STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315171	A. BUILDING _____ B. WING _____	C 03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND REHABILITATION AND HEALTHCARE CENTER	20 BREAKNECK ROAD OAKLAND, NJ 07436

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F 000	INITIAL COMMENTS Survey Dates: 02/27/23 through 03/02/23 Survey Census: 188 Sample Size: 35 Supplemental Residents: 3 A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the Bureau of Facilities Oversight. The facility was found to be in substantial compliance with 42 CFR 483 subpart B.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		4/12/23

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

Electronically Signed | 03/28/2023

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F 550	Continued From page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of facility policy, the facility failed to promote a dignified dining experience when staff served meals to residents who were seated at overbed tables in the hallway for 15 of 55 residents who resided on the facility's Unit 2E. Findings Include During an observation on 02/27/23 at 5:36 PM, staff on the facility's Unit 2E, which included resident rooms from 201 to 231, served meals to residents who were seated in the hallway. Eleven residents, with EX Order 26 § 4b1 , were served and ate their evening meal while seated at an overbed table in the hallway. During an observation on 02/27/23 at 5:40 PM, no residents were eating their evening meal in the facility's 200-hall dining room. During an observation on 02/28/23 from 5:21 PM	F 550	1. All fifteen residents affected were served their next meal in the dining room, their own room or their preferred location within the facility in a dignified manner. Resident's unable to make their needs/preferences known will cause the facility to contact the residents' responsible party(s)/guardian to gather locations they prefer and deem dignified for the resident(s) to receive their meal. All residents currently have access to eat meals with dignity in areas they designate according to their preference, or the preference of their responsibility party/guardian. 2. All residents have the potential of being affected. Resident(s) or their responsible party/guardian were interviewed regarding their preference of location(s) to eat their meals with dignity. The resident preferences were updated to	

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F 550	Continued From page 2 to 5:31 PM, staff on Unit 2E served meals to residents who were seated in the hallway. Fifteen residents, with EX Order 26 § 4b1, were served and ate their evening meal while seated at an overbed table in the hallway. During an observation on 02/28/23 at 5:33 PM, no residents were eating their evening meal in the facility's 200-hall dining room. During an interview on 03/02/23 at 9:55 AM, Licensed Practical Nurse (LPN) 4, who was the Nurse Manager of Unit 2E, confirmed staff served evening meals to residents while they were seated in the hallway on 02/27/23 and 02/28/23. LPN4 stated residents were served their evening meal in the unit's hallway because there was not enough staff working on the unit to assist residents to the 200-hall dining room to eat their meal and assist them back to the hallway when they were finished with their meal. Review of the facility's policy titled, "Dignity," dated 10/2022, indicated, "When assisting with care, residents are supported in exercising their rights. For example, residents are: ... e. provided with a dignified dining experience." NJAC 8:39-4.1(a)12	F 550	their care plans. An interdisciplinary (IDC) meal service planning committee met on 3/21/23 to coordinate responsiblities to assure meal delivery and consumption for residents is safe, timely and dignified. The IDC team made recommendations for staff to ensure dining service delivered and consumed in a dignified manner. 3. Residents on all units were interviewed by activity staff regarding their preferred location(s) for eating their meals. Care Plans were updated by unit managers to reflect their preferences. Staff in all departments were educated/re-educated on the facility policy for residents' rights and dignity. The facility assembled an interdisciplinary committee who met and developed new processes to ensuring residents receive and safely consume each meal in a dignified manner within the facility. Staff in all departments were educated on the new processes to assure resident dignity during each meal. 4. The Dietician, or his/her designee, will audit meal service throughout the facility twice weekly for four (4) weeks, then once weekly for three (3) months to ensure residents are eating meals in their preferred location(s) of the facility with dignity. The results of the meal service audits will be shared at each monthly quality assurance and performance improvement (QAPI) team meeting. The QAPI Committee will review each report for consistent compliance and determine the need for additional monitoring for a period no less than four (4) months.	

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F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, the facility failed to ensure one of 35 residents(Resident (R) 179) had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences. Specifically, R179 was readmitted to the facility to a locked EX Order 26 § 4b1 care unit after previously having been admitted to the NJ Exec. Order 26:4.b.1 unit. Findings include: Review of R179's Electronic Medical Record (EMR) under the "Profile" tab revealed a documented titled, "Admission Record" which indicated R179 was admitted EX Order 26 § 4b1 with diagnoses includin EX Order 26 § 4b1 [redacted] Review of R179's "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 01/18/23, revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15, which indicated the resident was NJ Exec. Order 26:4.b.1 and the MDS indicated the resident showed no behaviors of EX Order 26 § 4b1 [redacted]	F 558	1. Resident # 179 was discharged from the facility on NJ Exec. Order 26 [redacted] 2. All residents being admitted to the secured EX Order 26 § 4b1 unit have the potential to be affected. Residents residing on the secured EX Order 26 § 4b1 unit were assessed for appropriateness of residing on that unit and consent was obtained from resident and/or responsible party. 3. Social Services, Admission staff and Nursing Staff will be educated on the Secure Unit Evaluation Policy and Process. Prior to placement of a resident on the secure memory care unit, the resident will be evaluated by the interdisciplinary team (IDT) to determine if the resident meets the criteria for placement. The IDT evaluation and determination will be documented in the Secure Unit Evaluation. The resident and the resident's responsible party will be notified of the IDT determination. Prior to placement on the unit, written consent will be obtained from the resident or their responsible party, as appropriate. The resident's care plan will be initiated to reflect placement on the unit, goals of	4/14/23

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F 558	Continued From page 4 Review of R179's EMR under the "Evaluations" tab revealed a document titled "Social Services Assessment V 4" dated 01/12/23 indicated that the resident assisted in completion of the assessment and stated [NJ Exec. O] was "EX Order 26 § 4b1 [redacted]," had completed high school and her discharge plan was to NJ Exec. Order 26:4.b.1. Review of R179's EMR under the "Evaluations" tab revealed a document titled "Admission/Readmission Evaluation Packet V.6" dated [NJ Exec. Order 26:4.b] indicated that the resident was not EX Order 26 § 4b1 [redacted], did not EX Order 26 § 4b1 [redacted] Review of R179's EMR under the "Progress Notes" tab revealed [NJ Exec. Order 26:4.b.1] to Mood/Behavior during the time period 01/11/23-03/01/23. On 02/27/23 at 3:34 PM R179 was observed in her room and stated [NJ Exec. O] "wants to go back downstairs." [NJ Exec. O] stated that when [NJ Exec. O] was here previously, [NJ Exec. O] was on the subacute unit downstairs unit with more people who were like [NJ Exec], they were "peers". [NJ Exec. O] did engage in activities, but not since [NJ Exec.] came to this unit. [NJ Exec. O] said that [NJ Exec] roommate never says anything, [NJ Exec.] just lies there. [NJ Exec. O] stated other people are yelling out a lot of the time, especially at night. [NJ Exec. O] said people will just come into [NJ Exec] room. [NJ Exec. O] didn't understand why [NJ Exec. Order 26:4.b] readmitted to the facility on a different unit, and [NJ Exec.] did not want to stay on this unit. [NJ Exec. Or] stated that [NJ Exec] sister would be able	F 558	placement and the interventions to be implemented. Residents will be evaluated at least quarterly to determine if they continue to meet the criteria for the unit. 4. The administrator will audit three (3) randomly admissions to the secure unit once a week for two (2) months, then once a month for four (4) months to ensure compliance. The results of the audits will be shared with the quarterly quality assurance and performance improvement (QAPI) team meeting. The QAPI committee will make recommendations or determine the need for continued monitoring after a period of six (6) months.	

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to explain further.

Interview with R179's family member (FM) on 02/27/23 from 5:03 PM -5:32 PM in the resident's room, she stated that R179 was previously on the subacute unit for [EX Order 26 § 4b1] services. She then [NJ Exec. Order 26:4.b.1] was discharged back to [NJ Exec. Order 26:4.b.1] and then readmitted to this facility. She stated that at the time [NJ Exec. Order 26:4.b.1] was readmitted, they put the resident on the [EX Order 26 § 4b1] unit. She stated that R179 does not want to be on this unit, [NJ Exec. Order 26:4.b.1] doesn't feel that the other residents are [NJ Exec. Order 26:4.b.1] peers. The FM stated that the facility did not inform her that R179 would be readmitted to this unit as opposed to back to the subacute unit. FM did speak to the Director of Nursing (DON) after R179 was readmitted and the DON alleged to R179's FM that the resident had [NJ Exec. Order 26:4.b.1] while on the subacute unit and that is why they put [NJ Exec. Order 26:4.b.1] in the [EX Order 26 § 4b1] unit. R179 was supposed to be the on subacute unit. FM indicated that the facility never said anything about R179 calling out to other residents or showing other [NJ Exec. Order 26:4.b.1] FM stated that the facility told her there were no other rooms, but that it should be no problem to move [NJ Exec. Order 26:4.b.1] and they just had to check with the DON. FM stated at the time of this interview, they had not gotten back to her about changing the room and the administrator hasn't responded yet.

During an interview on 02/28/23 at 3:31PM with the DON she stated R179 originally came from a [NJ Exec. Order 26:4.b.1], [NJ Exec. Order 26:4.b.1] came back to the facility on the [NJ Exec. Order 26:4.b.1]. [NJ Exec. Order 26:4.b.1] was originally admitted on the first floor, [EX Order 26 § 4b1] The DON stated that R179 was very [EX Order 26 § 4b1] to the

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sub-acute unit and that she didn't fit in well with that population, "the sub-acutes stay in their room." The DON thought R179 might have done better on the [redacted] unit. [redacted] was here on the first floor, then went to the [redacted], then [redacted] was readmitted to the [redacted] unit. The DON said she offered to transfer [redacted] to the other unit for activities. "I was doing what I thought was good for the whole building, [redacted] very sweet. I wasn't punishing [redacted] a creature of habit." She indicated that the sister was upset that she was not told. Her sister has said she was the guardian though the Power of Attorney (POA) paperwork from the sister had not been provided. The DON stated that she didn't mean to punish R179, if anything it was negligence on her part. They didn't notify the sister of the change and then they readmitted [redacted] to a locked unit. When asked if the R179 was showing [redacted] when on the subacute unit, the DON stated that the unit manager would have told the sister if there was an issue.

During an interview on 03/01/23 at 3:10 PM with the Licensed Practical Nurse (LPN) 3 who admitted R179 to the facility, [redacted] was [redacted] and [redacted] when [redacted] was admitted, [redacted] was okay, didn't do much, didn't need much care, if [redacted] was [redacted]. The LPN stated that when the resident found out that [redacted] was on a different unit, [redacted] did say [redacted] wanted to be on a different unit, [redacted] said it's not fit for me but I just want to get better. The LPN stated that this was not a good unit for [redacted] to be on, [redacted] is more cognizant than the other residents.

During an interview on 03/02/23 at 08:36 AM with the Registered Nurse (RN) Unit Manager, she stated that R179 was only on this unit for less

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than a week, NJ Exec. Ord been very pleasant, NJ Exec. Ord came from a NJ Exec. Order 26:4.b.1, NJ Exec. O has not exhibited any NJ Exec. Order 26:4.b.1, NJ Exec. Ord very NJ Exec. Order 26:4.b.1 for this unit, The resident did ask her if there was another bed on unit 2E (an unlocked unit). RN stated that R179 NJ Exec. O might have had different NJ Exec. Order 26:4.b.1 downstairs (on the subacute unit.) The RN stated that she thought R179 would do better over on the other unit 2E. The RN stated that the resident was initially here in the facility for EX Order 26 § 4b1 on account of a EX Order 26 § 4b1 related issue, was discharged back to the EX Order 26 § 4b1 and ended up back in the EX Order 26 § 4b. She stated that "hopefully NJ Exec. O can get back to the NJ Exec. Order 26:4.b.1. This unit does have some people that don't have NJ Exec. Order 26:4.b.1, but mostly the residents on this unit are EX Order 26 § 4b1, which R179 is not."

Review of the facility policy titled, "Resident Rights," undated, indicated, " ...The resident has the right to a dignified existence ...Be treated with respect, kindness, and dignity ...refuse a transfer from a distinct part within the institution."

Review of the facility policy titled, "Dignity" dated October 2022, indicated, "Residents are treated with dignity and respect at all times ...The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values and beliefs. This begins with the initial admission and continues throughout the resident's facility stay ...Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example ...allowing residents unrestricted access to common areas open to the public, unless this poses a safety risk for the resident."

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F 558	Continued From page 8	F 558		
F 578 SS=D	NJAC 8:39-4.1(a)3,12 Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.	F 578		3/31/23

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F 578	Continued From page 9 (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and policy review, the facility failed to complete documentation of residents' wishes for treatment in the Practitioner Orders for Life-Sustaining Treatment (POLST-used as directions to emergency health personnel in the event of cardiac or respiratory failure)) for three of four residents (Resident (R) 116, R393, and R394) reviewed for advance directives in a total sample of 35 residents. This failure created the potential for residents to not have their wishes known should they suffer a health emergency. Findings include: 1.Review of R116's profile, located on the "profile" tab of the electronic medical record (EMR), revealed R116 was admitted to the facility on [redacted] with diagnoses that included [redacted] Review of R116's significant change "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 12/16/22 revealed R116 had a "Brief Interview for Mental Status (BIMS)" score of [redacted], indicating R116 was [redacted]. Review of R116's "POLST" (Practitioner Orders for Life-Sustaining Treatment - form located under the "Miscellaneous" tab of the EMR	F 578	1. Resident #119 (116 incorrect on resident sample) POLST was updated with residents name and date of birth. The POA paperwork was in place and located under the Misc. tab of EMR as of 1/20/20. Resident # 393 was discharged from the facility on [redacted]. Resident # 394's POLST was removed from [redacted] chart. Due to residents' [redacted] to sign the POLST no POLST was completed. 2. All residents have the potential to be affected. Residents with POLST forms were reviewed for accuracy and appropriate signatures and documentation. 3. Social worker audited residents with POLST forms to ensure they were complete and if signed by someone other than resident then POA documentation was in place. Social worker removed from residents chart any POLSTs that were signed by someone other than resident if POA or guardian paperwork was not in place. Admission staff were educated to ensure POA paperwork is obtained upon admission if applicable. Staff were educated on completing the POLST form in its entirety and that if resident cannot sign then the person	

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F 578	Continued From page 10 revealed the document was signed by a physician and the resident's daughter. The form lacked the resident's name and date of birth. Under section "D" (Cardiopulmonary Resuscitation [CPR]/Airway Management) section of the POLST form, NJ Exec. Order 26:4.b.1 [redacted]" was checked. Under "EX Order 26 § 4b1 ", "EX Order 26 § [redacted] was checked. Review of the EMR revealed there was not documentation of a POA for the residents daughter. During an interview with the Director of Social Services (DSS) on 03/01/23 at 6:45 PM, she could not explain why the resident's name was not on the POLST form and admitted the document was incomplete and could not represent the resident's o[redacted] family's wishes. 2. Review of R393's profile, located on the "profile" tab of the EMR, revealed R393 was admitted to the facility on [redacted] with diagnoses that included EX Order 26 § 4b1 [redacted]. Review of R393's "POLST" form located under the "Miscellaneous" tab of the EMR revealed there was no physician signature. The name and signature lines were not signed by R393 or any of [redacted] family members. The name on the form belonged to a nurse in the facility. R393 elected to be a [redacted] Under section "D" (Cardiopulmonary Resuscitation [CPR]/Airway Management) section of the POLST form, NJ Exec. Order 26:4.b.1 " was checked. Under "Airway Management", NJ Exec. Order 26:4.b.1 [redacted]" was checked. .	F 578	signing must have valid POA paperwork or if two physicians deem resident unable to make healthcare decisions then a surrogate such as a family member may sign in their place. 4. The Director of Social Services will audit five (5) residents with POLSTS weekly for four (4) weeks, then once a month for three (3) months to ensure compliance. The results of the audits will be shared with the quarterly quality assurance and performance improvement (QAPI) team meeting. The QAPI committee will make recommendations or determine the need for continued monitoring after a period of four (4) months.	

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F 578	Continued From page 11	F 578		

During an interview with the (DSS) on 03/01/23 at 6:45 PM, she produced a signed copy of R393's POLST that had been filled and signed by the Nurse Practitioner (NP) and dated 02/28/22,. When told that the surveyor had already observed the unsigned copy of the POLST form from R393's paper chart the previous day, the DSS admitted the NP had just signed, and must have made an error on the date.

3. Review of R394's profile, located on the "profile" tab of the EMR, revealed R393 was admitted to the facility on [redacted] with diagnoses that included [redacted]. Review of RR364's medical record failed to reveal any Power of Attorney (POA) documentation.

Review of R394's "POLST" form located under the "Miscellaneous" tab of the EMR revealed R34's daughter's name was handwritten on the signature line of the document. Healthcare/legal guardian was checked as the person signing the document, and "POA" handwritten. Under section "D" [redacted] section of the POLST form, "[redacted]" was checked. Under "[redacted]", [redacted] was checked.

During an interview on 03/02/23 at 6:45 PM, the Admissions Director (AD) was asked for the POA document referenced in the POLST. The AD confirmed there was no POA document in the

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F 578	Continued From page 12 medical record. During an interview on 03/02/23 at 3:15 PM, the AD stated the resident's signature section of the POLST form was in the same handwriting because the POLST was filled out as a "verbal" on the phone with R364's daughter who stated she was the POA, which is why POA was penned in the document. The AD stated she called the daughter on 03/01/23, and the daughter stated she was not R364's POA but was in the process of getting the paperwork done to become one. The DON signed the document. Review of the facility's undated policy titled "Advance Directives" revealed "The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy.. . .h. Physician Orders for Life-Sustaining Treatment (or POLST) paradigm form - a form designed to improve patient care by creating a portable medical order form that records patients treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patients current medical condition into consideration..." NJAC 8:39-4.1(a)2 NJAC 8:39-4.1(a)4	F 578		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an	F 660		4/7/23

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F 660	Continued From page 13	F 660		

effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-
(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's

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F 660	Continued From page 14 comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and policy review, the facility failed to provide a discharge plan and develop a discharge care plan for one of three residents (Resident (R) 112) reviewed for discharge out of a total sample of 37 residents. This failure increased the risk of incomplete	F 660	1. Resident # 112□s care plan was updated to include discharge plan on [redacted]. 2. All residents being discharged have the potential to be affected. Audit was	

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F 660	Continued From page 15 discharge planning for residents wanting to be discharged from the facility. Findings include: Review of R112's undated "Admission Record," under the "Profile" tab in the electronic medical record (EMR), revealed R112 was admitted to the facility on [redacted] with multiple diagnosis to includ [redacted]. Review of R112's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 01/31/23 and located in the EMR under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15 indicating R112 was [redacted]. Review of R112's "Social Services Assessment," under the "Assessments" tab in the EMR and dated 01/26/23, revealed ". . .Discharge Planning: The resident is at the facility for [redacted] Is active discharge planning already occurring for the resident to return to the community: Yes Is this resident receiving end-of-life care or service[redacted]." Review of R112's "Progress Notes," under the "Progress Notes" tab located in the EMR revealed the following: 02/22/23 ". . .[R112] [redacted] has been doing [redacted], is complaining mainly of [redacted]...." Signed by the Nurse Practitioner. 02/20/23 ". . .Chief complaint: f/u [follow up] visit, pt [patient] doing well, hopeful of getting better. Pt [patient] stated [redacted] doing well, [redacted]	F 660	conducted on all residents and discharge care plan was written for any residents missing a discharge care plan. 3. Social worker audited residents for discharge care plans. Social worker developed discharge care plan for residents missing care plan. Social worker will complete discharge care plan for residents upon completion of admission assessment. Social worker and MDS coordinator were educated on the requirement for every resident to have a discharge care plan in place. MDS coordinator will review care plans during initial navigation meeting to ensure discharge care plan is in place. MDS coordinator will conduct admission care plan review with IDT and ensure discharge summary is in place. 4. The MDS Coordinator will audit 5 residents dischrge care plans weekly for 4 weeks, then monthly for 3 months to ensure a discharge care plan is in place. The results of the audits will be shared with the quarterly quality assurance and performance improvement (QAPI) team meeting. The QAPI committee will make additional recommendations or determine the need for continued monitoring after a period of four (4) months.	

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is eager to go home and cont. [continue] w/ [with] [NJ Exec] life ...." Signed by the Nurse Practitioner.

02/13/23 ". . .[R112] [NJ Exec. Order 26:4.b.1] has been doing [NJ Exec. Order 26:4.b.1], is complaining mainly of [NJ Exec. Order 26:4.b.1]...." Signed by the Nurse Practitioner.

Review of R112's comprehensive "Care Plan," under the "Care Plan" tab located in the EMR, revealed no discharge care plan, goals, or interventions.

Interview on 02/27/23 at 11:45 AM, R112 stated that [NJ Exec] told the staff two weeks ago that [NJ Exec] wanted to be discharged from the facility because [NJ Exec] was [NJ Exec. Order 26:4.b.1] and wanted to go home to continue [NJ Exec.] life.

Interview on 02/28/23 at 6:33 PM, the Social Services Director (SSD) 2 confirmed that she started discharge planning with the residents at the facility on the day of their admission. The SSD2 stated that she was hired in October 2022 was not trained to develop a discharge care plan for residents. The SSD2 indicated discharge planning was not included on R112's care plan and she had not documented R112's discharge planning interventions in the progress notes.

Interview on 02/28/23 at 6:43 PM, the Director of Nursing (DON) stated the SSD should have developed the discharge planning care plan and entered progress notes regarding the progress of R112's discharge.

Review of the facility-provided policy titled, "Discharge Summary and Plan," undated, revealed "....When a resident's discharge is anticipated...post-discharge plan will be

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F 660	Continued From page 17 developed...Every resident will be evaluated for his or her discharge needs and will have an individualized post-discharge plan...The post-discharge plan will be developed by the Care Planning/Interdisciplinary with the assistance of the resident...Where the individual plans to reside...Arrangements that have been made for follow-up care and services...A description of the resident's stated discharge goals... Residents will be asked about their interest in returning to the community. If the resident indicates an interest in returning to the community, he or she will be referred to local agencies and support services that can assist in accommodating the resident's post-discharge...."	F 660		
F 661 SS=D	NJAC 8:39-35.2(d)15,16 Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge	F 661		4/7/23

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F 661	Continued From page 18 medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, and facility policy review, the facility failed to ensure one of three residents (Resident (R) 190) reviewed for closed records had a discharge recapitulation of stay, a medication reconciliation, and a discharge plan of care. This failure has the potential to have any resident that may discharge not have the information required regarding medical appointments, medication regimen, and other information for a successful discharge. Findings include: Review of R190's "Admission Record" from the facility electronic medical record (EMR) "Profile" tab showed a facility admission date of [redacted] with medical diagnoses that included [redacted] A review of the "Progress Notes" from the EMR "Prog Notes" tab showed, "12/29/22 0:938 Mental Status Questionnaire (MQS) Discharge Summary Social Services. R190 was discharged on [redacted] at 4:30PM." The responsible party was	F 661	1. Resident 190 had a discharge progress note entered on [redacted] detailing the residents discharge from the facility by a staff nurse. Resident 190s discharge summary was completed, in collaboration with the physician and IDCP team, reviewed and signed by activities on 12/29/23; nursing, dietary and social services on [redacted]. The staff reviewed the discharge summary with the resident□s daughter, who then signed the original and gave a copy of the document to the resident□s daughter at the time of discharge on [redacted]. The Physician note for resident #190 was completed on January 4, 2023. 2. All residents being discharged have the potential to be affected. IDT will complete their designated section of the discharge summary prior to the resident's discharge date. All residents discharge plans and summaries were reviewed by nursing and social services staff were found to be in compliance.	

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F 661	Continued From page 19 the daughter in law and the discharge destination was [NJ Exec. Order 2]. Mode of transportation was private vehicle. Medications were listed with prescription to responsible party. No services were requested, and the responsible party wanted to schedule any future appointments. A review of the EMR on 03/02/23 did not show any discharge progress notes or summary form nursing staff or the physician. During an interview on 03/02/23 at 11:24 AM with the Director of Nursing Services (DNS) and the Assistant Director of Nursing Services (ADNS), review the EMR "Progress Notes, and Documentation" and agreed there was no discharge summary for R190. There were able to see Social Services, MQS Discharge Summary. The DNS revealed the nursing, social services, and the doctor/nurse practitioner are always to write a discharge summary. During an interview on 03/02/23 at 11:40 AM with the Nurse Practitioner (NP) revealed while looking through the chart there was no discharge summary on R190 in the EMR. The NP stated unless the resident leaves Against Medical Advice (AMA), other than that a discharge summary is completed. NP indicated R190 was last seen on [NJ Exec. Order 26:4.b], and scripts were given. NP stated not sure what might have happened, only way it may have been missed if R190 had a probable discharge date and left in the evening. During an interview 03/02/23 at 11:48 AM with the Social Service Director (SSD), revealed the discharge was not all of a sudden. It was always planned for [NJ Exec. Order 26:4.b]. R190 became [NJ Ex] while visiting here for the holidays and had to be	F 661	3. The interdisciplinary team (IDT) was educated on completion of discharge progress notes from facility nursing staff or the physician upon discharge from the facility. Licensed nurses were educated to review the completed discharge summary with the resident or family on the day of discharge or the day prior and have the resident or family member sign. Licensed nurses were additionally educated on a writing discharge progress note upon discharge from the facility. Each facility unit manager will review residents discharged from facility the prior day to ensure a discharge progress note is written and signed by a facility physician or staff nurse and a full discharge summary has been completed. 4. The MDS Coordinator will audit five (5) residents weekly for four (4) weeks, then five (5) residents monthly for three (3) months to ensure compliance. The results of the audits will be shared with the quarterly quality assurance and performance improvement (QAPI) team meeting at least monthly. The QAPI committee will make recommendations or determine the need for continued monitoring after a period of no less than four (4) months.	

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NJ Exec. Order 26:4.b.1

No services or appointments were set up because the resident lived out of states and the responsible party was going to set the appointment up with her primary care doctor. The SSD indicated this was the plan that was set in place during the care plan meeting.

Review of the facility's policy titled "Discharge Summary and Plan," no date provided, showed:
"Policy Statement", When a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment.
"Policy Interpretation and Implementation"
The discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The discharge summary shall include a description of the resident's:
a. current diagnosis.
b. medical history (including any history of mental disorders and intellectual disabilities);
c. course of illness, treatment and./or therapy since entering the facility.
d. current laboratory, radiology, consultation, and diagnostic test results.
e. physical and mental functional status.
f. ability to perform activities of daily living.
g. sensory and physical impairments.
h. nutritional status and requirements:
(l) weight and height.
(2) nutritional intake; and
(3) eating habits, preferences, and dietary restrictions.
i. special treatments or procedures.

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F 661	Continued From page 21 j. mental and psychosocial status. k. discharge potential. l. dental condition: m. activities potential. n. rehabilitation potential. o. cognitive status and p. medication therapy." NJAC 8:39-35.2(d) 1-16	F 661		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to ensure staff followed care planned interventions to prevent [NJ Exec. O] for one of two residents (Resident (R) 10) reviewed for [EX Order 2] out of a total sample of 37 residents. This failure resulted in harm to R10 who was admitted to the [EX Order 26 § 4b1] with a EX Order 26 § 4b1 after sustaining a [EX Order] from being turned in bed by staff without assistance. Findings include: Review of R10's undated "Admission Record," under the "Profile" tab in the electronic medical	F 689	1. Resident #10s care plan and Kardex was updated on 3/22/23 to reflect the accurate ADL assistance required for each ADL. 2. All residents identified at risk for [NJ Exec. O] have the potential to be affected. Residents were audited to ensure the MDS, Care Plan and Kardex reflected the residents current ADL status and assistance required. Any discrepancies were corrected. 3. The MDS coordinator, Rehab Director, and Unit Manager audit current residents	4/4/23

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F 689	Continued From page 22 record (EMR), revealed R10 was admitted to the facility on EX Order 26 § 4b1 with multiple diagnoses to include EX Order 26 § 4b1 [redacted] Review of R10's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 06/01/22 and located in the EMR under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15 indicating R10 was EX Order 26 § 4b1. The MDS indicated R10 weighed [redacted] pounds. The MDS revealed R10 was NJ Exec. Order 26:4.b.1 on staff with NJ Exec. Order 26:4.b.1 for bed mobility, and transfers. The MDS indicated R10 was NJ Exec. Order 26:4.b.1 on staff with one-person EX Order 26 § 4b1 [redacted] Review of R10's "Care Plan," dated 03/07/22, located in the EMR under the "Care Plan" tab, revealed the Problem EX Order 26 § 4b1 [redacted] The care planned interventions for [redacted], initiated on 03/07/22, indicated EX Order 26 § 4b1 [redacted]."	F 689	to ensure the MDS, Care Plan and Kardex reflected the residents current ADL status and assistance required. The Nursing staff were educated on how to access the residents care plan and Kardex to check the residents interventions for fall prevention and assistance needed for ADLs. Rehab staff will initiate Nursing Therapy Communication Change of Status Form - V 4 after completing initial evaluation of residents ADL abilities and support needed. Rehab will initiate the resident ADL Care plan with interventions for Bed mobility including pulling up and moving side to side, dressing, toileting, and bathing. MDS coordinator will review the residents care plan upon completion of admission MDS and quarterly to ensure it reflects the appropriate number of staff to perform the residents ADLs. MDS coordinator will initiate Care Plan Review upon completion of admission MDS and then quarterly to review care plan including Falls Care Plan and ADL care plan with IDT and make changes as necessary. 4. The MDS Coordinator will audit ten (10) residents weekly for four (4) weeks and then once monthly for three (3) months to ensure MDS, Care Plan and Kardex all reflect the appropriate number of care givers for ADLs to ensure compliance. The results of the audits will be shared with the quarterly quality assurance and performance improvement (QAPI) team meeting. The QAPI committee will make recommendations or determine the need for continued	

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F 689	Continued From page 23 Review of R10's "CNA [Certified Nursing Assistant] Kardex," dated 06/30/22, located in the EMR under the "Tasks" tab, revealed R10 required EX Order 26 § 4b1 " The CNA Kardex did not indicate the NJ Exec. Order 26:4.b.1 required by staff for NJ Exec. Order 26:4 Review of R10's "Fall Risk Assessment," dated 05/25/22, located in the EMR under the "Evaluations" tab, revealed the facility assessed the resident with a score of NJ Exec indicating she was at EX Order 26 § 4b1 . Review of R10's "Progress Notes," under the "Progress Notes" tab located in the EMR revealed the following: 07/03/22 " ... @ [at] 11:40 Am, CNA called me that the patient EX Order 26 § 4b1 Patient was in sitting position in the EX Order 2. CNA said while turning the patient on NJ Exec side during Am [morning] care the patient's EX Order 26 § 4b1 CNA put the patient's bed down and she tried to grab the patient to prevent NJ Exec. O from EX Order 26 § but she was unable to. Patient EX Order 26 § 4b1 EX Order 26 § 4b1 but complained of EX Order 26 § 4b1 Patient said NJ Exec. EX Order 26 § 4b1 . No other visible EX Order 26 noted. Put patient back to EX Order 26 § 4b1 . Nursing supervisor notified (daughter) and [the Medical Director] PRN [as needed] EX Order 26 § 4b1	F 689	monitoring after a period of four (4) months.	

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EX Order 26 § 4b1 [redacted] signed by the Nurse.

07/03/22 " ...Admitted to EX Order 26 § 4b1 [redacted] signed by the Nurse.

07/25/22 " ... 8:30 PM; Admitted [R10] via EX Order 26 § 4b1 [redacted] signed by the Nurse.

7/29/22 " ... [R10] who presented to the EX Order 26 § 4b1 [redacted] signed by the

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Nurse Practitioner.

Review of the facility-provided "Incident Report," dated 07/03/22, revealed at 11:40 AM CNA1 turned R10 towards her after [redacted], then R10's legs came off the bed and R10 [redacted] CNA1 stated she attempted to hold onto R10 while [redacted]. CNA1 also stated she [redacted].

Observations on 02/27/23 at 5:27 PM, 02/28/23 at 4:51 PM, and 03/01/23 at 4:51 PM revealed R10 was laying in a [redacted]. Attempts to interview with resident was not possible due to the resident's [redacted].

During an interview on 02/27/23 at 5:27 PM, Family Member (FM) 1 stated that she was notified on [redacted] by facility staff that R10 [redacted]. FM1 also stated that R10 had [redacted] for the [redacted]

During an interview on 03/01/23 at 4:48 PM, Registered Nurse (RN) 2, Unit Manager on the first floor where the resident resided, stated that the CNAs were expected to follow the care plan which was [redacted] mobility prior to R10's [redacted].

During an interview on 03/01/23 at 7:51 PM, CNA1 confirmed that she turned R10 on [redacted] so that she could clean [redacted] without assistance of another CNA then R10 fell off the bed onto the floor. CNA1 stated that the R10 would not have [redacted] with the

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assistance of another CNA. CNA1 indicated that she was normally assigned to R10. CNA1 also stated that R10's required EX Order 26 § 4b1 ut only one EX Order 26 § 4b1 the CNA care plan.

During an interview on 03/02/23 at 8:41 AM, the Director of Nursing (DON) confirmed R10 NJ Exec. Order the bed after CNA1 turned her without assistance of another CNA while dressing R10 after providing a NJ Exec. Order 26:4.b on 07/03/22. The DON also confirmed that R10's CNA Kardex prior to the NJ Exec. O stated R10 required NJ Exec. Order 26:4.b.1 mobility and that NJ Exec. Order 26:4 was not addressed on the Kardex. The DON stated that she expected staff to follow the care plan. The DON indicated the meaning of NJ Exec. Order 26:4.b.1 was turning and pulling up a resident in bed.

During an interview on 03/02/23 at 9:08 AM, Licensed Practical Nurse (LPN) 4 revealed she was the Unit Manager on the first floor when R10 sustained a NJ Exec. from the bed on 07/03/22. LPN4 stated CNA1 turned R10 towards during morning care then R10 rolled off the bed onto the floor and complained of EX Order 26 § 4b1. LPN4 also stated that R10 was NJ Exec. Order 26:4.b.1 at the time due to a recent NJ Exec. Order 26:4.b.1 therefore she could not NJ Exec. Order 26:4.b.1. LPN4 indicated R10 was NJ Exec. Order 26:4.b.1 which included turning the resident and the CNAs were expected to follow the care plan.

During an interview on 03/02/23 at 10:26 AM, the Medical Director revealed he was notified on 07/03/22 that R10 NJ Exec. and was complaining of NJ Exec. Order 26:4.b.1 so NJ Exec. was sent to the emergency room. The Medical Director stated he

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F 689	Continued From page 27 admitted [NJ Exec. O] from the [NJ Exec. Order 26:4] on [EX Order 26 § 4b1] with a EX Order 26 § 4b1 . During an interview on 03/02/23 at 10:55 AM, the MDS Coordinator (MDSC) confirmed that R10 required EX Order 26 § 4b1 with [EX Order 26 § 4b1] which included turning the resident in bed. The MDSC stated the Unit Managers developed the CNA care plans which were a short version of the care plan. Review of the facility-provided policy titled, "Care Plans, Comprehensive Person-Centered," dated October 2022, revealed ". . .a comprehensive, person-centered care plan that includes objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident." Review of the facility-provided policy titled, "Falls and Fall Risk, Managing," version 1.2, revealed ". . .Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. . .Resident-Centered Approaches to Managing Falls and Fall Risk: 1. The interdisciplinary team will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. . ." NJAC 27.1(a)	F 689		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		4/5/23

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§483.45(c) Drug Regimen Review.
§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

§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:

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F 756	Continued From page 29 Based on record review, interview, and policy review, the facility failed to ensure the attending physician acted upon the pharmacist recommendations for one of five residents (Resident (R)161) reviewed for unnecessary medications out of a total sample of 35 residents. This failure increases the risk that residents will continue to receive unnecessary medications that potentially could cause serious adverse effects. Findings include: Review of the R161's "Face Sheet," located on the profile tab in the electronic medical record (EMR) revealed R161 was admitted to the facility on [redacted] with diagnoses that included [redacted] Review of "Physician Orders," under the "Orders" tab, revealed R161's medication regimen included the following medications: [redacted] Review of the "Medication Administration Record (MAR)" for R161 for revealed the two medications reviewed by the pharmacy continued to be administered to R161 as follows: [redacted]	F 756	1. The Pharmacy Consultant recommendation for resident #161 was reviewed and acknowledged by Physician on 3/1/23. Physician declined to make any changes. The Unit Manager responsible for completion of the Consultant Pharmacy Recommendations was counseled on 3/21/22. 2. All residents with Recommendations by the Pharmacy Consultant have the potential to be affected. The Director of Nursing conducted audit on Pharmacy Consultant recommendations on current residents for last 3 months and corrected any recommendations that were not reviewed. 3. Unit Mangers were educated on completion of all Pharmacy recommendations timely. DON or designee will print last 3 months of Pharmacy recommendations to check for completion and follow through. Variances will be addressed. DON or Designee will meet Consultant Pharmacists Monthly after completion of Monthly review to discuss each month□s review, any recommendations from previous month not acknowledged and any high-level concerns. DON will print Monthly pharmacy recommendations once received and distribute to unit managers for completion. Unit manager will complete Nursing portion of recommendations and document on recommendations actions completed within 7 days of receipt from DON. Unit manager will contact Physician regarding	

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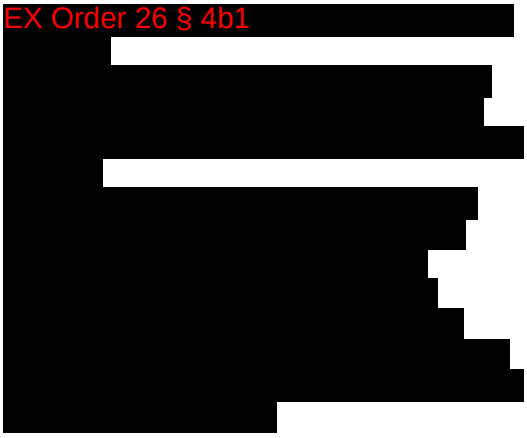
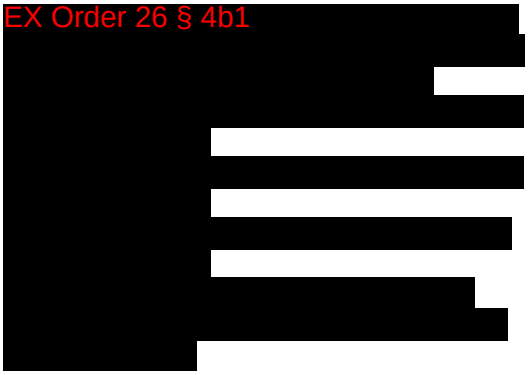
F 756	Continued From page 30 EX Order 26 § 4b1 [redacted]  Review of Monthly Consultant Pharmacist Report from the facility Pharmacy Consultant including consultant pharmacist activities between 04/06/22 and 04/07/2022, provided by the facility, revealed the following entries. EX Order 26 § 4b1 [redacted]  Review of document titled "Consultant Pharmacist Communication to the Physician", provided by the facility, revealed the following recommendation during a review period of December 2022, "please note the risk vs [versus]	F 756	physician portion of recommendations for orders and/or declination of recommendation and document on recommendations actions completed within 7 days of receipt from DON. Original recommendation will be uploaded into residents EMR. Unit manager will return completed recommendations (both nursing and copy of physician) to DON to be filed in Pharmacy Recommendation Binder. DON will compare the returned recommendations with the actual recommendations given to unit manager to ensure all are returned. DON will email completed recommendations to Pharmacy Consultant Monthly. Pharmacy Consultant will notify Administrator Monthly if any recommendations are not completed. 4. The Regional Director of Clinical Services will audit ten (10) residents with recommendations Monthly for three (3) months and then quarterly for three (3) quarters to ensure compliance. The results of the audits will be reviewed during QAPI Committee monthly. The QAPI Committee will make recommendations based upon the results of the audits. Upon attaining consistent compliance, the QAPI committee will determine the continuation of the audits.	

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EX Order 26 § 4b1 [redacted] .

Further review of the pharmacy recommendation revealed the Physician failed to:
1. Document in the resident's medical record that the pharmacist's recommendation had been reviewed and what, if any, action has been taken to address it.
2. Any change in the medication or the physician's rationale for continuing with the medications.

Interview with the Consultant Pharmacist on 03/01/23 at 3:47 PM revealed R161 was on two NJ Exec. Order 26:4.b.1, and she recommended to the physician that one of them be discontinued. The Consultant pharmacy confirmed that the physician never responded to the recommendation. The Consultant pharmacist stated that a response from the physician would either have been a written response on the pharmacy recommendation form, or if the physician acted on her recommendation by discontinuing the medication as recommended.

Interview with the Director of Nursing (DON) on 03/01/23 at 4:45 PM revealed that pharmacy recommendations go directly to each unit manager and the DON, and then are passed on the attending physician. The DON stated, 'there is a bunch of them waiting for the doctors review". When asked about the pharmacy review for R161, which had been left unaddressed for

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several months, the DON stated the MD "just never did it".

Review of R161'S "Medication Administration Record (MAR)" for December 2022, January 2023 and February 2023 for revealed the two medications reviewed by the pharmacy continued to be administered to R161 as follows:

"EX Order 26 § 4b1 [redacted] "

The medication was administered on 12/01/22 through 12/31/22, 01/01/23 through 01/09/23, 01/13/23 through 01/31/23, and 02/01/22 through 02/28/23.

"EX Order 26 § 4b1 [redacted] "

Review of the MAR revealed NJ Exec. Order 26:4.b.1 was administered to R161 on 12/01/22 through 12/31/22, 01/01/23 - 01/06/23, 01/12/23 through 01/13/23 through 01/31/23, and 02/1/23 through 02/28/23.

Review of undated facility policy titled "Medication Regimen Reviews" revealed as follows:
"1. The consultant pharmacist performs a medication regimen review (MRR) for every resident in the facility receiving medication ...
5. The MRR involves a thorough review of the resident's medical record to prevent, identify, report, and resolve medication related problems, medication errors and other irregularities, for example: ...

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F 756	Continued From page 33 c. duplicative therapies or omissions of ordered medications; ... 8. Within 24 hours of the MRR, the consultant pharmacist provides a written report to the attending physicians for each resident identified as having a non-life-threatening medication irregularity. The report contains: a. the resident's name; b. the name of the medication; c. the identified irregularity; and d. the pharmacist's recommendation. ... 12. The attending physician documents in the medical record that the irregularity has been reviewed and what (if any) action was taken to address it."	F 756		
F 760 SS=D	NJAC 8:39-23.2(a)(b) Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure proper injection technique was used for one of one residents (Resident (R) 138) reviewed for [NJ Exec. Order 2] during medication administration. This failure had the potential to result in the wrong dose of [NJ Exec. Order 2] administered to the resident. Findings include: Review of R138's undated "Admission Record,"	F 760	1. The Nurse responsible for Resident # 138 was educated by the staff development coordinator on the proper injection technique for administering [NJ Exec. Order 26:4.b] the resident. 2. All residents receiving [NJ Exec. Order 26:4.b.1] [redacted] he potential to be affected. Licensed nurses were educated on 3/1/23 by the staff development coordinator on the proper technique for administering	4/16/23

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OAKLAND REHABILITATION AND HEALTHCARE CENTER	20 BREAKNECK ROAD OAKLAND, NJ 07436

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F 760	Continued From page 34 under the "Profile" tab in the electronic medical record (EMR), revealed R138 was admitted to the facility on EX Order 26 § 4b1 with diagnosis of EX Order 26 § [redacted] Review of R138's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 01/05/23, found in the electronic medical record (EMR) under the "MDS" tab, revealed R138 had a "Brief Interview for Mental Status (BIMS)" score of EX Ord[redacted] out of 15, which indicated R138 was EX Order 26 § 4b1. The MDS also indicated R138 had a diagnosis of EX Order 26 § 4b1 [redacted] (DM) and received EX Order 26 § 4b1 during the last seven days. Review of R138's "Physician Orders," dated 09/01/21, found in the EMR under the "Orders" tab, revealed "EX Order 26 § 4b1 [redacted]" Observation on 03/01/23 at 2:28 PM revealed Licensed Practical Nurse (LPN) 1 retrieved R138's EX Order 26 § 4b1 [redacted] from the medication cart, wiped the top with an alcohol wipe and dialed the dose to eight units. LPN1 attached a needle to the EX Order 26 § 4b1 then carried the EX Order 26 § 4b1 to R138's room. LPN1 washed her hands, applied gloves, observed R138's EX Order 26 § 4b1 to find a spot that was not EX Order 26 § 4b, cleansed the EX Order 26 § 4b1 [redacted] with an alcohol wipe, gently inserted the	F 760	NJ Exec. Order 2[redacted] via including holding the needle in the injection site for a full 10 seconds after you finished pushing the done button. 3. Licensed nurses were educated on 3/1/23 on the proper technique for administering NJ Exec. Order 26 [redacted] via including holding the needle in the injection site for a full 10 seconds after you finished pushing the done button. Staff development coordinator will conduct NJ Exec. Order 2[redacted] administration via NJ Exec. Order 26:4.b.1 competencies with licensed nurses by 4/15/23. Staff development coordinator will conduct NJ Exec. Order 26 [redacted] administration via NJ Exec. Order 26:4.b.1 [redacted] competencies on licensed nurse upon hire and annually. Staff development coordinator will conduct medication administration pass on licensed nurses quarterly to include NJ Exec. Order 2[redacted]. Pharmacy Consultant will conduct medication administration pass on two licensed nurses monthly to include NJ Exec. Order 26 [redacted] administration using NJ Exec. Order 26:4.b.1 [redacted] 4. The Assistant Director of Nursing will audit three (3) licensed nurses once a month for three (3) months, then quarterly for three (3) quarters to assess competency regarding NJ Exec. Order 2[redacted] administration via NJ Exec. Order 26:4.b.1 The results of the audits will be shared with the quarterly quality assurance and performance improvement (QAPI) team meeting. The QAPI committee will make recommendations or determine the need for continued monitoring after a period of one (1) year.	

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F 760	Continued From page 35	F 760		

NJ Exec. Order 26:4.b.1 into the flesh, injected the dose then removed the needle from the EX Order 26 § 4b1. LPN1 carried the pen to the medication cart, disposed of the needle, and performed hand hygiene.

Interview on 03/01/23 at 2:33 PM, LPN1 stated that she had not received training on how to administer EX Order 26 § using an EX Order 26 § 4b1 by the Staff Educator during orientation when hired a month ago. LPN1 also stated that she primed the needle by pressing the end of the pen after she applied the needle on the pen, and she should wait 10 seconds for the NJ Exec. Order 26 to absorb in the EX Order 26 § 4b1 before removing the pen.

Interview on 03/01/23 at 5:06 PM, the Director of Nurse Education stated that she had been the staff educator for one year and had not provided training to staff on the procedure for NJ Exec. Order 26:4.b.1 administration and did not have guidance to follow. The Director of Nurse Education also stated that she did not have a nurse competency for NJ Exec. Order 26:4.b.1 administration. The Director of Nurse Education indicated the procedure for injecting NJ Exec. Order 26:4.b.1 was to read the physician's order, follow the sliding scale, sanitize hands, apply gloves, take off the top of the pen, calibrate the pen to the units by turning the dial, clean the top with an alcohol wipe, apply the needle, and then inject the NJ Exec. Order 26 in the site then remove the pen. The Director of Nurse Education confirmed that she was not aware that the pen had to primed and that the pen had to remain in the site for 10 seconds for the resident to receive the correct amount of NJ Exec. Order 26

Interview on 03/01/23 at 5:38 PM, Registered Nurse (RN) 2, Unit Manager, indicated the

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F 760	Continued From page 36 procedure for administering NJ Exec. Order 26:4.b.1 was to dial up the amount of [redacted] on the pen per the physician's order, clean the top with an alcohol wipe and attach the needle, then push down on the plunger after inserting the needle in the site. RN2 stated she was not aware that the pen had to be primed or that the needle had to remain in the site for 10 seconds so that correct amount of [redacted] would be administered to the resident. Review of the BD guidance titled "BD Injecting NJ Exec. Order 26:4.b.1," undated, assessed on 03/01/23 at https://www.bd.com/en-uk/NJ Exec. Order 26:4.b.1 -learning-centre/injection-technique/[redacted] revealed "... set the dial to 2 [two] units ... press the dose button ... Set your dose ... With the pen at 90 degrees to the skin surface, gently push the needle through the skin into the injection site. Use a lifted skin fold if necessary. Push down the dose button with your thumb. Hold the needle in the injection site for a full 10 seconds after you have finished pushing the dose button. Then gently remove the needle from the skin."	F 760		
F 812 SS=E	NJAC 8:39-29.2(d) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		4/5/23

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F 812	Continued From page 37 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interview, record review and policy review the facility failed to ensure that the kitchen was maintained in a sanitary manner for 185 out of 188 residents (3 residents were receiving tube feedings). Specifically, unit pantry refrigerators were found to contain unlabeled food items brought in by residents' family and were observed to have grime and food residue on the inside. Findings include: A tour of the "Unit Pantry" refrigerators, which was where the residents could store their food from outside, was conducted on 03/01/23 at 1:14 PM with the Food Service Director (FSD.) In the refrigerator on the 2 North (2N) unit, there is a 16 ounce, opened Greek yogurt noted in the refrigerator. The item has a room number [NJ Exec. Orde] on it but was not labeled or dated. The Registered Nurse (RN) 4 on the unit, outside the pantry, was interviewed immediately. She stated food items brought in by family "Has to have a	F 812	1. The Greek yogurt labeled for resident in room [NJ Exec. O] was discarded from the refrigerator. The 16-ounce bowl of mixed fruit labeled for resident in room [NJ Exec. O] was labeled by nurse with name and date. 1C refrigerator was cleaned by dietary staff and the garbage in the 1C pantry room was emptied by the housekeeping department. 2. All residents except for those utilizing gastronomy tubes have the potential to be affected. All unit pantry areas and their refrigerators were re-checked for cleanliness and sanitary conditions. All unit pantry refrigerators were checked and cleared for proper labeling and dating of foods/drinks. 3. Dietary and nursing personnel were re-educated on the facility policy for □Foods Brought by Family/Visitors□. The dietary manager (DM), or DM(s) designee will continue to round each unit pantry	

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F 812	Continued From page 38 name and a date on it and if the item is past three days it has to be thrown out." She was not sure when the food item was placed in the refrigerator. In the refrigerator on the 1AB unit, a 16-ounce bowl of mixed fruit was observed in the refrigerator. The item had a room number [redacted] on it, but was not labeled or dated. The Licensed Practical Nurse (LPN) 2 on the unit, outside the pantry was interviewed immediately. The LPN stated that the food item should be labeled with today's date and room number. She stated she would check with the family and see when it was brought in At 1:28 PM, the unit pantry on the 1C unit is observed. Garbage was noted to be overflowing. The refrigerator temperature was noted 28 degrees Fahrenheit (F) on the thermometer. The refrigerator was noted with a brownish grime along the bottom of the base of the fridge above the kickplate and a large, dried splash an orange liquid is noted on the back, lower inside panel of the refrigerator. Interview with the FSD during the 1:28PM observation stated that the kitchen staff had checked the refrigerators this morning and that these food items must have just been placed in the refrigerator. She also stated that the kitchen staff is responsible for cleaning the refrigerator. They were currently finishing the line and that she would send them down to clean after they take their breaks. She took a temperature of one of the yogurts and it was 42 degrees. She said she would send maintenance down to check on the refrigerator, even though the temperature was correct on the thermometer. On 03/01/23 at 01:38 PM the tour of pantry refrigerators was	F 812	daily to ensure food is labeled and dated, and refrigerator is clean. Housekeeping staff were re-educated on the requirements for ensuring sanitary conditions in unit pantry rooms. Signs on each unit pantry refrigerator were updated to inform families and staff that all food must have residents name, room number and proper date labeling requirements. Upon discovery of any areas found to be out of compliance additional policy education to both families and staff where required will be performed. 4. The Administrator will audit all unit panty rooms and their refrigerators for proper food storage, safe and sanitary conditions three (3) times a week for four (4) weeks, then weekly for three (3) months to ensure compliance. The results of the audits will be shared with the quarterly quality assurance and performance improvement (QAPI) meeting. The QAPI committee will make recommendations or determine the need for continued monitoring after a period of four (4) months.	

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F 812	Continued From page 39 concluded. On 03/02/23 at 11:04 AM during a follow up visit to unit 1AB, the 16-ounce bowl of fruit is still in the refrigerator, undated and unlabeled. Review of the undated facility's policy titled, "Foods Brought by Family/Visitors", revealed, "Food brought to the facility by visitors and family is permitted. Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of resident ...Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that it is clearly distinguishable from facility-prepared food... Perishable foods are stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and the "use by" date ...Safe food handling practices are explained to family/visitors in a language and format they understand." NJAC 8:39-17.2(g) NJAC 8:39-19.7(d)	F 812		
F 882 SS=E	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field;	F 882		3/31/23

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F 882	Continued From page 40 §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on staff interviews and facility policy review, the facility failed to ensure their designated Infection Preventionist (IP) completed specialized training in infection prevention before assuming the position of infection preventionist. This failure had the potential to affect the residents residing in the facility. Findings include: During the entrance conference at the facility on 02/27/23 at 10:57 AM the Administrator stated the facility's IP February 14, 2023 and had no yet completed specialized infection prevention training. During an interview on 03/02/23 at 2:27 PM the IP stated she had been working on completing the infection control training in the last year and had been the Infection Preventionist in another building during that time. IP was able to complete the training during the survey. During an interview with the Director of Nursing (DON) on 03/02/23 at 2:50 PM she stated "it was the terms of her accepting the position (as IP) that she would have to complete it (the training)". The DON admitted the training was not	F 882	1. No residents were identified by the deficient practice. 2. All residents have potential to be affected by the deficient practice. . A house wide audit was completed related to infection prevention and control and no residents were found to have been negatively affected. 3. The Administrator will educate the Human Resources Director and Nursing Administration on the certification requirements for IP(s) who are responsible for the facility's Infection Prevention and Control Program prior to extending future job offers. Additional nurse leaders in the facility will obtain the required infection control certification Nursing Home Infection Preventionist Training Course to serve as back up in the event the IP resigns. Administrator will designate one of the nurse leaders holding certification as Interim IP until a qualified IP is hired. 4. The IP(s) qualifications will be reviewed by the Regional Director of	

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F 882	Continued From page 41 completed until after the IP assumed the position. NJAC 8:39-5.1(a)	F 882	Clinical Services monthly for three months, then quarterly for one month to ensure compliance. The results of the audits will be shared with the quarterly quality assurance and performance improvement (QAPI) team meeting. The QAPI committee will make recommendations or determine the need for continued monitoring after a period of six (6) months.	

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S 000	Initial Comments The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:39, Standards for Licensure of Long-Term Care Facilities. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of 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 interviews, facility document review, and a New Jersey Department of Health (NJDOH) memo dated 09/19/2021, it was determined the facility failed to ensure staffing ratios were met. The facility was deficient in certified nursing assistant (CNA) staffing for residents on 14 of 14 day shifts for the weeks of 02/12/2023 - 02/19/2023, and 02/19/23-02/25/23. This deficient practice had the potential to affect all residents. Findings included: Reference: NJDOH memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing	S 560	1. No Residents were identified. 2. All residents have the potential to be affected. 3. Director of Nursing, Staffing Coordinator and Administrator will meet daily each week to review recruitment efforts, staffing for next day, and staffing for upcoming week. Trends identified from these meetings will be presented during monthly QAPI meeting. The facility has implemented a multifaceted approach for recruitment and retention of employees, which includes Job fairs, Flexible scheduling, Increased	4/5/23

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

Electronically Signed | 03/28/23

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S 560	Continued From page 1 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 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 certified nurse aides, and each direct staff member shall be signed in to work as a certified nurse aide 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 certified nurse aide and perform certified nurse aide duties. A review of the "Nurse Staffing Report," completed by the facility for the weeks of 02/12/2023 through 02/19/2023, and 02/19/23 through 2/25/23, revealed staff-to-resident ratios that did not meet the minimum requirements as listed below: The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -02/12/23 had 17 CNAs for 180 residents on the day shift, required 22 CNAs. -02/13/23 had 17 CNAs for 180 residents on the day shift, required 22 CNAs. -02/14/23 had 15 CNAs for 180 residents on the day shift, required 22 CNAs.	S 560	utilization of PRN/Per diem staff (Staff hired without any set hours, usually staff who have another job and pickup extra shifts when the need arises),Implementation of advanced staffing management software system, Multimedia advertisements, Partnership with schools, Sign on bonuses, Referral bonuses, Pick-up shift bonuses, Boomerang campaign to rehire staff that have resigned, Rate adjustments, Benefit adjustments, Text message campaigns. The facility continues to hire Temporary Nurse Aides who worked before Jan 11th 2022 for 80 hours under a licensed nurse with a letter of competency from their DON at the time, and the facility assists these staff to enroll in CNA course. The facility has developed a Culture Committee focused on recruitment and retention of staff by enhancing the employee experience, some of the committee's activities include a weekly event for staff where food is provided, as well as bi-monthly large fun event with food and prizes with 2 employees of the Month chosen. The facility also has seasonal holiday parties, gives all employees gifts during each holiday season and celebrates all employee's birthday's once a month. The facility has implemented the Care Champion Program to mentor new employees where the champions/mentors(senior CNA staff) receive a bonus if the new employee stays for a certain period of time. The facility participates in a weekly interdisciplinary Quality Care Resource call with consultants to review open	

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OAKLAND REHABILITATION AND HEALTHCARE CEN	20 BREAKNECK ROAD OAKLAND, NJ 07436

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S 560	Continued From page 2 -02/15/23 had 16 CNAs for 180 residents on the day shift, required 22 CNAs. -02/16/23 had 18 CNAs for 186 residents on the day shift, required 23 CNAs. -02/17/23 had 18 CNAs for 186 residents on the day shift, required 23 CNAs. -02/18/23 had 20 CNAs for 186 residents on the day shift, required 23 CNAs. -02/19/23 has 15 CNAs for 185 residents on the day shift, required 23 CNAs. -02/20/23 had 18 CNAs for 184 residents on the day shift, required 23 CNAs. -02/21/23 had 17 CNAs for 184 residents on the day shift, required 23 CNAs. -02/22/23 had 19 CNAs for 184 residents on the day shift, required 23 CNAs. -02/23/23 had 15 CNAs for 184 residents on the day shift, required 23 CNAs. -02/24/23 had 14 CNAs for 188 residents on the day shift, required 23 CNAs. -02/25/23 had 16 CNAs for 187 residents on the day shift, required 23 CNAs.	S 560	positions, recruitment tactics, and changes to improve outcomes. The facility has implemented processes to increase communication with employees through monthly Townhall meetings and a Digital Suggestion Box. 4. The Administrator/designee will review minutes from daily staffing meeting to determine whether all efforts are resulting in meeting staffing requirements. The Administrator/designee will interview five residents weekly for 4 weeks and then monthly for an additional 3 months to determine if needs are being met. The results of the audits will be reviewed during QAPI Committee. The QAPI Committee will make recommendations based upon the results of the audits. Upon attaining consistent compliance, the QAPI committee will determine the continuation of the audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315171	A. BUILDING _____ B. WING _____	R-C 05/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND REHABILITATION AND HEALTHCARE CENTER	**20 BREAKNECK ROAD OAKLAND, NJ 07436**

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{F 000}	INITIAL COMMENTS An onsite revisit was conducted on 5/1/23 to verify the POC for the 3/3/23 recertification survey. The facility was found to be in compliance.	{F 000}		

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

Electronically Signed | 05/15/2023

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

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	060223	A. BUILDING: _____ B. WING _____	R-C 05/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{S 000}	Initial Comments An onsite revisit was conducted on 05/01/2023 regarding the 03/03/2023 recertification survey. The facility was found to be not in compliance of thier POC. 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 provisions of 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 facility document review, and a New Jersey Department of Health (NJDOH) memo dated 09/19/2021, it was determined the facility failed to ensure staffing ratios were met. The facility was deficient in certified nursing assistant (CNA) staffing for residents on 14 of 14 day shifts for the weeks of 04/09/2023 - 04/15/2023, and 04/16/23-04/22/23. This deficient practice had the potential to affect all residents. Findings included: Reference: 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	{S 560}	What corrective action will be accomplished for those residents effected by the deficient practice? No Residents were identified. How will you identify other residents having the potential to be affected by the deficient practice and what corrective action will be taken? All residents have the potential to be affected. What measures will be put into place or what systemic changes have you made to	5/11/23

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{S 560}	Continued From page 1 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 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 certified nurse aides, and each direct staff member shall be signed in to work as a certified nurse aide 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 certified nurse aide and perform certified nurse aide duties. A review of the "Nurse Staffing Report," completed by the facility for the weeks of 04/09/2023 through 04/15/2023, and 04/16/23 through 04/22/23, revealed staff-to-resident ratios that did not meet the minimum requirements as listed below: The facility remained deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -04/09/23 had 18 CNAs for 168 residents on the day shift, required 21 CNAs. -04/10/23 had 16 CNAs for 168 residents on the day shift, required 21 CNAs. -04/11/23 had 16 CNAs for 168 residents on the day shift, required 21 CNAs. -04/12/23 had 19 CNAs for 168 residents	{S 560}	ensure the deficient practice will not reoccur? Director of Nursing, Staffing Coordinator and Administrator will meet daily during the week to review recruitment efforts, staffing for next day, and staffing for upcoming week. Trends identified from these meeting will be presented during monthly QAPI meeting. The facility has implemented a multifaceted approach for recruitment and retention of employees, which includes Job fairs, Flexible scheduling, Increased utilization of PRN/Per diem staff (Staff hired without any set hours, usually staff who have another job and pickup extra shifts when the need arises),Implementation of advanced staffing management software system, Multimedia advertisements, Partnership with schools, Sign on bonuses, Referral bonuses, Pick-up shift bonuses, Boomerang campaign to rehire staff that have resigned, Rate adjustments, Benefit adjustments, Text message campaigns. The facility continues to hire Temporary Nurse Aides who worked before Jan 11th2022 for 80 hours under a licensed nurse with a letter of competency from their DON at the time, and the facility assists these staff to enroll in CNA course. The facility has developed a Culture Committee focused on recruitment and retention of staff by enhancing the employee experience, some of the committee's activities include a weekly	

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{S 560}	Continued From page 2 on the day shift, required 21 CNAs. -04/13/23 had 18 CNAs for 168 residents on the day shift, required 21 CNAs. -04/14/23 had 19 CNAs for 168 residents on the day shift, required 21 CNAs. -04/15/23 had 13 CNAs for 170 residents on the day shift, required 21 CNAs. -04/16/23 had 13 CNAs for 169 residents on the day shift, required 21 CNAs. -04/17/23 had 17 CNAs for 169 residents on the day shift, required 21 CNAs. -04/18/23 had 19 CNAs for 168 residents on the day shift, required 21 CNAs. -04/19/23 had 20 CNAs for 168 residents on the day shift, required 21 CNAs. -04/20/23 had 18 CNAs for 168 residents on the day shift, required 21 CNAs. -04/21/23 had 18 CNAs for 168 residents on the day shift, required 21 CNAs. -04/22/23 had 15 CNAs for 168 residents on the day shift, required 21 CNAs.	{S 560}	event for staff where food is provided, as well as bi-monthly large fun event with food and prizes with 2 employees of the Month chosen. The facility also has seasonal holiday parties, gives all employees gifts during each holiday season and celebrates all employee's birthday's once a month. The facility has implemented the Care Champion Program to mentor new employees where the champions/mentors(senior CNA staff) receive a bonus if the new employee stays for a certain period of time. The facility participates in a weekly interdisciplinary Quality Care Resource call with consultants to review open positions, recruitment tactics, and changes to improve outcomes. The facility has implemented processes to increase communication with employees through monthly Townhall meetings and a Digital Suggestion Box. The facility conducts an exit interviews with any employee who resigns to better improve the employee experience and help with retention. How will the corrective actions be monitored to ensure the deficient practice will not reoccur? (QA Programs). Starting on 4/1/23 the Administrator/designee will review the minutes from monthly resident council meetings for 3 months to determine	

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{S 560}	Continued From page 3	{S 560}	whether there are any concerns regarding care and services. Starting on 4/4/23 the Administrator/designee will review the minutes from the daily staffing meeting to determine whether all efforts are resulting in meeting staffing requirements. The Administrator/designee will interview five residents weekly for 4 weeks and then monthly for an additional 3 months to determine if needs are being met. The results of the audits will be reviewed during QAPI Committee. The QAPI Committee will make recommendations based upon the results of the audits. Upon attaining consistent compliance, the QAPI committee will determine the continuation of the audits.	

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
315171 Y1	A. Building B. Wing Y2	5/1/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND REHABILITATION AND HEALTHCARE CENTER	20 BREAKNECK ROAD OAKLAND, NJ 07436

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 F0550	Correction	ID Prefix F0558	Correction	ID Prefix F0578	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(e)(3)	Completed	Reg. # 483.10(c)(6)(8)(g)(12)(i)-(v)	Completed
LSC	04/12/2023	LSC	04/14/2023	LSC	03/31/2023
ID Prefix F0660	Correction	ID Prefix F0661	Correction	ID Prefix F0689	Correction
Reg. # 483.21(c)(1)(i)-(ix)	Completed	Reg. # 483.21(c)(2)(i)-(iv)	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	04/07/2023	LSC	04/07/2023	LSC	04/04/2023
ID Prefix F0756	Correction	ID Prefix F0760	Correction	ID Prefix F0812	Correction
Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.45(f)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	04/05/2023	LSC	04/16/2023	LSC	04/05/2023
ID Prefix F0882	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(b)(1)-(4)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/31/2023	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?
3/3/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060223	A. Building B. Wing	5/19/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND REHABILITATION AND HEALTHCARE CENTER	20 BREAKNECK ROAD OAKLAND, NJ 07436

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 05/11/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/3/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315171	A. BUILDING **01** B. WING _____	C **03/03/2023**

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OAKLAND REHABILITATION AND HEALTHCARE CENTER	**20 BREAKNECK ROAD** **OAKLAND, NJ 07436**

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E 000	Initial Comments . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 03/03/23. The facility was found to be in compliance with 42 CFR 483.73. .	E 000		
K 000	INITIAL COMMENTS . A Life Safety Code Survey was conducted by the Health Care Management Solutions LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 03/03/23 and was found not to be in compliance with requirements for participation in Medicare/Medicaid at 42 CFR 483.90 (A) Life Safety from fire and the 2012 edition of the National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), chapter 19 EXISTING health care occupancy. Oakland Rehabilitation and Healthcare Center was constructed in 1978. Residents occupy the first and second floors. The lower level is a walkout and contains therapy. The facility is three stories with concrete flooring and concrete steel deck roofing and block bearing walls with metal studs and a concrete and brick exterior. Oakland Rehabilitation and Healthcare Center is noted to be a type II (222) noncombustible construction with complete sprinkler system and smoke detection at smoke barrier doors. The facility has a 150 KW (kilowatt) diesel generator. The facility is tested under load at 46%. The facility has 182 occupied beds. The facility has 11 smoke zones. .	K 000		

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

Electronically Signed | 03/27/2023

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K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to ensure that one exit was provided with a hard packed, all-weather travel surface in accordance with Survey and Certification Letter 05-38. This deficient practice had the potential to affect 16 residents using this area for an exit. Findings include: An observation of the exit discharge near bedroom 157 on 03/03/23 at 10:55 AM revealed that the exit discharge was a steel pit grate leading to a two-foot-wide path to a grated area with metal fencing. The only additional path to the public way was through a mulch patch with shrubs leading to a sidewalk to the public way. The five-foot section of mulch between the steel pit grate and the sidewalk to the public way was soft and non-passable by wheelchairs or walkers. The area also had two shrubs. It had rained on the day of the observation making the path even more non-passable. Further observation revealed the exit was labeled as an exit with a continuously illuminated exit sign above the door. The exit was also labeled as an exit on the facility floor plan posted on the wall.	K 271	1. The facility will install pavers providing a solid surface in accordance with Survey and Certification letter 05-38. 2. All other exits in the facility will be checked and corrected if necessary to ensure discharge from exits are a hard packed all-weather travel surface. 3. The Director of Maintenance will revise the maintenance schedule to include checking all discharge from exits are a hard packed all-weather travel surface on a quarterly basis. 4. The quarterly maintenance schedule will be performed by maintenance personnel, monitored by the Director of Maintenance services, and reported to the Administrator upon completion and the results will be reported to the quarterly Quality Assurance committee.	4/14/23

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K 271	Continued From page 2 Interview with the Maintenance Director and Regional Director of Plant Operations at the time of the observation both verified the lack of hard packed all weather surface to the public way. They both went onto indicate this exit has always been this way. NJAC 8:39-31.1(c), 31.2(e) .	K 271		
K 311 SS=E	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: . Based on observations and interviews the facility failed to ensure that four of 15 stairway exit doors had two-hour fire ratings and were in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 8.6 to 8.5 to 8.5.4.4. to 7.1. to 7.1.3.2.1. (3). This deficient practice had the potential to affect 57 residents on all three floors and three smoke zones. Findings include:	K 311	1. A certified contractor will inspect all fire doors to ensure they have a fire resistance rating of at least 2 hours. Doors missing fire rating information will be recertified and relabeled in accordance with NFPA Life Safety Code requirements. 2. All other fire doors in the facility have been audited to ensure stairway exit doors have two (2) hour fire ratings and follow NFPA Life Safety Code requirements.	5/1/23

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	315171	A. BUILDING **01** B. WING _____	C **03/03/2023**

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K 311	Continued From page 3 An observation of the stairway door on the second floor, located near bedroom 232, on 03/03/23 at 9:30 AM revealed the door lacked a fire rating. There was no evidence of a tag on the side or top of the door and no evidence a tag had been removed or painted over indicating the door provided a two hour fire resistance rating. The stairway door communicated as an exit stairway with all three floors. An observation of the stairway door on the first floor, located off the large dining room, on 03/03/23 at 10:20 AM revealed the door lacked a fire rating. There was no evidence of a tag on the side or top of the door and no evidence a tag had been removed or painted over indicating the door provided a two hour fire resistance rating. The stairway door communicated as an exit stairway with all three floors. An observation of the stairway door on the first floor, located near bedroom 115, on 03/03/23 at 10:35 AM revealed the door lacked a fire rating. There was no evidence of a tag on the side or top of the door and no evidence a tag had been removed or painted over indicating the door provided a two hour fire resistance rating. The stairway door communicated as an exit stairway with all three floors. An observation of the stairway door on the lower-level area, located off therapy, on 03/03/23 at 12:05 PM revealed the door lacked a fire rating. There was no evidence of a tag on the side or top of the door and no evidence a tag had been removed or painted over indicating the door provided a two hour fire resistance rating. The stairway door communicated as an exit stairway	K 311	3. The Director of Maintenance will revise the maintenance schedule to include checking all stairway exit doors fire safety ratings and certification of two (2) hours fire protection on a quarterly basis. 4. The quarterly maintenance schedule will be performed by maintenance personnel, monitored by the Director of Maintenance services who will forward a report to the Administrator upon completion and the results will be reported to the quarterly Quality Assurance committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315171	A. BUILDING **01** B. WING _____	C **03/03/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND REHABILITATION AND HEALTHCARE CENTER	**20 BREAKNECK ROAD** **OAKLAND, NJ 07436**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 311	Continued From page 4 with all three floors. An interview with the Regional Director of Plant Operations and the facility Maintenance Director at the time of each observation verified the lack of fire rating on the stairway door. Both also said the doors had been in place for years. NJAC 8:39-31.1(c), 31.2(e) .	K 311		
K 347 SS=E	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: . Based on observations and interviews, the facility failed to ensure that spaces open to the corridor had smoke detection systems in accordance with NFPA 101 Life Safety Code, (2012 edition) Sections 19.3.6.1. (7 A and B) in four areas on two of three floors. This deficient practice had the potential to affect 17 residents on two floors. Findings include: An observation of the front lobby, located on the first floor and at the main entrance, on 03/03/23 at 10:10 AM revealed the area was without doors, open to the corridor, and lacked a smoke detection system. The area measured 768 square feet. The room was a use area and contained two large couches and a desk	K 347	1. Smoke detectors will be installed in the front lobby, first floor dining room, 1B dining room and lower-level vending area. 2. All other in the facility without doors have been inspected to ensure compliance with NFPA Life Safety Code requirements for smoke detection. 3. The Director of Maintenance will revise the maintenance schedule to include checking all areas without doors possess smoke detectors on a quarterly basis. 4. The quarterly maintenance schedule will be performed by maintenance personnel, monitored by the Director of	5/1/23

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K 347	Continued From page 5 occupied by one staff during business hours. The entire smoke zone did not have quick response sprinkler heads in the storage areas, offices, and the conference room. An observation of the dining room, located on the first floor, on 03/03/23 at 10:15 AM was without doors, open to the corridor, and lacked a smoke detection system. The room was a use area for dining and activities and measured 1872 square feet. The room was a use area containing 25 dining room tables and over 100 chairs. The entire smoke zone did not have quick response sprinkler heads in the storage areas, offices, and the conference room. An observation of the dining room 1B, located near bedroom 132 on the first floor, on 03/03/23 at 10:40 AM revealed the area was without doors, open to the corridor, and lacked a smoke detection system. The room was a use area and measured 520 square feet and contained two couches, two dining room tables and chairs. The entire smoke zone did not have quick response sprinkler heads in storage areas, bathrooms, offices, janitor closets and medication rooms. An observation of a lower level vending area, located near the elevators, on 03/03/23 at 12:00 PM revealed an area without doors and open to the corridor that lacked a smoke detection system. The area was a use area and contained two chairs and two vending machines. The area measured 200 square feet. The entire smoke zone did not have quick response sprinkler heads in storage areas, bathrooms, offices, janitor closets and medication rooms. An interview with the Maintenance Director and	K 347	Maintenance services who will forward a report to the Administrator upon completion and the results will be reported to the quarterly Quality Assurance committee.	

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K 347	Continued From page 6 Regional Director of Plant Operations verified at each observation that the rooms lacked doors and smoke detection systems and were used by residents and staff. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72 .	K 347		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to ensure one storage room was protected with automatic sprinkler in accordance with NFPA 13 "Standard for Installation of Sprinkler Systems" (2010 Edition) Section 8.1.1.(1). This	K 351	1. The facility will install proper sprinkler coverage in the one storage area located in the main dining room on the second floor. 2. All other in the facility without	5/1/23

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K 351	Continued From page 7 deficient practice had the potential to affect 24 residents in one smoke zone. Findings include: An observation of a "Storage Area", located in the main dining room on the second floor, on 03/03/23 at 9:35 AM revealed the room measured six feet in length and four feet wide. The storage room was lacking sprinkler coverage. The room contained air handling equipment and the view of a large portion of the ceiling was blocked by air handling equipment. An interview with the Maintenance Director at the time and date of the observation verified the room was lacking sprinkler coverage. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25 .	K 351	sprinklers have been inspected to ensure compliance with NFPA Life Safety Code requirements for automatic sprinkler protection. 3. The Director of Maintenance will revise the maintenance schedule to include inspection of the second-floor storage area automatic sprinkler detection on a quarterly basis. 4. The quarterly maintenance schedule will be performed by maintenance personnel, monitored by the Director of Maintenance services who will forward a report to the Administrator upon completion and the results will be reported to the quarterly Quality Assurance committee.	
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	K 531		5/1/23

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K 531	Continued From page 8 A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key 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, record review, and interview the facility failed to ensure that two of two elevators having a travel distance 25 feet or move above or below the level that best serves the needs of emergency personnel were equipped with emergency in car-key operation, machine room smoke detection and elevator lobby smoke detection in accordance NFPA 101 Life Safety Code (2012 Edition) Section 9.4.3.2 to ASME (American Society of Mechanical Engineers (2011 edition) of A17-3. This deficient practice had the potential to affect all 182 residents. Findings include: An observation on 03/03/23 at 1:00 PM of elevator car two and three, located in the three-story building, had a travel distance of 30 feet and lacked an emergency in car-key operation. In addition, there were no smoke detectors at the first floor lobby and no smoke detection in the machine room serving both elevator two and three. Elevator car two had a key operation but the key operation was for the fan in the car not for emergency operation. The key area was labeled "fan". Smoke detection was provided on the second lobby and lower-level lobby.	K 531	1. The facility will install an emergency an in car-key operating device in elevator #2 and elevator #3 to conform with ASME/ANSI A17.3. The facility will additionally install smoke detection in the 1st floor lobby and the machine room. 2. All other elevators in the facility have been inspected to ensure in car-key operation and compliance with ASME/ANSI A17.3. All other machine rooms, sitting rooms and common areas were inspected for smoke detection areas of the facility and were found to be in compliance with NFPA Life Safety Coded (2012 edition). 3. The Director of Maintenance will revise the maintenance schedule to include testing and functioning of all in car-key elevators, machine room smoke detection and lobby smoke detection in the facility on a quarterly basis. 4. The quarterly maintenance schedule will be performed by maintenance personnel, monitored by the Director of Maintenance services who will forward a report to the Administrator upon completion and the results will be reported to the quarterly Quality Assurance	

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K 531	Continued From page 9 A review of the facility maintenance documents provided by the Maintenance Director in loose leaf form revealed no reference to the lack of key operation for emergency, machine room smoke detection or lobby smoke detection. An interview with the Maintenance Director and Regional Director of Plant Operations on 03/03/23 at 1:00 PM verified the lack of in car-key emergency operation function and smoke detection on the first-floor lobby and the elevator machine room serving both elevators. NJAC 8:39-31.2(e) .	K 531	committee.	
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where	K 741		5/1/23

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K 741	Continued From page 10 smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: . Based on observation, interview, and record review, the facility failed to ensure ashtrays of noncombustible material and safe design and a metal container with a self-closing over device was provided and readily available to all areas where smoking was permitted and smoking regulations were enforced in accordance with NFPA 101 Life Safety Code (2012 edition) section 19.7.4. This deficient practice had the potential to affect one smoker. Findings include: An observation of the smoking area, located on the second-floor patio area, on 03/03/23 at 10:55 AM revealed five picnic tables were lined up end to end in the smoking area and did not have an ash tray. The ash tray was located on the other side of the picnic tables and was full of trash and debris. Ashes and cigarettes were observed on the ground near the tables. In addition, three smoking towers were noted in the area. There were no self-closing ash trays or self-closing metal containers for which to empty ash trays. A review of the facility policy provided by the Administrator via email titled "Smoking Policy-Residents" (no date) revealed item five indicated "metal containers with self-closing cover	K 741	1. The facility will install ash trays of noncombustible material with safe design and metal container with a self-closing device and ensure they are readily available in all smoking areas. 2. All other smoking areas of the facility have been inspected to ensure ash trays of noncombustible material with safe design and metal container with a self-closing device are readily available in all smoking areas. 3. The Director of Maintenance will revise the maintenance schedule to include inspection of all available smoking areas containing ash trays of noncombustible material with safe design and metal container with a self-closing devices on a quarterly basis. 4. The quarterly maintenance schedule will be performed by maintenance personnel, monitored by the Director of Maintenance services who will forward a report to the Administrator upon completion and the results will be reported to the quarterly Quality Assurance committee.	

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K 741	Continued From page 11 are available in smoking areas." Item six indicated "ash trays are emptied into designated receptacles." An interview with the Administrator at the time of the observation indicated the area was for staff primarily and one resident smoker. He verified there were no ash trays and no self-closing metal containers to empty ash trays available in the smoking area. The Administrator went onto to indicate that the facility was considering a non-smoking policy. NJAC 8:39-31.2(e), 31.6(e) .	K 741		

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
315171 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/1/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND REHABILITATION AND HEALTHCARE CENTER	20 BREAKNECK ROAD OAKLAND, NJ 07436

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 K0271	04/14/2023	LSC K0311	05/01/2023	LSC K0347	05/01/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	05/01/2023	LSC K0531	05/01/2023	LSC K0741	05/01/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/3/2023	☐ YES ☐ NO