DOM or designee will have fire doors inspected at a minimum annually and forward the results of the inspection to the Administrator.	6/24/22

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K 211	Continued From page 2 provided on fire door inspections (Annual) for the last 12-months as identified in the S&C 17-38-LSC documentation. The Administrator was informed of the finding at the Life Safety Code exit conference on 6/1/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 80 NFPA 101 2012 edition Life Safety Code 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* to 7.2.1.15.8 S&C 17-38-LSC	K 211	Results of the inspection will be presented to QAPI Committee annually to corollate to annual inspection.	
K 225 SS=F	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 6/1/22, the facility failed to provide stair tread marking stripe (applied as a material that is integral with the nosing of each step, each floor's landing, and handrails) with solid and continuous marking stripe in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.3, 7.2.2, 7.2.2.5.5, 7.2.2.5.5.2, and 7.2.2.5.5.3. The deficient practice was observed in 3 of 3 stairwells identified by the Maintenance Director and Regional Plant Operations Director as	K 225	Element 1: Stairwells painting was initiated the same day. Element 2: Patients/Residents residing in facility have the potential to be affected, none were identified that were affected Element 3: The stairwell painting/identification will be completed and check monthly	6/24/22

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K 225	Continued From page 3 stairwell 1,2 and 3. While touring the facility on 6/1/22, from approximately 9:40 AM to 3:00 PM, the Surveyor, Maintenance Director and Regional Plant Operations Director, observed that the exit/egress stairwells revealed that marking stripes were not present on each step, floor landing, and handrails for the 2- stairwells observed. The Administrator was informed of this finding during the Life Safety Code survey exit conference on 6/2/22. NJAC 8:31.2(e) NFPA 101:2012 - 19.2.2.3, 7.2.2	K 225	Element 4: Inspections of the stairwell will be completed by Maintenance Director or Designee monthly for 3 months. Results of inspection will be presented monthly to the QAPI Committee for 3 months.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no	K 363		6/24/22

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K 363	Continued From page 4 impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 6/1/22, the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring that resident room doors would restrict the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place, for 10 of 45 resident room doors observed in the following resident room #'s. Resident Room: [redacted] and [redacted] The above resident room doors, when closed left a gap at the top of the resident room side-light	K 363	Element 1: Repair began when materials purchased and work began by CareOne staff to address the repairs needed on [redacted] Element 2: Patients/residents residing in facility have potential to be affected, none were identified that were affected. Element 3: Work and repairs were completed by completion date of 6/24/22 to the Resident rooms doors to resist the passage of smoke in accordance with the requirements in NFPA. Administrator provided re-education	

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K 363	Continued From page 5 door's, approximately 1/4 to 1/2 inch, due to a short cut in the door moulding installation: An interview was conducted with the Maintenance Director and Regional Plant Operations Director at the time of the observations who stated and confirmed that when the door's were closed, the moulding did not go to the top of the double doors (side-light doors) leaving a gap approximately 1/4 to 1/2 inch at the top of the meeting point of the moulding to the door frame. The Administrator was informed of the finding at the Life Safety Code exit conference on 6/2/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	Maintenance Director & Maintenance Staff related to monthly door inspection. Element 4: Inspections of resident rooms doors will be complete by Maintenance Director monthly for three months. Results of the inspection will be presented monthly to the QAPI Committee for a period of three months.	
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key	K 531		6/24/22

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315485	A. BUILDING **01** B. WING _____	C **06/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WALL	**2621 HIGHWAY 138** **WALL, NJ 07719**

(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) COMPLETION DATE
K 531	Continued From page 6 operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, on 6/1/22, it was determined that there was no evidence that Fire Fighters' Emergency Operations Inspection and Test were performed and written record of Phase I recall by use of the key switch, and a minimum of one-floor operation, including findings documented monthly testing for 2 of 2 elevators, in accordance with NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3. This deficient practice was evidenced by the following: During a tour with the Surveyor, Maintenance Director and Regional Plant Operations Director observed that 2 of 2 elevators; having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes conformed with Firefighter's Service Requirements of ASME/ANSI A17.3 (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key.19.5.3, 9.4.2, 9.4.3). The findings were verified by the Maintenance Director and Regional Plant Operations Director at the time of the observations. The Administrator was informed of the finding at the Life Safety Code exit conference on 6/2/22. NJAC 8:39-31.2(e)	K 531	Element 1: An inspection log was immediately put in place. Element 2: Patients/Residents residing in facility have the potential to be affected, none were identified that were affected. Element 3: The Fire Fighter Emergency Operations inspection log was initiated for the elevators within facility Element 4: Inspections of the elevators will be completed by the Director of Maintenance monthly for three months related to clearance requirements. Results of the inspection will be presented monthly to the QAPI committee for a period of 3 months.	

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K 531	Continued From page 7 NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3.	K 531		
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 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	K 918		6/24/22

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K 918	Continued From page 8 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 6/1/22, it was determined that the facility did not ensure a remote manual stop station for 1 of 1 generator, which was provided in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice could affect all residents and was evidenced by the following: At 11:00 AM, the Surveyor, Maintenance Director and Plant Operations Director, observed the exterior diesel generator. There was no remote manual stop station to prevent inadvertent or unintentional operation for the emergency generator observed. An interview was conducted during the observation with the Maintenance Director and Regional Plant Operations Director, where they stated that at the time of observation, the exterior generator was observed to not have a remote manual stop station. The Administrator was informed of the finding at the Life Safety Code exit conference on 6/1/22. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	Element 1: The vendor was contacted the same day to have the remote generator stop installed. Element 2: Patients/residents residing in facility have the potential to be affected, none were identified that were affected. Element 3: Remote Generator Stop will be installed by the contracted vendor. Element 4: Inspections of the generator will be completed by the maintenance director or designee weekly for 4 weeks, then monthly for to months related to remote generator stop. Results of the inspection will be presented monthly to the QAPI Committee for a period of three months.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only	K 920		6/24/22

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K 920	Continued From page 9 used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 6/1/22, the facility did not prohibit the use of extension cords beyond temporary installation, as a substitute for adequate wiring, exceeding 75% of the capacity, in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.5, 19.5.1, 9.1, 9.1.2. NFPA 70, 2011 LSC Edition, Section 400.8 and 590.3 (D). NFPA 99, 2012 LSC Edition, Section 10.2.3.6 and 10.2.4. This deficient practice does not ensure prevention of an electrical fire or electric shock hazard. This deficient practice was evidenced by the following: At 9:40 AM, the Surveyor, Maintenance Director	K 920	Element 1: The extension cord was removed immediately. Element 2: Patients/Residents residing in facility have the potential to be affected, non were identified that were affected. Element 3: The facility Educator or Designee will re-educated center staff on the use of extension cords within facility. Education included notifying Director of Maintenance to determine alternate solutions.	

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K 920	Continued From page 10 and Regional Plant Operations Director, observed in the MDS office, that electronics were plugged into a red/black extension cord. The red/black extension cord was then plugged into a 7-plug multi-outlet power strip. The 7-plug power strip was observed to have 7-electrical wires plugged into it and was then plugged into a duplex wall outlet. The finding was verified by the Maintenance Director and Regional Plant Operations Director at the time of the observation, where they stated and confirmed that extensions cords were not a substitute for fixed wiring. The Administrator was notified of the findings at the Life Safety Code exit conference on 6/2/22. NJAC 8:39-31.2(e)	K 920	Element 4: During facility rounding, the Maintenance Director or designee will document weekly for four weeks, then twice monthly for two months to ensure no extension cords are in permanent use. Results of the observation will be presented monthly to Quality Assurance Performance Improvement Committee for period of three months	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet	K 923		6/24/22

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K 923	Continued From page 11 In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 6/1/22, in the presence of the Maintenance Director and Regional Plant Operations Director, it was determined that the facility failed to prohibit combustible storage within 5-feet of quantities of oxygen exceeding 300 cubic feet in accordance with NFPA 99. This deficient practice was identified for 14 of 14 portable oxygen cylinders and was evidenced by the following: On 4/22/22 at 10:38 AM, the surveyor, Maintenance Director, and Regional Plant Operations Director observed on floor #1 by the nurse station that in the Oxygen Storage room, 14 portable oxygen cylinders (more then 300 cubic feet), were stored next to 14 plus combustible plastic adult incontinence brief	K 923	Element 1: Two oxygen cylinders were removed immediately from the area. The packages of the incontinence briefs were removed immediately and placed in personal care closet. Element 2: Patients/Residents residing in facility have the potential to be affected, none were identified that ere affected. Element 3: The facility educator or designee will re-educate center staff on the proper storage of oxygen and that only 12	

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K 923	Continued From page 12 packages (20 per bag). An interview was conducted with the Maintenance Director and Regional Plant Operations Director, who stated that the cylinders must be separated by five-feet (5') from combustibles when an automatic fire sprinkler system is provided. The building has a fully functional sprinkler system. The Administrator was informed of the finding at the Life Safety Code exit conference on 6/1/22. NJAC 8:39-31.2(e) NFPA 99	K 923	cylinders (e-tank) can be kept in room. Additional signage was installed as a visual reminder to staff. Element 4: During facility rounding daily, the Maintenance Director or designee will document weekly for 4 weeks, then twice monthly for two months the results of the inspection related to findings of the oxygen room. Results of these inspection will be presented monthly to the QAPI Committee for a period of three months.	
K 927 SS=F	Gas Equipment - Transfilling Cylinders CFR(s): NFPA 101 Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility did not store and trans fill liquid oxygen in accordance with NFPA 99, 2012 Edition, Section 11.3.3.2 and 11.3.2.7 by ensuring that the room is	K 927	Element 1: Switch was removed and cover with wall covering plate and a licensed electrician was contacted to arrange for relocation of	7/8/22

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K 927	Continued From page 13 properly designed and protected. This deficient practice was evidenced for 2 of 2 wall light switches and 1 of 2 light fixtures by the following: 1. At approximately 10:38 AM, the Surveyor, Maintenance Director, and Regional Plant Operations Director, observed in the floor-2 liquid oxygen storage and trans filling room, that a source of ignition (light switch) within the room was observed, along with a non-explosion proof drop ceiling fluorescent light fixture. 2. At approximately 11:40 AM, the Surveyor, Maintenance Director, and Regional Plant Operations Director, observed in the floor-1 liquid oxygen storage and trans filling room, that a source of ignition (light switch) within the room was observed. An interview was conducted during the observation with the Maintenance Director and Regional Plant Operations Director, who both stated and confirmed that the room had a source of ignition, (2) Light Switches and (1) non-explosion proof Light fixture. The Administrator was informed of the finding at the Life Safety Code exit conference on 6/2/22. NJAC 8:39-31.2(e)	K 927	light switch Element 2: Patients/Residents residing in facility have the potential to be affected, none were identified to be affected Element 3: Switch will be relocated to the exterior of the room and an explosion proof light fixture will be installed Element 4: Upon completion of work, maintenance director or designee will provide results to the administrator. Results of these scope of work will be presented to monthly Quality assurance Performance Improvement Committee.	

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
315485 Y1	A. Building 01 - MAIN BUILDING B. Wing Y2	9/6/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WALL	2621 HIGHWAY 138 WALL, NJ 07719

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 K0211	06/24/2022	LSC K0225	06/24/2022	LSC K0363	06/24/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0531	06/24/2022	LSC K0918	06/24/2022	LSC K0920	06/24/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0923	06/24/2022	LSC K0927	07/08/2022	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
6/2/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO