STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315339	A. BUILDING _____ B. WING _____	C 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT ORADELL	**600 KINDERKAMACK ROAD ORADELL, NJ 07649**

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F 000	INITIAL COMMENTS Complaint #s: NJ00166154, NJ00163185, NJ00162619, NJ00160781, NJ00157351, NJ00156726, NJ00155283, NJ00154889 Survey Date: 9/08/23 Census: 119 Sample: 24 (sample) + 3 (Closed Records) + 21= 48 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information	F 585		9/19/23

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

Electronically Signed | 09/28/2023

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F 585	Continued From page 1 on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;	F 585		

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F 585	Continued From page 2 (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Complaint#00154889 Based on interviews, record review, and review of pertinent facility documentation, it was	F 585	It is the policy of Care One at Oradell to ensure grievances are completed in a timely manner for resident and family concerns.	

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F 585	Continued From page 3 determined that the facility failed to: a) ensure written grievance decisions met documentation requirements and b) maintain evidence of the result of all grievances for no less than three (3) years from the date the grievance decision was issued according to facility practice and policy. 1. The surveyor reviewed Resident #161's medical records. The Admission Record (AR; or face sheet; an admission summary) revealed that the resident was admitted to the facility with diagnoses that included but were not limited to Ex Order 26. 4B1 in other diseases classified elsewhere without Ex Order 26. 4B1 [redacted] The admission Minimum Data Set (aMDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of 4/21/22 showed a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which indicated that the resident's cognitive status was Ex Order 26. 4B1 . A review of the 5/19/22 at 10:01 AM phone interview of another surveyor with the resident's Responsible Party (RP) revealed that according to the RP, the resident had Ex Order 26. 4B1 [redacted]. The RP alleged that the previous Director of Nursing (pDON) was notified of the Ex Order 26. 4B1 [redacted] upon the resident's discharge home and that the investigation was started, and the Ex Order 26. 4B1 was Ex Order 26. 4B1 Furthermore, the RP indicated that the previous Licensed Nursing	F 585	Resident #161 was Ex Order 26. 4B1 [redacted] and the grievance was completed. For the other affected residents #22, 23, and 31, grievances were completed. All the grievances were completed and meet documentation requirements. All residents with grievances have potential to be affected. The facility will maintain a grievance log as per regulation and be kept for a period of 3 years. All grievances were reviewed as per regulation. All staff were in service on the grievance process The Administrator or designee will complete and audit all grievances 2 times a week for 1 month, then weekly ongoing. Report will be submitted QAPI monthly.	

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Home Administrator (pLNHA) told the RP to submit receipts for reimbursement. The RP further stated that reimbursement was not received.

A review of the Misc (Miscellaneous) tab of the electronic medical record showed a copy of a cheque dated *Ex Order 26. 4B1* paid to the order of RP.

On 8/24/23 at 11:52 AM, the surveyor asked for a close record of Resident #161 from the new LNHA (nLNHA) including investigation and grievance reports.

On 8/25/23 at 11:18 AM, the surveyor asked the nLNHA for a copy of the *Ex Order 26. 4B1* report from March 2022 to July 2022.

On 8/28/23 at 11:35 AM, the surveyor followed up with the nLNHA on the pending documents that the surveyor previously asked for including any grievance and report of *Ex Order 26. 4B1* from April 2022 through July 2022. He stated that he would get back to the surveyor.

On 8/28/23 at 12:31 PM, the nLNHA informed the surveyor that the Grievance Officer was the nLNHA. The nLNHA stated that the facility files the reported grievance in a binder. He further stated that anyone (facility staff and management) can fill out the Grievance Form (GF), and the resident and RP can file a grievance in the form of complaints and *Ex Order 26. 4B1* . He informed the surveyor that the facility had no log for *Ex Order 26. 4B1*. The nLNHA stated, *Ex Order 26. 4B1* He acknowledged

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that the facility should have kept a file for resident RP's grievance of Ex Order 26. 4B1.

The nLNHA informed the surveyor that he started working at the facility in July 2022 and the incident of Resident #161's Ex Order 26. 4B1 report was on April 2022.

On 8/29/23 at 11:01 AM, the survey team met with the nLNHA, Infection Preventionist Nurse (IPN), and Vice President of Clinical Special Project (VPoCSP) and were made aware of the above findings and concerns.

2. A review of the Residents' Council Meeting minutes (RCMm) that were provided by the Recreation Director (RD) for the last three (3) months showed the following:

A. RCMm on 8/21/23 included concerns with laundry where Resident #31 was Ex Order 26. 4B1 [redacted]. Attached to RCMm was the Department Response to Issues (DRtI) revealed that Residents #23 and #31 laundry concerns Ex Order 26. 4B1 [redacted] and that the Housekeeping Director (HD also known as Housekeeping Supervisor) will address the situation. The DRtI form was incomplete, the Department Supervisor and the Administrator were blank and the date was blank to indicate that both Department Supervisor and Administrator were notified of the concern.

B. RCMm on 7/17/23 showed no concern with regard to laundry.

C. RCMm on 6/19/23 included concerns with laundry where Resident #22 was Ex Order 26. 4B1. The attached DRtI included that the HD was

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F 585	Continued From page 6 looking for Resident #23's Ex Order 26. 4B1. A review of the Grievance Concern Log revealed that 6/19/23 and 8/21/23 reported concerns of Residents #22, #23, and #31 of Ex Order 26. 4B1 were not included in the log. There were no provided grievance reports. The surveyor reviewed Residents#22, #23, and #31's MDS as follows: A. The quarterly MDS (qMDS) of Resident #22 with an ARD of 7/11/23 showed a BIMS score of [redacted] out of 15 which indicated that the resident's cognitive status was Ex Order 26. 4B1. B. The qMDS of Resident #23 with an ARD of 5/29/23 showed a BIMS score of [redacted] out of 15 which indicated that the resident's cognitive status was [redacted]. C. The annual MDS of Resident #31 with an ARD of 7/25/23 revealed a BIMS score of [redacted] out of 15 which indicated that the resident's cognitive status was [redacted]. On 8/29/23 at 12:25 PM, the surveyor notified the nLNHA of the concern regarding RCMm of Ex Order 26. 4B1 of Residents #22, #23, and #31, and that the GF was not done. On 8/29/23 at 12:46 PM, the survey team met with the nLNHA and the VPoCSP and were made aware of the above concern regarding RCMm of Ex Order 26. 4B1 of Residents #22, #23, and #31, and that the GF was not done. The VPoCSP stated that the RD used a different form when getting the information from the resident council meeting reports of concerns. She further stated that the RD documented the resolution in that paper (DRtI).	F 585		

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On that same date and time, the surveyor notified the facility management that the DRtI was done and attached to the printed copy of RCMm that was provided to the surveyor, and the DRtI forms were filled out by the RD and it was incomplete.

At that time, the facility management acknowledged that a GF should have been initiated, and as per regulation, the grievance should be kept within three (3) years.

On 8/30/23 at 8:35 AM, the surveyor interviewed the RD. The RD informed the surveyor that she started working in the facility on 4/10/23. The RD stated that during the resident council meeting, if there will be a concern reported by the residents about Ex Order 26. 4B1, she will fill out the DRtI, attached to the RCMm and that there should be a resolution.

On that same date and time, the RD informed the surveyor that she was not aware that once a resident voiced out a problem about Ex Order 26. 4B1 [redacted], she had to initiate a grievance report and utilize the GF. The RD stated that she thought that she had to do the grievance once the problem was resolved. She further stated that "I am aware now of the GF," and that she should have immediately filled out the Grievance Form for Residents #22, #23, and 31. She indicated that was why there were no grievances on 6/19/23 and 8/21/23.

On 8/30/23 at 11:16 AM, the surveyor met with the nLNHA and VPoCSP in the presence of another surveyor and notified the facility management of the above concerns.

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F 585	Continued From page 8 On 8/31/23 at 12:29 PM, the survey team met with the VPoCSP and IPN. Later on, the nLNHA joined the meeting. The VPoCSP informed the surveyor that the GF should be utilized for any report of the problem including *Ex Order 26. 4B1* from the residents and RP. She further stated that the grievance should be investigated and obtain resolution to the reported problem. A review of the facility's Resident Council Policy that was provided by the nLNHA with a revised date of February 2021 included that the purpose of the resident council is to provide a forum for residents, families, and resident representatives to have input in the operation of the facility; discussion of concerns and suggestions for improvement, and a Resident Council Response Form will be utilized to track issues and their resolution. The facility department related to any issues will be responsible for addressing the item(s) of concern. A review of the Grievances/Complaints, Recording, and Investigating Policy that was provided by the nLNHA with an edited date of 4/12/18 included that All grievances and complaints filed with the facility will be investigated and corrective actions will be taken to resolve the grievance(s). Policy Interpretation and Implementation: The investigation and report will include, as applicable. The Resident Grievance/Complaint Investigation Report Form will be filed with the Administrator within 5 working days of the incident. NJAC 8:39-4.1(a)(35);13.2(c)	F 585		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		9/25/23

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F 641	Continued From page 9 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Complaint # NJ00160781 Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, for one (1) of 24 residents, (Resident #262) reviewed for MDS accuracy, and was evidenced by the following: According to the Centers for Medicare & Medicaid Services (CMS) Minimum Data Set 3.0 Public Reports page last modified 12/01/21, included that the MDS is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. Care Area Assessments (CAAs) are part of this process, and provide the foundation upon which a resident's individual care plan is formulated. MDS assessments are completed for all residents in certified nursing homes, regardless of the source of payment for the individual resident. MDS assessments are required for residents on admission to the nursing facility, periodically, and on discharge. All assessments are completed within specific guidelines and time frames. On 8/29/23 at 10:02 AM, the surveyor reviewed	F 641	It is the policy of Care one at Oradell that the Minimum Data set (MDS) is completed timely and accurately. Resident #262 was discharged on [redacted]. The MDS was modified to reflect the assessment as pointed out. All residents with [redacted] at the time of discharge from the facility have potential to be affected. All residents with [redacted] will have weekly assessments. To accurately code the MDS, the specialist will review discharge summary in addition to nursing documentation. MDS specialist was educated to review the discharge summary in addition to nursing documentation prior to coding. The Director of Nursing/Administrator or designee will complete an audit of 2 discharge coding every week for 1month, then monthly x 3 months with reports to QAPI monthly.	

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F 641	Continued From page 10 Resident #262's closed medical record. A review of Resident #262's Admission Record (or face sheet; an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted] The Discharge Assessment Return Not Anticipated MDS, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that Resident #262's cognition was [redacted]. Further review indicated under Section M Skin Conditions that Resident #262 did not have one or more [redacted]. A review of the "Patient Discharge Summary/Instructions-V7" included the following: Section III. Nursing ... 5. Treatments A. Skin Status b [redacted] at time of discharge (See treatment list) A1. Treatment list [redacted] On 8/31/23 at 9:41 AM, the surveyor called the visiting nurse services that was listed on the discharge instruction sheet and spoke with the	F 641		

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Executive Director of Continuous Care (EDCC) regarding Resident #262. The EDCC stated that a day after discharge from the facility, a nurse was sent to the home of Resident #262 to start a home care visit and that an assessment was done. She stated that Resident #262 was assessed and had an *Ex Order 26. 4B1* that was unstageable with *Ex Order 26. 4B1* *Ex Order 26. 4B1* and *Ex Order 26. 4B1* ; NJ Exec. Order 26:4.b.1 For example, in a NJ Exec. Order 26:4.b.1 and *Ex Order 26. 4B1* . She added that the measured *Ex Order 26. 4B1* .

On 8/31/23 at 01:15 PM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator, ADON/IPN and the Vice President of Special Clinical Projects (VPoSCP) the concern that Resident #262 had a documented *Ex Order 26. 4B1* on the Discharge Summary/Instruction form and that the MDS was coded inaccurately.

On 9/08/23 at 11:32 AM, the surveyor interviewed the MDS Specialist regarding MDS. The MDS Specialist stated that she followed the RAI (Resident Assessment Instrument) manual and that the facility did not have policy. The surveyor asked about Resident #262's inaccurate coding of a *Ex Order 26. 4B1* . The MDS Specialist stated that she based her coding on the nursing notes and orders and that the resident did not have a *Ex Order 26. 4B1* according to those. She added

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F 641	Continued From page 12 that she did not usually look at the Ex Order 26. 4B1 summary/instruction form. On 9/08/23 at 12:56 PM, in the presence of the survey team, the VPoSCP stated that there was no documentation of the Ex Order 26. 4B1 in the seven (7) day look back period. She added that she educated the MDS Specialist to look at the discharge summary/instruction form and that she contacted the visiting nurse services for the Ex Order 26. 4B1 note and will update the residents MDS. The facility did not provide a policy. N.J.A.C. 8:39-11.1	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint#NJ00157351 Based on interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to adhere to professional standards of clinical practice for a) not initialing the Electronic Treatment Administration Record (eTAR) for one (1) of three (3) residents (Resident#110), reviewed for Ex Order 26. 4B1 order and b) ensure that the Ex Order 26. 4B1 recommendations were followed through for one (1) of two (2) residents (Resident #263), reviewed	F 658	Resident #110 and 263 no longer reside in the facility. All residents have the potential to affected. - The DON and Clinical Team performed an audit of all residents admitted in the facility with a order for Ex Order 26. 4B1. - The DON/ADON provided re-education to the nursing staff regarding order entry and treatment administration documentation in PCC.	9/27/23

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F 658	Continued From page 13 for NJ Exec. Order 26:4.b.1 The deficient practices are evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. The surveyor reviewed Resident #110's medical records. The resident's Admission Record (AR or face sheet; admission summary) reflected that the resident was admitted to the facility and had diagnoses that were not limited to Ex Order 26. 4B1	F 658	- The DON and Clinical Team met with the dietitian, Ex Order 26. 4B1 performed an audit of all residents on Ex Order 26. 4B1, NPO, and modified diet with Ex Order 26. 4B1 [redacted] consult in the facility. - The DON/ADON provided re-education to the nursing staff regarding dietitian and Ex Order 26. 4B1 consults, recommendation and the process of communicating their recommendations to attending physician. " The DON/ADON or designee will complete Ex Order 26. 4B1 order audits weekly X1 month, then monthly for three months, and report findings to administrator, as well as to QAPI quarterly to ensure compliance. The QAPI team to determine if further action is required " The DON/ADON or designee will complete 5 chart audits of patient with Ex Order 26. 4B1 consult and weekly X1 month, then monthly for three months, and report findings to administrator, as well as to QAPI team quarterly to ensure compliance. The QAPI team to determine if further action is required	

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F 658	Continued From page 14	F 658		

Ex Order 26. 4B1 other *Ex Order 26. 4B1* .

A review of the resident's Minimum Data Set (MDS), an assessment tool used to facilitate the management of care showed that the resident had no most recent admission MDS (aMDS) and quarterly MDS (qMDS) because the resident was in the facility for a total of 6 (six) days and did not require to have an aMDS and qMDS.

The electronic medical records dated 7/07/23 showed that the MDS 3.0 Brief Interview for Mental Status (BIMS) assessment revealed that Resident #110's BIMS score was [redacted] which indicated that the cognitive status was *Ex Order 26. 4B1* .

The Order Summary Report (OSR) active orders as of 7/06/23 showed that the resident had an order for *Ex Order 26. 4B1* via *Ex Order 26. 4B1* as needed (PRN) for *Ex Order 26.* .

The above order for PRN *Ex Order 26. 4B1* was transcribed to the eTAR for July 2023. No signature of nurses reflected in the July 2023 eTAR.

A review of the Progress Notes (PN) showed that on 7/05/23 at 6:30 PM the Licensed Practical Nurse (LPN) and on 7/10/23 at 01:10 AM the Registered Nurse (RN) documented that the resident with *Ex Order 26. 4B1* in use *Ex Order 26. 4B1* .

Further review of the above medical records

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F 658	Continued From page 15 revealed that there was a discrepancy between the July 2023 eTAR and the PN of the LPN and the RN. Both the LPN and RN did not initial the eTAR for dates 7/05/23 and 7/10/23 when PRN [redacted] was administered. On 8/30/23 at 11:16 AM, the surveyor in the presence of another surveyor met with the Licensed Nursing Home Administrator (LNHA) and the Vice President of Special Clinical Projects (VPoSCP) and made aware of the above findings that the July 2023 eTAR was not signed on 7/05/23 and 7/10/23 when the nurses administered the [redacted] according to the PN. The VPoSCP stated that the July 2023 eTAR should have been signed by the RN and LPN when nurses administered the PRN [redacted]. On 9/05/23 at 8:56 AM and 01:45 PM, the surveyor called the LPN, and the nurse did not return the surveyor's call. On 9/05/23 at 1:32 PM and 9/06/23 at 8:22 AM, the surveyor called the RN, and the nurse did not return the call of the surveyor on the first call and the second call, the mailbox was full and could not leave a message. A review of the facility provided Oxygen Administration Policy with an edited date of 4/02/19 that was provided by the LNHA included that the purpose of this procedure is to provide guidelines for safe [redacted] administration. Documentation: After completing the [redacted] setup or adjustment, the following information should be recorded in the resident's medical record: the date and time that the procedure was performed; the name and title of the individual who performed the procedure; and the reason for	F 658		

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F 658	Continued From page 16 PRN administration. 2. The surveyor reviewed Resident #263's medical records. The AR reflected that the Resident #263, was admitted to the facility with a diagnosis that included but was not limited to *Ex Order 26. 4B1* [redacted]. The admission MDS, with an ARD of 7/15/22 revealed that the Section C Cognitive Patterns showed a BIMS score of [redacted] out of 15 which indicated that the resident's cognition was *Ex Order 26. 4B1* . A review of the OSR, dated 7/14/22 without an end date, revealed resident #263 had an order for *Ex Order 26. 4B1* and *Ex Order 26. 4B1* and *Ex Order 26. 4B1* with *Ex Order 26. 4B1* to be flushed six (6) times daily with *Ex Order 26. 4B1* water with feedings for a total of *Ex Order 26. 4B1* . A review of Diet Order and Communication form dated 8/15/22 written by the Unit Manager identified the diet as: *Ex Order 26. 4B1* . A review of the form *Ex Order 26. 4B1* dated 8/16/22 by Certificate of Clinical Competence in *Ex Order 26. 4B1* (CCC-SLP) identified a recommendation for diet texture: *Ex Order 26. 4B1* :	F 658		

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F 658	Continued From page 17 continue *Ex Order 26. 4B1* . A further review, revealed under patient care giver education section: *Ex Order 26. 4B1* [redacted]. Further review of the electronic medical records showed that there were no documentation that the 8/16/22 recommendations of the CCC-SLP were followed. There were no documentation why the recommendations were not followed. There were no documentation that the physician was called about the recommendations and if the physician declined the recommendations. On 8/30/23 at 11:16 AM, the surveyor in the presence of another surveyor met with the LNHA and the VPoSCP and made aware of the above findings that the 8/16/22 recommendations from the CCC-SLP were not followed through. On 9/07/23 11:24 AM, the surveyor interviewed the Registered Dietician (RD) to explain the process and communication with the CCC-SLP for nutrition orders. She stated "the CCC-SLP and I work together. We update each other as we see patients, trialing or upgrading. I will let her know if the resident needs an evaluation or screen. I then review that resident as a whole but she does alert me to her recommendations verbally and when I go to the unit I review the chart. The nurse is responsible to notify the physician and get the order, if the order is not prescribed by the physician there should be documentation on why. For a *Ex Order 26. 4B1* the doctor must order first then I would confer with her re: what type of *Ex Order 26. 4B1*, doctor order must come first	F 658		

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F 658	Continued From page 18 before Ex Order 26. 4B1 would be done. The consistency of Ex Order 26. 4B1 as appropriate must be put in as a physician order then it would say Ex Order 26. 4B1 in comments such as: Ex Order 26. 4B1 On 9/08/23 at 01:32 PM, the survey team met for exit conference with the LNHA, DON, VPoSCP. There was no additional information provided by the facility management, and the facility did not refute findings.	F 658		
F 661 SS=E	NJAC 8:39-11.2(b) 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 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	F 661		9/22/23

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F 661	Continued From page 19 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: Complaints#: NJ00160781 and NJ00157351 Based on interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure that: a) the discharge summary provides necessary information to continuing care providers pertaining to the course of treatment while the resident was in the facility and the resident's plans for care after discharge and b) the discharge summary must include an accurate and current description of the clinical status of the resident and sufficiently detailed, individualized care instructions, for four (4) of five (5) residents (Residents #108, #109, #262, and 263) reviewed for discharge home. This deficient practice was evidenced by the following: 1. The surveyor reviewed the medical records of Resident #108. The Admission Record (or AR; face sheet; an admission summary) reflected that the resident was admitted to the facility and had diagnoses that were not limited to [redacted]	F 661	It is the policy of Care one at Oradell that all resident discharge is completed accurately and timely. Resident #108's order was clarified with the [redacted] before discharge, [redacted] was not necessary. The Dietician section was not completed prior to discharge. The section was completed on 09/06/2023. #109: Dietician section was not completed prior to discharge; it was corrected on 09/02/2023. Resident #109 was safely discharged from the facility on [redacted]. Resident #262 was safely discharged from the facility on [redacted]. Resident #263 was safely discharged from the facility on [redacted]. All residents discharged from the facility, with pending orders have potential to be affected. The Unit Manager (or designee) will review discharge booklets to ensure completion. Nurses were educated on printing the Order Summary to include all physicians orders (medications as well as treatments). The Order Summary will be	

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F 661	Continued From page 20 Ex Order 26. 4B1 [redacted].	F 661	provided to residents in addition to the discharge summary (booklet). The dietician was educated on completing the Nutrition Portion of the discharge summary (booklet). The ADON/UM (or designee) will complete 5 discharge audits per week for 1 month, then monthly x 3 months. Report to be submitted to QAPI monthly x 3 months.	

A review of the admission Minimum Data Set (aMDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of 5/16/23 and with a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, reflected that the resident's Ex Order 26. 4B1 [redacted] was intact.

A review of the Ortho (Orthopedic) Consultation report dated 6/12/23 signed by PA-C (A physician assistant-certified (PA-C) is a graduate of an accredited physician assistant educational program who has undergone testing by the National Commission on Certification of Physician Assistants. PA-Cs are state-licensed to practice medicine with a supervising physician), included an A/P (assessment/plan) for Resident #108 as follows:

A. To continue Ex Order 26. 4B1 [redacted] precautions to [redacted].
B. To continue Ex Order 26. 4B1 [redacted] as needed (PRN) to control [redacted].
C. To follow up in two (2) weeks for repeat [redacted] and re-evaluation.

The above A/P was transcribed as an order dated 6/12/23 via a phone order to a physician and electronically signed by Licensed Practical Nurse#1 (LPN#1).

The active orders as of June 2023 in the Order

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F 661	Continued From page 21 Summary Report (OSR) included but were not limited to the following: -*Ex Order 26. 4B1* , NJ Exec. Order 26:4.b at breakfast (start date 5/10/23) -*Ex Order 26. 4B1* a day for supplement (start date 5/11/23) *Ex Order 26. 4B1* *Ex Order 26. 4B1* (start date 5/19/23) *Ex Order 26. 4B1* on in am off at bedtime every day and evening shift (start date 5/11/23) A review of the Patient Discharge Summary/Instructions (PDS/I) dated 6/14/23 revealed the following: -Physician-Community Primary Care Physician=a copy of the discharge summary and complete medication that was sent to the Community Care Physician was not checked off if the information was sent via fax, email, mail, and other. -Nutritional Needs for diet type, texture, route, fluid consistency, supplements, and special instructions were blank. There was no signature of the Dietician reflected in the PDS/I. The nursing section was incomplete, there was no signature from the nurse. The Transfer/Discharge Report (T/DR) current medications dated 6/14/23 that was attached to the PDS/I included all medications of the resident except for the orders of *Ex Order 26. 4B1* and Ex Order 26. .	F 661		

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F 661	Continued From page 22	F 661		

The Progress Notes (PN) of LPN#1 dated 6/14/23 included that Resident #108 was picked up by the Responsible Party (RP), "paperwork gone over and signed by resident. Scripts to be called into [pharmacy] in [town]. belongings packed by RP."

Further review of LPN#1's PN did not include information about the repeat [redacted] in two weeks, and [redacted] and *Ex Order 26. 4B1* orders.

The PN dated 6/14/23 by the Social Worker (SW) included that the SW called the RP to discuss the plan after following up with [redacted] and ordered to remain in *Ex Order 26. 4B1*.

Further review of the SW's PN revealed that the SW did not inform the RP regarding the repeat [redacted] recommendation of the [redacted] doctor and that P#1 ordered to repeat [redacted] of the [redacted] in two weeks.

On 9/05/23 at 8:56 AM and 01:45 PM, the surveyor called LPN#1, and the nurse did not return the surveyor's call.

On 9/06/23 at 10:48 AM, the survey team met with the Vice President of Special Clinical Project (VPoSCP), Infection Preventionist Nurse (IPN), Director of Nursing (DON), and Licensed Home Administrator (LNHA). The VPoSCP informed the surveyor that the PDS/I was incomplete for the Dietician and Nursing parts.

On that same date and time, the surveyor notified the facility team about the physician's order on 6/12/23 and Ortho's recommendation for a repeat [redacted]. The facility management acknowledged that the order for repeat [redacted] should have been

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F 661	Continued From page 23 included in the PDS/I. On 9/07/23 at 11:24 AM, the surveyor interviewed the Dietician in the presence of another surveyor. The surveyor asked the Dietician about the facility's practice and protocol for PDS/I. The Dietician informed the surveyor that the SW and Nurse should fill out PDS/I for Nutrition in their absence according to previous education that the facility management and nurses received when the new form for PDS/I was introduced to the facility. The Dietician was unable to remember when the new PDS/I was introduced to the facility and when was the education provided. The Dietician stated that she knew ahead of time who would be discharged because the MDS Coordinator provided their department list of residents for discharge and that the SW also "at times" initiated in the electronic medical records the PDS/I. She further stated that the Dietician can also initiate the PDS/I. On that same date and time, the surveyor asked the Dietician, if she was aware ahead of time of the resident's discharge date, and why Resident#108's PDS/I was not done. The Dietician stated, "I do not know why it was not done." The Dietician stated that she was not aware that according to the VPoSCP that there were at least 20% of 500 audited PDS/I of Nutrition part were not done. She further stated that was the first time that she was notified of the concern and there was no QAPI (Quality Assurance Performance Improvement) discussion about it until the surveyor's inquiry. 2. On 8/29/23 at 10:02 AM, the surveyor reviewed Resident #262's closed medical record.	F 661		

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F 661	Continued From page 24 The AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to Ex Order 26. 4B1 and Ex Order 26. 4B1 and Ex Order 26. 4B1 . A review of Resident #262's Discharge Assessment Return Not Anticipated Minimum Data Set (MDS), dated Ex Order 26. 4B1, reflected that the resident had a BIMS score of [redacted] out of 15, which indicated that Resident #262's cognition was Ex Order 26. 4B1. Further review indicated that Resident #262 was discharged to the community. A review of the PDS/I indicated that section II. Nutrition was not filled out and was not signed or dated by a staff member. Further review of the PDS/I included the following: Section III. Nursing ... 5. Treatments A. Skin Status b. NJ Exec. Order 26:4.b.1 at time of discharge (See treatment list) A1. Treatment list NJ Exec. Order 26:4.b.1 The T/DR current medications dated 8/02/22 that was attached to the PDS/I included all medications of the resident except for the order of Ex Order 26. 4B1 dressing.	F 661		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT ORADELL	**600 KINDERKAMACK ROAD ORADELL, NJ 07649**

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F 661	Continued From page 25 3. The surveyor reviewed the medical records of Resident #109. The AR reflected that the resident was admitted to the facility and had diagnoses that were not limited to Ex Order 26. 4B1 [redacted] and Ex Order 26. 4B1 [redacted]. A review of the aMDS with an ARD of 4/22/23 and with a BIMS score of [redacted] out of 15, reflected that the resident's cognitive status was [redacted] A review of the OSR, date range 01/01/23-6/01/23 revealed resident #109 had an order for Ex Order 26. 4B1 [redacted] A review of the PDS/I, dated 6/01/23 showed that the nutrition section was not signed or documented. The social service and nursing description was signed on 6/01/2023. The nutrition description was signed on 9/02/23 after surveyor inquiry. A review of the PDS/I dated 6/01/23 revealed the following: -Physician-Community Primary Care Physician=a copy of the discharge summary and complete medication that was sent to the Community Care Physician was not checked off if the information was sent via fax, email, mail, and other. -Nutritional Needs for diet type, texture, route, fluid consistency, supplements, and special instructions were blank. There was no signature	F 661		

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F 661	Continued From page 26 of the Dietician reflected in the PDS/I. -The nursing section was incomplete. A review of the treatment section did not indicate the [redacted] and the *Ex Order 26. 4B1* [redacted] as prescribed on the discharge medication from the physician. The T/DR current medications dated 6/01/23 that was attached to the PDS/I included all medications of the resident except for the orders of *Ex Order 26. 4B1* [redacted] apply to *Ex Order 26. 4B1* [redacted] every day for [redacted] and *Ex Order 26. 4B1* [redacted] apply to [redacted] every day shift for [redacted] The PN of LPN #1 dated 6/01/23 included that Resident #109 was picked up by two (2) transportation staff via stretcher, *Ex Order 26. 4B1* [redacted] Further review of LPN #1 PN did not include information about the *Ex Order 26. 4B1* and the *Ex Order 26. 4B1* [redacted] as prescribed on the discharge medication from the physician. 4. The surveyor reviewed the medical records of Resident # 263. The AR reflected that the Resident #263, was admitted to the facility with a diagnosis that included but was not limited to *Ex Order 26. 4B1* [redacted]	F 661		

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F 661	Continued From page 27 *Ex Order 26. 4B1* following *Ex Order 26. 4B1* The aMDS with an ARD of 7/15/22 revealed a BIMS score of [redacted] out of 15 which indicated that the resident's cognition was *Ex Order 26. 4B1*. A review of the OSR, dated 7/14/22 with out an end date, revealed resident #263 had an order for *Ex Order 26. 4B1* and *Ex Order 26. 4B1* and *Ex Order 26. 4B1* with *Ex Order 26. 4B1* daily to be flushed 6 times daily with *Ex Order 26. 4B1* with feedings for a total of *Ex Order 26. 4B1*. A review of the PDS/I dated 8/17/22 revealed the following: -Physician-Community Primary Care Physician=VHS working with daughter to establish PCP in the community. A review of section (Aa) was not checked off if the information was sent via fax, email, mail, and other. -Nutritional Needs for diet type, texture, route, fluid consistency, supplements, and special instructions were blank. There was no signature of the Dietician reflected in the PDS/I. The PN of LPN #2 dated 8/18/22 included that Resident #263 was *Ex Order 26. 4B1* A review of the PDS/I, dated 8/17/22 showed that the nutrition section was not signed or documented. The nutrition description was signed on 9/6/23 after surveyor inquiry.	F 661		

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F 661	Continued From page 28 A review of the facility's Discharge Summary and Plan Policy that was provided by the VPoSCP with a revised date of October 2022 included that when a resident's discharge is anticipated, a discharge summary and post-discharge plan is developed to assist the resident with discharge. Policy Interpretation and Implementation: 1. The discharge summary includes a recapitulation of the resident's stay at the facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing the 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 including; 1. bathing, dressing and grooming, transferring and ambulating, toilet use, eating, and using speech, language, and other communication systems; 2. the need for staff assistance and assistive devices or equipment to maintain or improve functional abilities; and 3. the ability to perform relationships, make decisions including health care decisions, and participate in the day-to-day activities of the facility..... h. nutritional status and requirements including; 1. weight and height; 2. nutritional intake; and	F 661		

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F 661	Continued From page 29 3. eating habits, preferences, and dietary restrictions; j. special treatments or procedures (treatments and procedures that are not part of basic services provided);..... p. medication therapy (all prescription and over-the-counter medications taken by the resident including dosage, frequency of administration, and recognition of significant side effects that would be most likely to occur in the resident). 2. As part of the discharge summary, the nurse reconciles all pre-discharge medication with the resident's post-discharge medications. The medication reconciliation is documented..... 12. A copy of the following is provided to the resident and receiving facility and a copy will be filed in the resident's medical records: a. an evaluation of the resident's discharge needs; b. the post-discharge plan; and c. the discharge summary. On 9/08/23 at 01:32 PM, the survey team met with the LNHA, DON, and VPoSCP. There was no additional information provided by the facility management, and the facility did not refute findings. NJAC 8:9-36.1(b), (c)	F 661		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		9/22/23

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F 684	Continued From page 30 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Complaint # NJ00160781 Based on interviews and record review and review of pertinent facility documentation, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice that meet each resident's physical, mental and psychosocial needs. This deficient practice was identified for one (1) of four (4) residents reviewed for closed record review, (Resident #262) and was evidenced by the following: Reference: NEW JERSEY ADMINISTRATIVE CODE TITLE 13 LAW AND PUBLIC SAFETY CHAPTER 37 NEW JERSEY BOARD OF NURSING 13:37-6.5 NON-DELEGABLE NURSING TASKS b) A registered professional nurse shall not delegate the physical, psychological, and social assessment of the patient, which requires professional nursing judgment, intervention, referral, or modification of care. The surveyor reviewed Resident #262's closed medical record. The Admission Record (or face sheet; an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to Ex Order 26. 4B1 and Ex Order 26. 4B1	F 684	It is the policy of Care one at Oradell that all new NJ Exec. Order 26:4.b will be investigated, and appropriate interventions implemented. Resident #262 was safely discharged from the facility on Ex Order 26. 4B1. Resident #262 visiting nurse services obtained treatment orders for NJ Exec. Order 26 4.b.1 after discharge. All residents with NJ Exec. Order 26:4.b at time of discharge have potential to be affected. The Unit Manager (or designee) will review discharge booklets to ensure completion. All Nurses were educated on the process when a Ex Order 26. 4B1 is identified including investigation, MD notification, treatment, and care plan updates. All nurses were educated on conducting a NJ Exec. Order 26:4.b.1 for residents prior to discharge. All nurses were educated to print the Order Summary which will include medications as well as treatments. The Order Summary will be provided to residents in addition to the discharge summary (booklet). The DON/ADON or designee will audit all	

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F 684	Continued From page 31 *Ex Order 26. 4B1* and *Ex Order 26. 4B1* A review of the most recent Resident #262's Discharge Assessment Return Not Anticipated Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that Resident #262's cognition was *Ex Order 26. 4B1*. Further review indicated under Section M Skin Conditions that Resident #262 did not have one or more *Ex Order 26. 4B1*. A review of the most recent "Patient Discharge Summary/Instructions-V7" included the following: Section III. Nursing ... 5. Treatments A. Skin Status b. NJ Exec. Order 26:4.b.1 at time of discharge (See treatment list) A1. Treatment list Clean *Ex Order 26. 4B1* and covered with gauze pad or *Ex Order 26. 4B1*. Ensure *Ex Order 26. 4B1* dressing is in place to *Ex Order 26. 4B1*. The form was signed by a Licensed Practical Nurse (LPN). A review of the last "Physician Discharge Summary" signed by the physician did not include any information about a *Ex Order 26. 4B1* and/or treatment for a *Ex Order 26. 4B1*. The "Transfer/Discharge Report" did not include a	F 684	new and discharge charts for investigation of NJ Exec. Order 26:4.b, assessment, treatments, care plan, and MD orders weekly X1 month. Then monthly for three months, and report findings to administrator, as well as to QAPI team quarterly to ensure compliance. Clinical Reimbursement Director or designee to audit all discharge MDS for accuracy and report to QAPI monthly x 3 months and quarterly x 3 quarters.	

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diagnosis of a Ex Order 26. 4B1 . Further review of the current medication list provided to the resident at time of discharge did not include any medication or treatment for a Ex Order 26. 4B1 .

A review of Resident #262's care plan, with an initiated date of 5/26/22, indicated the resident was at risk for alteration in Ex Order 26. 4B1 related to Ex Order 26. 4B1 . It did not indicate the resident had an actual Ex Order 26. 4B1 . Further review of Resident #262's care plan indicated that the resident had an actual Ex Order 26. 4B1 related to a Ex Order 26. 4B1 to the Ex Order 26. 4B1 which was initiated on 5/26/22 and was resolved on 6/18/22.

A review of Resident #262's electronic Progress Notes did not indicate the resident had a Ex Order 26. 4B .

A review of Resident #262's "Universal Transfer Form" dated Ex Order 26. 4B1 indicated the resident was transferred from the hospital to the facility and included the following:
Ex Order 26. 4B1 Type: .. Ex Order 26. 4B1 ...

Further review of Resident #262's electronic medical record did not indicate that the resident was being seen by a Ex Order 26. 4B1 physician.

A review of Resident #262's July and August 2022 Medication Administration Record (MAR) and Treatment Administration Record (TAR) included the following order:
Apply Ex Order 26. 4B1 dressing to Ex Order 26. 4B1 every day shift every 3 day(s) for
Ex Order 26. 4B1 prevention for 30 Days Ex Order 26. 4B1 and discomfort -Start Date-7/07/2022 0700. The last date that a nurse signed that the NJ Exec. Order 26:4.b.1 was

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F 684	Continued From page 33 administered was 7/31/22. On 8/31/23 at 9:41 AM, the surveyor called the visiting nurse services that was listed on the discharge instruction sheet and spoke with the Executive Director of Continuous Care (EDCC) regarding Resident #262. The EDCC stated that the following day after discharge from the facility, a nurse was sent to the home of Resident #262 to start a home care visit and that an assessment was done. She stated that Resident #262 was assessed and had an *Ex Order 26. 4B1* that was unstageable with *Ex Order 26. 4B1*), *Ex Order 26. 4B1* *Ex Order 26. 4B1* appears smooth as opposed to *Ex Order 26. 4B1*. For example, in a NJ Exec. Order 26:4 that is clean but *Ex Order 26. 4B1*, the *Ex Order 26. 4B1* surface appears NJ Exec. Order 26:4.b.1 as opposed to *Ex Order 26. 4B1*). She added that the *Ex Order 26. 4B1* measured *Ex Order 26. 4B1* . On 8/31/23 at 11:47 AM, in the presence of another surveyor, the surveyor interviewed the Licensed Practical Nurse (LPN) that signed Resident #262's "Discharge Summary/Instructions" form regarding the process when a new *Ex Order 26. 4B1* is identified. The LPN stated that when a new *Ex Order 26. 4B1* was identified she would inform the physician, the family and NJ Exec. Order 26 nurse if there was one at the time. She then stated that she would document in risk management and in the progress notes. The surveyor asked if an assessment was done and what it would include. The LPN stated that an assessment would be done and it would include	F 684		

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F 684	Continued From page 34 what it looked like, the measurement and if any discharge. The surveyor then asked what the process was in regards to discharge instructions and a *Ex Order 26. 4B1* and if an assessment was done. The LPN stated that she would notify the physician for prescriptions and would do a skin assessment before the resident leaves. She added if there was a Ex Order 26. 4B1 the resident would continue the treatment. The surveyor asked who would do the assessment. The LPN stated that she would do the assessment as the discharge nurse. The surveyor then showed the discharge summary of Resident #262 and asked the LPN if the resident had a *Ex Order 26. 4B1*. The LPN stated that she did not remember and just read the treatment that was listed on the summary. The surveyor asked the LPN if she took care of the resident or if she just did the discharge summary/instruction form. The LPN stated that she did not remember. On 8/31/23 at 11:55 AM, in the presence of another surveyor, the surveyor interviewed the Assistant Director of Nursing/Infection Preventionist Nurse (ADON/IPN) regarding the process when a *Ex Order 26. 4B1* is initially identified. The ADON/IPN stated that when a *Ex Order 26. 4B1* is identified, the nurse would write an incident report, notify the physician, family and NJ Exec. Order 26:4 nurse. She added that the care plan would be updated and a progress note or NJ Exec. Ord note would be documented with the assessment which would include the characteristics and measurement. The ADON/IPN stated that the nurses do not do staging of the Ex Order 26. 4B1 but that the NJ Exec. Order 26:4 team would stage the *Ex Order 26. 4B1*. She then stated that the nurse documented the assessment and the Unit Manager who is usually a Registered Nurse (RN) would follow up and	F 684		

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sign off that if the assessment was done by an LPN that the assessment was correct.

At that same time, the surveyor asked if an investigation was done. The ADON/IPN stated that an investigation was done as part of the incident report. The surveyor asked if an assessment is done at discharge and if it should be done by an LPN or RN. The ADON/IPN stated that the expectation was always to do an assessment and document it at discharge and that she was not sure if it had to be an LPN or RN.

On 8/31/23 at 12:07 PM, the surveyor asked the ADON/IPN and the Director of Nursing from another facility if there were any incident reports or investigations for Resident #262 during the residents stay at the facility.

On 8/31/23 at 01:15 PM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator, ADON/IPN and the Vice President of Special Clinical Projects (VPoSCP) the concern that Resident #262 had a new *Ex Order 26. 4B1* that was not assessed and documented to include the characteristics and measurement by an RN, that the physician was not notified and the care plan was not updated to include an actual NJ Exec. Order 26:4.b.1.

On 9/01/23 at 10:41 AM, the VPoSCP stated that there were no incident reports or investigations for Resident #262 in the computer system. The surveyor then notified the VPoSCP that was also a concern that an investigation was not done.

On 9/06/23 at 10:48 AM, the survey team met with the LNHA, Director of Nursing (DON),

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ADON/IPN and VPoSCP. The VPoSCP stated that she was unable to locate the weekly [NJ Exec. Order 26:4] measurement form for Resident #262 and that she did not find an investigation for a [NJ Exec. Order 26:4]. She stated that process was to investigate a [NJ Exec. Order 26:4] and document in the Risk assessment. The VPSCP stated that there was a progress note written by the [NJ Exec. Order 26:4] nurse that was not employed at the facility anymore and that she did an assessment and documented that she called the doctor for a *Ex Order 26. 4B1* dressing on 7/06/22. She added that there should have been a risk assessment note and that there should have been a weekly flow sheet for weekly [NJ Exec. Order 26:4] which would have been done on paper and that she could not locate any flow sheets for Resident #262. The VPoSCP then stated that the [NJ Exec. Order 26:4] nurse who documented on 7/06/23 should have called the family and documented it in progress notes "ideally."

On 9/08/23 at 12:56 PM, in the presence of the survey team, the VPoSCP stated that on 7/06/22 Resident #262 was having [NJ Exec. Order 26:4] in the *Ex Order 26. 4B1* and the nurse did an assessment and there was a [NJ Exec. Order 26:4.b.1] and notified the physician who ordered a *Ex Order 26. 4B1* dressing. She added that there was no incident report done. The surveyor asked if the *Ex Order 26. 4B1* should have been documented in the medical record prior to the discharge summary/instruction sheet and include the measurement. The VPoSCP stated "yes." The surveyor asked if the physician and family should have been notified. The VPoSCP stated "yes." The surveyor asked if there should have been an investigation done for the *Ex Order 26. 4B1*. The VPoSCP stated "yes." The surveyor asked if the discharge summary/instruction form assessment should be done by an RN. The

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CAREONE AT ORADELL	**600 KINDERKAMACK ROAD ORADELL, NJ 07649**

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F 684	Continued From page 37 VPoSCP stated that an LPN can do it. A review of the facility provided policy titled "*Ex Order 26. 4B1* Breakdown-Clinical Protocol" with a revised date of April 2018, included the following: Assessment and Recognition ...2. In addition, the nurse shall describe and document/report the following: a. Full assessment of *Ex Order 26. 4B1* including location, stage, length, width and depth, presence of NJ Exec. Order 26:4.b.1 tissue.	F 684		
F 689 SS=E	N.J.A.C. 8:39-27.1 (a) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent documentation it was determined the facility failed to: a) ensure the facility policy for Accidents and Incidents was followed to thoroughly investigate each fall, appropriately assess a resident, determine the causal factor of each fall and provide conclusion and summary, implement appropriate interventions to prevent recurrent falls, and update care plan for six (6) out of six (6) investigations, b) implement policies and	F 689	It is the policy of Care one at Oradell that all [NJ Exec. Or] and [NJ Exec. Order 26:4.b.1] are investigated, and appropriate interventions implemented. Resident #46's [NJ Exec. Order 26:4.b.] assessed by the RN Unit Manager; MD notified and NJ Exec. Order 26:4.b.1 [redacted] The [NJ Exec.] was investigated to understand the causes and risk factors, and for appropriate intervention.	9/20/23

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F 689	Continued From page 38 procedure for reporting a fall that resulted in a major injury to State Agency in accordance to current guidelines for one (1) of three (3) residents, (Resident #46) reviewed for falls; and c) complete an initial smoking assessment and initiate a care plan for smoking for one (1) of one (1) resident reviewed for smoking (Resident #93). This deficient practice was evidenced by the following: According to the N.J. (New Jersey) Admin. (Administrative) Code § 8:43E-10.6 Current through Register Vol. 54, No. 41, September 5, 2023 Section 8:43E-10.6 - Reporting of serious preventable adverse events (a) A health care facility shall report to the Department or, in the case of a State [Ex Order 26. 4B1] hospital, to the Department of Human Services, every serious preventable adverse event that occurs in the facility.... 1. On 8/23/23 at 10:53 AM, the surveyor observed Resident #46 sitting on a [NJ Exec. Order 26 4.b.1] next to the bed, well dressed, wearing sneakers and conversant. The resident stated he/she [Ex Orde] here in the facility and went to the [Ex Order 26. 4B1]. The resident stated the [Ex Orde] occurred in the bathroom while alone; [Ex Order 26. 4B1] The surveyor observed the call bell was on the bed, within reach by the resident. The surveyor reviewed the medical record for Resident #46. The Admission Record (AR; or face sheet; an admission summary) reflected that Resident #46 was admitted to the facility with diagnoses that	F 689	It is the policy of Care one at Oradell that all residents identified as smoker have appropriate care plan and assessment. Resident # 93 was assessed by the RN for safe smoking. [Ex Order] smoking care plan was updated as well. All residents involved in [NJ Exec] -related incidents have the potential to be affected. All residents who smoke have the potential to be affected. All Nurses were educated on the process for [NJ Exec. Or] and [NJ Exec. Order 26 4.b.1] including assessment, investigation, interventions, MD & family notifications, treatment, and care plan updates. Unit Manager (or designee) will present all incidents involving [NJ Exec. Or] at the next clinical meeting. Clinical meetings are held daily during the week. Director of Nursing (or designee) will investigate the incident, assess the resident, and along with the other interdisciplinary team members, determine the causal factor of the incident and document a conclusion and summary. The Director of Nursing (or designee) will update the residents' plan of care with applicable interventions. Incidents involving serious adverse events	

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F 689	Continued From page 39 included Ex Order 26. 4B1 without loss of Ex Order 26. 4B1 of unspecified part of [redacted] According to admission Minimum Data Set (aMDS), an assessment tool used to facilitate management of care dated, 7/13/23, Resident #46 was documented as having a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, indicating the resident had a Ex Order 26. 4B1 cognition. Further review of the MDS under section G Functional Status revealed that the resident was an extensive assist for Ex Order 26. 4B1 and required NJ Exec. Order 26:4.b.1 except when [redacted] The surveyor reviewed the facility Risk Management Report (RMR) dated: 5/08/23, 5/12/23, 5/22/23, 7/16/23, 7/29/23, and 8/16/23 revealed Resident #46 had [redacted] on each one of these dates. The RMR on 5/08/23, 5/12/23, 5/22/23, 7/16/23, 7/29/23, and 8/16/23 showed the following: A review of the RMR dated 5/08/23 revealed that the [redacted] was unwitnessed in the bathroom, with no [redacted] The predisposing factor was [redacted] There were no indications of other interviews and/or signed statements, the conclusion was missing, and the Report of Incident/Accident form as per facility policy was missing.	F 689	will be fully investigated and reported timely to the Department of Health. The Unit Manager (or designee) will review for timely completion of assessments for all residents who smoke. All nurses were educated to initiate assessments, timely. Director of Nursing (or designee) will review 100% of incidents per week, on an on-going basis, with report to Administrator and QAPI monthly. Director of Nursing (or designee) will review smoking assessments for accuracy and completion for 100% of smoking residents and any residents who are admitted who desire to smoke. Audits will be conducted weekly x 4 weeks and monthly x 3 months with results reported to QAPI monthly x 6 months.	

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F 689	Continued From page 40 A review of the RMR dated 5/12/23 revealed that the [redacted] was witnessed by the aide by the bed, with no[redacted]. The predisposing factor was [redacted]. The report did not reflect the name of the aide, who was also the witness. There were no indication of other interviews or witness statements, the conclusion was missing, and the Report of Incident/Accident form as per facility policy was not provided. A review of the RMR dated 5/22/23 revealed that the [redacted] was unwitnessed with no[redacted], the location of the [redacted] was not specific. The predisposing factor were *Ex Order 26. 4B1* [redacted]. There were no indications of other interviews and/or signed statements, the conclusion was missing, and the Report of Incident/Accident form as per facility policy was missing. Further review of the RMR under incident description reflected the resident [redacted]. The report did not include the description or evidence of *Ex Order 26. 4B1* [redacted] A review of the RMR dated 7/16/23 revealed that the [redacted] was unwitnessed in the bathroom, with no [redacted]. The predisposing factors were [redacted]. There were no indication of other interviews and/or signed statements, the conclusion was missing, and the Report of Incident/Accident form as per facility policy was missing. A review of the RMR dated 7/29/23 revealed that the [redacted] was unwitnessed in the bathroom, with no [redacted]. The predisposing factors were [redacted], and currently on *Ex Order 26. 4B1* [redacted]. There were no indication of other interviews and/or signed statements, the conclusion was missing, and the	F 689		

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F 689	Continued From page 41 Report of Incident/Accident form as per facility policy was missing. A review of the RMR dated 8/16/23 revealed the NJ Exec. was unwitnessed in the bathroom, with no NJ Exec. Order. The predisposing factors were Ex Order [redacted] or *Ex Order 26. 4B1* [redacted] medications. There were no indication of other interviews and/or signed statements, the conclusion was missing, and the Report of Incident/Accident form as per facility policy was missing. A review of Resident #46's Care Plan (CP) revealed it was not updated to include new interventions to reduce the risk for Ex Order [redacted] after each identified Ex Ord[redacted]. The NJ Exec. [redacted] interventions remained unchanged from the initiated date of 5/06/23. The interventions included the following: -*Ex Order 26. 4B1* [redacted] and treatment as ordered; date initiated 5/06/23 -Encourage NJ Exec. Order 26:4.b.1 [redacted]; date initiated Ex Order 26. 4B1 -NJ Exec. Order 26:4.b.1 [redacted]; date initiated 5/06/23 -Provide NJ Exec. Order 26:4.b.1 [redacted] as needed; date initiated Ex Order 26. 4B1 -Reinforce the need to call for assistance; date initiated 5/06/23 -Reinforce Ex Order 26. 4B1 safety as needed such as locking brakes; date initiated 5/06/23 -Report development of pain, bruises, change in *Ex Order 26. 4B1* [redacted] function, appetite, or Ex Order 26. 4B1 status per facility guidelines; date initiated 5/06/23 A review of the Progress Note (PN) revealed the following: On 5/22/23 at 01:45 AM "late entry", the	F 689		

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F 689	Continued From page 42	F 689		

Registered Nurse (RN) documented the resident was seen on the floor. When the RN asked what happened the resident replied "I don't know."

On 5/22/23 at 10:51 AM, the Unit Manager (UM) documented in the PN, based on the resident and family statement, the resident [redacted] while trying to get up and go to the bathroom ...The resident was described as having a preexisting [redacted] on the [redacted] and [redacted] that looked like an older stage of [redacted]... The UM also documented that the family was concerned about the [redacted] and the resident's [redacted].

On 5/22/23 at 3:59 PM "late entry" the UM documented in the PN at 01:30 AM, patient was seen on the floor. When asked what happened patient stated, "I don't know."

On 5/22/23 at 6:09 PM Licensed Practical Nurse#1 (LPN#1) documented in the PN, hospital.

On 5/23/23 at 3:48 AM, the Registered Nurse/Supervisor (RN/Supervisor) documented in the PN, patient admitted to [redacted] with [redacted]

On 8/29/23 at 12:46 PM, during a meeting with the surveyors, and the Licensed Nursing Home Administrator (LNHA), the Vice President of Special Clinical Projects (VPoSCP) informed the surveyors of the facility's process for investigating [redacted] The VPoSCP stated for an unwitnessed/witnessed [redacted] the Certified Nursing Assistant (CNA) speaks with the nurse who would conduct an assessment, followed by a team meeting and a root cause analysis. The interview

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F 689	Continued From page 43 statements, root cause analysis, and conclusion were obtained on paper. The VPoSCP stated she did not know where the papers were. The surveyor discussed the concern regarding the incomplete investigation for each identified [NJ Exec. Ord].	F 689		
	On that same date and time, the VPoSCP confirmed that no new intervention was made in CP after each resident [Ex Ord]. The surveyor asked the VPoSCP, if the CP should have been updated after each identified [Ex Ord], no response was given.			
	At that same time, the LNHA stated there were few incidents of reportable found but was unsure if the incident involving Resident #46 on 5/22/23 was reported to the State Agency. The concern regarding the missing report for the resident's unwitnessed [Ex Ord] resulting in [NJ Exec. Order 26:4.b.1] was discussed with the VPoSCP and LNHA.			
	On 8/31/23 at 12:29 PM, in the presence of the survey team, Registered Nurse/ Infection Preventionist Nurse (IPN), and LNHA, the VPoSCP. The VPoSCP stated that the Post [Ex Ord] assessment by the interdisciplinary team and signed witness statements were not found as part of the [Ex Ord] investigation. The VPoSCP did not provide further information to the surveyors regarding the [Ex Ord] investigations form "paper documents" for Resident #46.			
	On that same date and time, The VPoSCP stated that there should have been previous post [Ex Ord] interventions in the CP to reduce the risk of [Ex Ord] after each identified [Ex Ord]. In addition, the VPoSCP stated that in relation to the previous [Ex Order 2], the team was relying on the Director of Nursing (DON) for direction. The VPoSCP stated there is now a committee for [Ex Order 2]. The VPoSCP was			

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F 689	Continued From page 44 unsure if the facility reported the [redacted] with injury sustained on 5/22/23, to the State Agency and was unable to provide proof of submission. The VPoSCP informed the survey team that a reportable event was then submitted on at 8/29/23 at 4:00 PM, after surveyor inquiry. [redacted] further stated that all departments were educated, and a quality assurance (QA)was initiated post surveyor inquiry. At that time, the LNHA stated a Quality Assurance and Performance for Improvement (QAPI; a data driven and proactive approach to quality improvement that included QA and Performance Improvement to ensure services are meeting quality standard and assuring care reached a certain level) was also initiated after surveyor inquiry. On 9/07/23 at 9:28 AM, during an interview with the surveyor, the Rehabilitation Director (RD) stated she has been the director in the facility since 2017. She was part of the [redacted] team which met once or twice a week. The RD stated she was familiar with Resident #46 because when a resident had a [redacted], and was receiving [redacted], it was noted. The RD informed the surveyors that the interventions were to continue with [redacted]. On 9/7/23 at 12:16 PM, the RD submitted pages from her personal notebook that included the following: 5/08/23, the resident was status/post [redacted] 5/05/23, on [redacted]. 5/17/23, the resident was status/post [redacted] 5/8 and 5/12, (no skilled authorization from insurance needed, needed [redacted] follow-up). 7/17/23, the resident was status/post [redacted] 7/16/23,	F 689		

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F 689	Continued From page 45 continue with *Ex Order 26. 4B1* [redacted]. Further review of the above provided documents of the RD showed that there was no evidence that the Care Plan interventions were re-assessed, or updated by the facility team to prevent the risk or recurrent [redacted]. A review of the facility provided policy Accidents and Incidents edited 4/24/19, included: Policy Statement: all accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. Policy Interpretation and Implementation: 1. The nurse supervisor/ charge nurse and/ or the department director or supervisor shall promptly initiate and document investigation of the accident or incident 2. The following data, as applicable, shall be included on the Report of Incident/Accident form ... 3. This facility is in compliance with current rules and regulations governing accidents and/ or incidents involving a medical device. 5. The nurse supervisor/ charge nurse and/ or the department director or supervisor shall complete a report of incident/ accident form and submit the original to the director of nursing services within 24 hours of the incident or accident. 6. the director of nursing shall ensure that the administrator receives a copy of the report of incident/ accident form for each occurrence. 7. Incidents/ accidents reports will be reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities.	F 689		

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F 689	Continued From page 46 2. On 8/23/23 during entrance conference, Resident #93 was identified as a smoker by the facility. On 8/23/23 at 10:15 AM, the surveyor interviewed the IPN regarding residents on the 2 South unit that smoked. The IPN stated that she was [redacted] as Unit Manager (UM) for [redacted] since there was not a UM currently for the unit. She stated that Resident #93 smoked. On 8/23/23 at 10:58 AM, the surveyor toured Resident #93's unit but the surveyor did not observe Resident #93 in their room. On 8/24/23 at 11:25 AM, the surveyor interviewed the Receptionist regarding the process for residents that smoked. The Receptionist stated that nursing gave the residents their cigarettes and lighter and that she only knew which residents went outside to smoke. She stated that Resident #93 was one of the residents that was on her list. On 8/24/23 at 11:37 AM, the surveyor interviewed Resident #93's assigned LPN #2 regarding the process for residents that smoked. LPN #2 stated that the facility was a non-smoking facility but that there were residents that smoked. She stated that there were certain times that residents could go outside to smoke and that nursing kept the cigarettes and lighter in the medication cart. The surveyor asked LPN #2 if Resident #93 smoked. LPN #2 stated that Resident #93 only smoked when the resident's spouse came to visit and that the facility did not have any of Resident #93's smoking supplies. On 8/24/23 at 12:04 PM, the surveyor reviewed	F 689		

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F 689	Continued From page 47 Resident #93's medical record. A review of Resident #93's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted] Resident #93's quarterly MDS dated 6/08/23, reflected that the resident had BIMS score of [redacted] out of 15, which indicated that Resident #93 was [redacted]. A review of Resident #93's care plan did not indicate that there was a care plan for smoking. Further review of Resident #93's electronic medical record indicated that Resident #93 had a [redacted] an assessment used to evaluate if a resident was able to smoke independently or needed to be supervised, done on 8/23/23 at 12:15 PM. The evaluation indicated the following: Determination: [redacted] ... Additional comments/information Patient's [spouse] accompanies patient while smoking and is responsible for smoking materials. Patient smokes while [spouse] is visiting which is daily and remains with patient from time he/she wakes up until the time he/she is put to bed. Patient's [spouse] is aware of smoking policy and designated smoking area.	F 689		

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F 689	Continued From page 48 On 8/24/23 at 12:17 PM, the surveyor interviewed Resident #93's spouse who stated that Resident #93 was not smoking when first admitted but that the resident started smoking about a month ago. Resident #93 was then brought to the smoking section by Ex Order 26. 4B1 by a Ex Order 26. 4B1 staff member. Resident #93 stated that he/she started smoking about three weeks ago after being in bed for three months. On 8/28/23 at 9:29 AM, the surveyor interviewed Resident #93's assigned LPN #3 regarding the process for a resident that smoked. LPN #3 stated that on admission a smoking evaluation is done to see if the resident can hold the cigarette and is safe to smoke. He added that the nurses keep the resident's cigarettes and lighter. The surveyor asked LPN #3 if there should be a care plan for smoking. LPN #3 stated that there should be a care plan for smoking and that the UM would do the care plan. He added that there was no manager on the unit right now and that the ADON/IPN was covering the unit. The surveyor then asked LPN #3 when the smoking evaluation should be done if a resident decided to start smoking after admission. LPN #3 stated that when you find out if someone is smoking or wants to start smoking that the evaluation should be done as soon as possible. The surveyor then asked if Resident #93 smoked. LPN #3 stated that the resident smoked and that the resident started to smoke about two months ago but was not sure. The surveyor asked if Resident #93 started smoking last week. LPN #3 stated "no." At that time, the surveyor then asked LPN #3 to view Resident #93's Ex Order 26. 4B1 [redacted]. LPN #3 confirmed that Resident #93 only had a Ex Order 26. 4B1 [redacted]	F 689		

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F 689	Continued From page 49 done on 8/23/23. The surveyor asked if Resident #93 should have had a *Ex Order 26. 4B1* [redacted] done prior to that date. LPN #3 stated that he believed it should have been done prior. The surveyor then asked LPN #3 if Resident #93 had a care plan for smoking. LPN #3 confirmed that Resident #93 did not have a care plan for smoking and that he believed that the resident should have one. On 8/28/23 at 12:45 PM, the surveyor interviewed the ADON/IPN regarding the process for smoking. The ADON/IPN stated that the facility was usually smoke free but that there were longterm residents that smoked and they had the right to smoke. She added that we do an assessment to see if they can safely smoke but that she was not sure of what the facility policy was. The surveyor asked when the assessment should be done. The ADON/IPN stated that once we know the resident smoked the assessment should be done on initial admission but that she was not quite sure how often after that. The surveyor asked about what if a resident decided to smoke after admission. The ADON/IPN stated that if we find out if a resident smoked that the assessment should be done right away and that a care plan should be updated with a smoking care plan at the same time as the assessment is done. On that same date and time,the surveyor then asked about Resident #93. The ADON/IPN stated that she just found out last week that Resident #93 smoked. She added that she did not know how long the resident had been smoking. The surveyor asked who does the smoking assessment and care plan. The ADON/IPN stated that if the nurse that has the resident is aware that the resident was smoking that nurse could do	F 689		

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F 689	Continued From page 50	F 689		

the assessment and update the care plan. She then added that if the nurse would let the management know then we would do it. The surveyor then asked what the expectation of when the assessment should have been done. The ADON/IPN stated that the expectation would be that an assessment should have been done when the resident started smoking. She then stated that she thought the resident was a longtime smoker and that the resident was so sick when admitted and was not going out to smoke. The surveyor asked if the resident should have a care plan for smoking. The ADON/IPN stated that the resident should have a care plan for smoking ideally. She added that when the nurse knew the resident was smoking the nurse should have done the assessment and care plan or notify someone else to do it. She then stated that she was not always on the floor and that she was outside and saw the resident smoking last week.

On 8/29/23 at 11:01 AM, in the presence of the survey team, the surveyor notified the LNHA, ADON/IPN, and the VPoSCP the concern that Resident #93 did not have a smoking assessment and care plan for smoking done prior to surveyor inquiry.

On 8/31/23 at 12:54 PM, in the presence of the survey team, LNHA, ADON/IPN, the VPoSCP stated that the facility did an audit on all residents that smoked to ensure an assessment and care plan for smoking were done. She added that she did not know why Resident #93's assessment was done that day and that she did not know when the resident was smoking before then. The VPoSCP stated that an assessment for safe smoking should be done as soon as a resident is

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F 689	Continued From page 51 identified as a smoker and that ideally a care plan for smoking should be done at that time. A review of the facility provided policy titled, "Smoking Policy; Residents", with a revision date of 10/25/22, included the following: Process: 1. Prior to and at time of admission the Admissions Director, or designee, will review the smoking policy and rules with prospective and new admissions. 2. In center where smoking is permitted in designated outdoor areas: 2.1. Complete the smoking evaluation for residents who express a desire to continue smoking upon admission, despite being aware of risks associated with smoking. The evaluation is updated quarterly, and with each significant change in condition ... 2.6. Develop a plan of care that addresses smoking with input from the interdisciplinary team. 2.6.1 Consider the need for individualized interventions such as smoking schedules, safety devices such as smoking aprons, and the need for direct supervision or assistance ... N.J.A.C. 8:39-27.1(a)	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		9/20/23

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F 690	Continued From page 52 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is NJ Exec. Order 26:4.b.1 receives appropriate treatment and services to restore as much NJ Exec. Order 26:4.b.1 as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide appropriate Ex Order 26. 4B1 care and services for one (1) of two (2) residents (Resident #72) reviewed for Ex Order 26. 4B1. This deficient practice was evidenced by: On 8/24/23 at 10:39 AM, the surveyor observed Resident #72 sitting on a Ex Order 26. 4B1, dressed	F 690	Resident #72 was provided a NJ Exec. Order 26:4 [redacted] the Ex Order 26. 4B1 [redacted] All residents with Ex Order 26. 4B1 [redacted] have potential to be affected. All residents with Ex Order 26. 4B1 [redacted] were assessed to ensure NJ Exec. Order 26:4.b.1 were in place. All staff were educated on the use of	

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F 690	Continued From page 53 and was conversant. The resident stated they were being discharged that morning. The surveyor observed the resident had a Ex Order 26. 4B1 [redacted] secured to the bottom of Ex Order 26. 4B1 without a privacy cover. The surveyor reviewed Resident #72's medical record. According to the Admission Record (or face sheet; an admission summary), Resident #72 was admitted with diagnoses that included Ex Order 26. 4B1 [redacted] Ex Order 26. 4B1 [redacted]. A review of Resident #72's Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 7/21/23, included the resident had a Brief Interview Mental Status (BIMS) score of [redacted] out of 15, indicating the resident was Ex Order 26. 4B1. Further review of the MDS under section H Bladder and Bowel revealed the resident had an Ex Order 26. 4B1 and was frequently Ex Order 26. 4B1. The Resident's Care Plan dated 5/16/23, and revised 7/25/23, did not include an intervention to provide a NJ Exec. Order 26:4.b.1 On 8/28/23 at 12:51 PM, the surveyor interviewed the Certified Nursing Assistant (CNA) assigned to the resident's hallway. The CNA informed the	F 690	NJ Exec. Order 26:4.b.1 [redacted] for Ex Order 26. 4B1 [redacted]. Central supply ordered a new stock number of Ex Order 26. 4B1 [redacted] covers to ensure proper coverage. The Director of Nursing (or designee) will conduct audits of all residents with NJ Exec. Order 26:4.b.1 to ensure NJ Exec. Order 26:4 [redacted] are in place. Audits will be conducted at least 3 times per week x 4 weeks; and monthly x 3 months. Report to QAPI monthly x 3 months.	

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F 690	Continued From page 54	F 690		

surveyor that when a resident was to be discharged to home with a [redacted], she ensured that the resident would have a [redacted].

On 8/28/23 at 01:03 PM, during an interview with the surveyor, the Licensed Practical Nurse (LPN) confirmed the resident was discharged with a [redacted] which should have had a [redacted].

On 8/29/23 at 11:01 AM, during a meeting with the surveyors, the surveyor discussed the concern regarding the failure to provide a [redacted] to a resident who was waiting to be discharged on that day with the Vice President of Special Clinical Projects (VPoSCP), the Registered Nurse/Infection Preventionist (IPN) and the Licensed Nursing Home Administrator (LNHA).

On 8/31/23 at 12:29 PM, during a meeting with the surveyors, the VPoSCP stated all the residents in the facility were assessed and education was given to the staff. The VPoSCP acknowledged the resident should have had a [redacted]. The VPoSCP stated a specification of standard for quality of care also known as quality assurance was initiated for the use of [redacted] with a [redacted] located on the bed and on the [redacted].

A review of the facility provided policy [redacted] revised August 2022, included the following:
Preparation
1. Review the resident's care plan to assess for any special needs of the resident.
2. Assemble the equipment and supplies as

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F 690	Continued From page 55 needed. Steps in the procedure; Routine NJ Exec. Order 26:4.b.1 6. Provide [redacted]	F 690		
F 695 SS=D	N.J.A.C. 8:39-27.1 (a) Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that a.) Ex Order 26. 4B1 care and services were provided according to the standard of practice for one (1) of two (2) residents (Resident #28) reviewed for Ex Order 26. 4B1 and b.) a resident received Ex Order 26. 4B1 as ordered by the physician for one (1) of two (2) residents (Resident #58) reviewed for Ex Order 26. 4B1. This deficient practice was evidenced by the following: 1. On 8/23/23 at 11:07 AM, surveyor observed Resident #28, lying in bed with their eyes closed, Ex Order 26. 4B1 that provides an alternative Ex Order 26. 4B1 clean, dry, and intact.	F 695	Resident #28 received Ex Order 26. 4B1 care as per standard of practice by the RN Unit Manager; tolerated procedure well. Resident #58 Ex Order 26. 4B1 was changed. Ex Order 26. reflected proper settings. Ex Order 26. 4B1 assessed with no untoward changes. All residents who receive Ex Order 26. 4B1 care have potential to be affected. All residents receiving Ex Order 26. 4B1 via Ex Order 26. 4B1 have potential to be affected. All nurses were educated by the Ex Order 26. 4B1 on procedure for Ex Order 26. 4B1 care. All nurses were educated on the procedure for hand hygiene - prior to	9/27/23

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F 695	Continued From page 56 The surveyor reviewed the medical records for resident #28. The Admission Record (AR; or face sheet; an admission summary) reflected that the resident was admitted to the facility with a diagnosis that included but was not limited to *Ex Order 26. 4B1* [redacted], contact with and (suspected) exposure to other *Ex Order 26. 4B1* [redacted]. A review of the Minimum Data Set (MDS) dated August 16, 2023, reflected that Cognitive Skills for Daily Decision Making was *Ex Order 26. 4B1* [redacted]. The Care Plan dated 7/11/2018 and revised 5/10/2019 revealed a focus for *Ex Order 26. 4B1* [redacted] related to *Ex Order 26. 4B1*, under the interventions and / tasks section it read, *Ex Order 26. 4B1* care per protocol, dated 7/11/2018. A review of the August 2023 Active Order Summary Report (OSR) reflected a physician order (PO) dated 5/10/19 to *Ex Order 26. 4B1* [redacted] and *Ex Order 26. 4B1* as *Ex Order 26. 4B1* [redacted]. A review of the August 2023 Treatment Administration Record (TAR) revealed *Ex Order 26. 4B1* [redacted] On 9/05/23 at 10:32 AM, during surveyor observation of *Ex Order 26. 4B1* care of Licensed Practice Nurse#1 (LPN#1), the LPN donned (applied) a new pair of gloves, disinfected the table, doffed (removed) off used gloves, donned a new pair of gloves without performing hand	F 695	donning and after doffing of gloves. All nurses were educated to ensure oxygen administration according to physician's orders. All *Ex Order 26. 4B1* were evaluated by Director of Environmental Services. 100% were in proper working order. DON/ADON will conduct five weekly nursing competency audit * 4 weeks on NJ Exec. Order 26:4.b.1 care in accordance with standard of practice. Then monthly x 3 months with results reported monthly to QAPI x 3 months. DON/ADON will conduct audits for 100% of residents with NJ Exec. Order 26:4.b.1 to ensure oxygen administration according to physician's orders for 100% of residents weekly for 4 weeks; then monthly x 3 months with results reported monthly to QAPI x 3 months.	

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F 695	Continued From page 57 hygiene and immediately prepared Ex Order 26. 4B1 care supplies, turned on the Ex Order 26. 4B1, and then doffed off the used gloves. Afterward LPN#1 donned a new pair of gloves without performing hand hygiene. On 9/07/23 at 12:24 PM, the surveyor interviewed the Infection Prevent Nurse (IPN) regarding handwashing during a Ex Order 26. 4B1 suctioning treatment. Ex Order 2 stated, Ex Order 26. 4B1 [redacted]. Surveyor asked what was the reason for washing after gloves discarded? Facility protocol is to wash your hands after glove removal to prevent transferring of bacteria. It does not matter that gloves were worn they are only another barrier to decrease prevention, but fluid could get into the gloves and have skin contact. That is why we wash our hands it is another way to prevent infection. A review of policy titled, Ex Order 26. 4B1 [redacted] or Ex Order 26. 4B1, level III, dated 2001, revised 10/2010, edited 6/25/2015. Revealed under Ex Order 26. 4B1 perform hand antisepsis. On 9/07/23 at 01:00 PM the surveyor discussed the above finding with the Licensed Nursing Home Administrator (LNHA), and the Director of Nursing (DON). 2. On 8/23/23 at 10:26 AM, the surveyor observed the resident's head on the bed elevated, fitted with a Ex Order 26. 4B1 and humidifier (add moisture to the air) with an integrated flow generator [manufacturer name redacted;]	F 695		

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F 695	Continued From page 58	F 695		

reflected the fraction of Ex Order 26. 4B1 was at Ex Order 26. The resident was no verbal and could not be interviewed.

At that time, the Ex Order 26. 4B1 (NJ Exec) had entered the room and stated he was there to provide Ex Order 26. 4B1 care to Resident #58.

On 8/24/23 at 11:17 AM, during an interview with the surveyor, LPN #2), stated that the resident received Ex Order 26. care three time a day, once per shift.

On 8/24/23 at 11:18 AM, the surveyor observed the resident's head on the bed elevated, eyes open and nonverbal. The surveyor and LPN #2 reviewed the humidifier. LPN#2 identified the humidifier was at Ex Order 26.

On 8/31/23 at 10:41 AM, the surveyor observed the resident's head on the bed elevated and observed the humidifier was at Ex Order 26.

On 8/31/23 at 10:42 AM, during an interview with the surveyor, LPN #1 stated she NJ Exec. Order 26 4.b.1 and NJ Exec. Order 26:4.b.1 the Ex Order 26. 4B1 for the resident that day on her shift. LPN#1 admitted to not checking the NJ Exec. Order 2 indicator after providing care to the resident although she knew how. LPN#1 also stated she had not touched the humidifier that was set up by the RT which was her reason for not checking the Ex Order 26. at that time. The surveyor and the LPN reviewed the humidifier which reflected the Ex Order 26. was at Ex Order 26.

At that time, the surveyor and LPN#1 reviewed the Treatment Administration Record (TAR) together. The LPN confirmed the TAR contained

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F 695	Continued From page 59 a physician order that indicated [manufacturer name redacted] humidifier at [redacted] per minute (LPM), [redacted] On 8/31/23 at 10:55 AM, the surveyor with the LPN #2 spoke with LPN #3, who was at the nurses' station about Resident #58. The surveyor and both LPNs entered the resident's room and reviewed the humidifier and exited the room. At that time, in the presence of the surveyor and LPN#2, LPN #3 confirmed the [redacted] was at [redacted] and should have been at [redacted]. LPN#3 informed the surveyor that she would contact the Infection Preventionist Nurse and the RT. The surveyor reviewed the medical record for Resident #58 A review of the Admission Record, Resident #58 was admitted to the facility with diagnoses that included [redacted] and [redacted]. According to the admission MDS dated 5/16/23, Resident #58 was documented as having a BIMS score of [redacted] out of 15, indicating that the resident had a [redacted]. A review of the OSR, dated 8/31/23, revealed an order for [manufacturer name redacted; humidifier] at [redacted] LPM, [redacted] started on 7/21/23. A review of the TAR for 8/2023, reflected the resident's order for [manufacturer name redacted;	F 695		

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F 695	Continued From page 60 humidifier] at [redacted] LPM, [redacted] started on 7/21/23 was signed every day on every shift. On 8/31/23 at 11:42 AM, during an interview with the surveyor, the VPoSCP stated it was important to follow physician orders for the resident to receive the correct [redacted] order. The VPoSCP also confirmed it was important for the staff to know how to use the [manufacturer name redacted] humidifier. The VPoSCP also stated the humidifier length of use was dependent on the physician's order. On 8/31/23 at 11:45 AM, LPN #3 informed the surveyor that the RT who was contacted had not yet responded. On 8/31/23 at 11:46 AM, the surveyor and the VPoSCP reviewed the physician's order together. The VPoSCP stated the checks on the TAR meant the nurse had checked the [redacted]. The surveyor asked the VPoSCP as to the reason why the nurses did not change the humidifier to a [redacted] when the order was available as an alternative. The VPoSCP stated she would investigate the matter personally. On 8/31/23 at 12:01 PM, during an interview with the surveyors, the Registered Nurse Educator (RN/E) stated she would give an in-service based on when someone had a problem. As for equipment the RN/E stated she would call the company to provide education to the staff which she would document. At that time, the RN/E informed the surveyors that she gave an orientation to agency and new staff	F 695		

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F 695	Continued From page 61 nurses. She stated she was not aware that there was a concern regarding any machine including the [manufacturer name redacted] humidifier nor has any staffed approached her about not knowing how to use the machine. The RN/ E confirmed she had not provided education regarding the same humidifier. On 8/31/23 at 12:30 PM, the VPoSCP informed the surveyor that the malfunction did not involve the humidifier and it involved a faulty Ex Order 26. 4B1 [redacted]. The regulator was changed immediately and was corrected to deliver the correct Ex Order 26. to the resident. All nurses were educated and the *Ex Order 26. 4B1* were audited within the resident's hall by the director of maintenance. The VPoSCP confirmed education for the nurses was needed. A review of the facility provided policy NJ Exec. Order 26:4.b.1 Administration edited 4/2/2019 included under Preparation, section 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for NJ Exec. Order 26:4 administration. NJAC 8:39-27.1(a)	F 695		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care	F 725		9/18/23

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F 725	Continued From page 62 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Complaints #: NJ00163185, NJ00166154, NJ00157351, NJ00155283 Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to provide sufficient nursing staff to ensure resident's highest practical wellbeing by failing to: a.) maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey (NJ) and b.) ensure that 7 AM-3 PM, 3-11 PM, and 11-7 shifts were staffed to provide the ADLs (activities of daily living) for nine (9) of 17 residents, (Residents#4, #13, #22, #23, #32, #233, #235, #312, and #263) according to facility practice, required minimum direct care staff-to-shift ratios as mandated by the state of NJ, and facility assessment.	F 725	It is the policy of Care one at Oradell that sufficient staff to meet the needs of our residents are available 24 hours/7days, 365 days of the year. Residents: #4, #13, #22, #23, #32, #233, #235, #312, #263 have been assessed and reveal no decline in [redacted] related to nursing staffing not meeting minimum direct care staff-to-shift ratios (NJ). All residents have potential to be affected. Residents #4, #32, #233 and #235 were assessed and found to be [redacted] during [redacted] rounds by the surveyor and LPN#1. All [redacted] residents were assessed by nursing and found to be [redacted].	

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F 725	Continued From page 63 This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. On 8/24/23 at 11:04 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who informed the surveyor that the 2 North unit census was 54 with three LPNs including the LPN/UM, five CNAs, and there was no Registered Nurse in the unit. A review of the facility's Nursing Home Resident Care Staffing Report (NHRCSR) that was provided by the Vice President of Special Clinical Projects (VPoSCP) for 8/24/23 Day Shift, shift	F 725	To ensure that the problem of staffing does not recur: *CNA class approved for this facility and commenced on 9/12/23 with goal to offer 10 candidates free Certified Nursing Assistant courses in preparation to sit for the PSI Certified Nursing Assistant examination. The 5-week course will continue to be offered every 6-weeks, on-going. As an encouragement, students that signed up for the class, will be paid on hourly basis to complete the class. *Nursing agency usage as needed to assist in filling open positions. * The facility has implemented a significant above-market rate increase for nurses and certified nursing assistants. Incentives are offered which include tuition reimbursement, sign-on bonus, employee referral program. The facility continues to offer job fairs with on-the-spot interviews as well as walk-in applicants and could expedite contingency offers at the time of interview. Staffing plan developed to meet the professional, technical, and administrative needs of the center. The plan is based on historical experience and projected changes. DON/Administrator (or designee) will review staffing ratios daily and document a weekly review of the daily staffing x 4 weeks, then twice monthly x 3 months. Staffing audits will be presented to the Administrator for review at QAPI monthly	

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F 725	Continued From page 64 hours 7:00 AM - 3:00 PM included a census of 118 and Staff to Resident Ratio as follows: Registered Nurse (RN)=1 (one) RN: 39.3 Residents Licensed Practical Nurse (LPN)=1 LPN: 14.8 Residents Certified Nurses Aide (CNA)=1 CNA: 9.1 Residents On 8/28/23 at 6:30 AM, the surveyor in the presence of another surveyor entered the facility lobby and observed the NHRCSR posted near the reception area date was 8/25/23 Day Shift with a census of 118 and included the following Staff to Resident ratio: 1 RN: 29.5 Residents 1 LPN: 13.1 Residents 1 CNA: 11.8 Residents At the back of the 8/25/23 NHRCSR Day shift were the following: 8/25/23 Evening Shift 3:00 PM - 11:00 PM=Census 118=the Staff to Resident Ratio: 1 RN: 118 Residents, 1 LPN: 19.7 Residents, 1 CNA: 9.1 Residents 8/25/23 Night Shift 11:00 PM - 7:00 AM=Census 118; Staff to Resident Ratio: 1 RN: 118 Residents, 1 LPN: 19.7 Residents, 1 CNA: 16.9 Residents Further review of the NHRCSR revealed that there was no posted information of Staff to Resident Ratio from 8/26/23, 8/27/23, and 8/28/23. On 8/28/23 at 6:47 AM, the surveyor went to the 2 North unit and interviewed LPN#1. LPN#1	F 725	on an on-going basis.	

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F 725	Continued From page 65 informed the surveyor that she was the assigned nurse of 2 North for the 11-7 shift. On 8/28/23 at 6:57 AM, the surveyor interviewed LPN#1 after the Ex Order 26. 4B1 round of Residents #32, #4, #233, and #235. The four residents were found to be NJ Exec. Order 26:4.b.1, and NJ Exec. Order 26:4.b.1 inside their room during the Ex Order 26. 4B1 round of both the surveyor and LPN#1. During an interview of the surveyor with LPN#1 in the nursing station, the LPN informed the surveyor that the 2 North Census was 56, there were two CNAs, and that no one called out in their unit. She further stated that there was no other nurse except the LPN and that was the regular schedule in the unit with one nurse in the 11-7 shift. On that same date and time, LPN#1 provided the surveyor with a copy of 2 North Assignment and showed the following: Nurse 1: LPN#1 Nurse 2: blank Census: 55 Date: 8/27/23-8/28/23 Room Ex Order D-250=CNA#1; total residents=28 Room Ex Order D-265=CNA#2; total residents=28 LPN#1 also provided The Daily Staffing Schedule Week#2 with the following information but were not limited to: Date: 8/27/23 11P-7A (11-7 shift) 2 North: Nurses: LPN#1 CNA's: CNA #1 and #2, and CNA#3 c/o (called out)	F 725		

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F 725	Continued From page 66 On 8/28/23 at 7:01 AM, the surveyor interviewed CNA #1. The CNA informed the surveyor that she was the regular aide for the 11-7 shift and was assigned last night (Sunday) at 2 North with another CNA, a total of two CNAs in the unit last night. The CNA confirmed that there were more than 50 residents in the unit last night and was divided into two CNAs. On that same date and time, the surveyor asked CNA #1 how many CNAs regularly work in the 2 North for the 11-7 shift and how it was working with two CNAs last night. The CNA stated, "I don't want to talk about it and I don't want to lose my job." The CNA later walked away and went to the employee clock to punch out, and stated while walking "It's crazy here." On 8/28/23 at 7:05 AM, the surveyor interviewed LPN#1 in the 2 North Dining Room. The LPN informed the surveyor "I want to correct, that there were three CNAs in the schedule but one called out." LPN#1 stated that the "regular schedule" in the 11-7 shift of 2 North was one nurse and three CNAs but "occasional" call out and that it varies weekdays and weekends. At the same time, LPN#1 stated that the CNA "tries their best to work out if only two CNAs, they start earlier than usual when providing incontinence care to residents." She further stated, "I help with care but I was not assigned to certain or specific residents and I am not in the assignment as a CNA." On 8/29/23 at 8:23 AM, the surveyor interviewed the Registered Nurse/Supervisor (RN/S). The RN/S informed the surveyor that he was the	F 725		

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regular 11-7 shift supervisor. The RN/S stated that he was aware of NJ mandated nurse staffing law, and confirmed that 1 CNA: 14 residents ratio for 11-7 shift. He further stated, "I would say most of the time we are complying with the law unless there is a call out." He further stated that 2 North usual staffing was one nurse and four CNAs. The RN/S informed the surveyor that in the fourth year that he was in the facility, he recommended to the administration that three CNAs were not enough for the 2 North unit because of the "workload" and it was changed from three CNAs to four CNAs. He further stated that lately (he can not remember when it started) there had been three CNAs assigned to the 2 North unit.

On that same date and time, the RN/S stated "It is harder in a weekend for staffing." The RN/S confirmed that on Sunday, 8/27/23, 1 CNA: 28 Residents for 2 North unit 11-7 shift because the census was 56 and there were two CNAs. He further stated, "It was hard for them (CNAs)."

On 8/29/23 at 11:01 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Infection Preventionist Nurse (IPN), and Vice President of Special Clinical Projects (VPoSCP) and were made aware of the above findings.

A review of the 2 North paper list of residents that was provided by the LNHA showed that there were 56 residents in 2 North and 32 out of 56 were incontinent residents.

2. On 8/28/23 at 10:35 AM, the surveyor met with eight residents for a resident council meeting. The surveyor asked the group does staff respond to your call light timely. One resident stated that the regular facility staff would answer the call bell

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within 15 to 30 minutes but that sometimes they would have to wait for one to one and half hours or more and it was worse on the weekends. Five additional residents agreed with the statement.
3. Review of the requested staffing for the weeks of 5/29/2022 to 6/04/2022 showed that the NJDOH Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing for residents on 4 of 7 overnight shifts as follows:

-05/29/22 had 14 CNAs for 121 residents on the day shift, required at least 15 CNAs.
-06/02/22 had 13 CNAs for 114 residents on the day shift, required at least 14 CNAs.
-06/03/22 had 10 CNAs for 114 residents on the day shift, required at least 14 CNAs.
-06/04/22 had 13 CNAs for 114 residents on the day shift, required at least 14 CNAs.

4. On 8/23/23 at 12:00 PM, the surveyor asked the LNHA and the VPoSCP the whereabouts of Resident #263 and the LNHA informed the surveyor that the resident was discharged (d/c).

The surveyor reviewed the medical records of Resident #263 as follows:

The Admission Record (AR; or face sheet; an admission summary) reflected that the resident was admitted to the facility with a diagnosis that included but was not limited to Ex Order 26. 4B1

[redacted] Ex Order 26. 4B1

The admission Minimum Data Set (aMDS), an

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assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of 7/15/22 revealed that the Section C Cognitive Patterns showed a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which indicated that the resident's cognition was *Ex Order 26. 4B1* [redacted]. The aMDS in Section G Functional Status for toilet use was coded [redacted] *Ex Order 26. 4B1* [redacted]

A review of the Detailed Census Report for August 2022 in the electronic medical record (eMR) revealed that Resident #263 was on [redacted] from 7/9/22 through 8/18/22.

Review of the requested staffing for the weeks of 8/14/2022 to 8/20/2022 showed that the NJDOH Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:

-08/14/22 had 8 CNAs for 122 residents on the day shift, required at least 15 CNAs.
-08/15/22 had 11 CNAs for 122 residents on the day shift, required at least 15 CNAs.
-08/16/22 had 12 CNAs for 122 residents on the day shift, required at least 15 CNAs.
-08/17/22 had 9 CNAs for 120 residents on the day shift, required at least 15 CNAs.
-08/18/22 had 10 CNAs for 119 residents on the day shift, required at least 15 CNAs.
-08/19/22 had 12 CNAs for 119 residents on the day shift, required at least 15 CNAs.
-08/20/22 had 9 CNAs for 119 residents on the day shift, required at least 15 CNAs.

5. On 8/6/23 at 10:30 AM, the surveyor asked the

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LNHA and the VPoSCP for any grievances, incidents/accident reports, and reportable events since the last recertification and the facility management stated that they will get back to the surveyor.

The surveyor reviewed the medical records of Resident #4 as follows:

The AR reflected that the resident was admitted to the facility with a diagnosis that included but was not limited to *Ex Order 26. 4B1* and *Ex Order 26. 4B1*

The aMDS with an ARD of 8/16/23 revealed that the Section C Cognitive Patterns showed a BIMS score of [redacted] out of 15 which indicated that the resident's cognition was *Ex Order 26. 4B1*. The aMDS in Section G Functional Status for toilet use was coded *Ex Order 26. 4B1*

A review of the Detailed Census Report in the electronic medical record (eMR) revealed that Resident #4 was on [redacted].

Review of the requested staffing for the weeks of 4/02/2023 to 4/08/2023 showed that the NJDOH Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:

-04/02/23 had 7 CNAs for 112 residents on the day shift, required at least 14 CNAs.
-04/03/23 had 8 CNAs for 111 residents on the day shift, required at least 14 CNAs.

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-04/04/23 had 8 CNAs for 109 residents on the day shift, required at least 14 CNAs.
-04/05/23 had 10 CNAs for 109 residents on the day shift, required at least 14 CNAs.
-04/06/23 had 8 CNAs for 109 residents on the day shift, required at least 14 CNAs.
-04/07/23 had 6 CNAs for 109 residents on the day shift, required at least 14 CNAs.
-04/08/23 had 5 CNAs for 109 residents on the day shift, required at least 14 CNAs.

6. On 8/23/23 at 11:14 AM, Resident #13 was observed sitting in a [redacted], well dressed, the call bell was on the bed adjacent to the resident and conversant.

The surveyor reviewed the medical record for Resident #13.

A review of the AR reflected the resident was admitted to the facility with diagnoses that included [redacted].

The MDS dated 5/21/23 showed a BIMS score of [redacted] out of 15, indicating the resident had a [redacted].

A review of the requested staffing for the weeks of 7/30/23 to 8/5/23 showed that the NJDOH Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:

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F 725	Continued From page 72	F 725		

-07/30/23 had 7 CNAs for 114 residents on the day shift, required at least 14 CNAs.
-07/31/23 had 10 CNAs for 112 residents on the day shift, required at least 14 CNAs.
-08/01/23 had 10 CNAs for 112 residents on the day shift, required at least 14 CNAs.
-08/02/23 had 13 CNAs for 112 residents on the day shift, required at least 14 CNAs.
-08/03/23 had 13 CNAs for 112 residents on the day shift, required at least 14 CNAs.
-08/04/23 had 10 CNAs for 112 residents on the day shift, required at least 14 CNAs.
-08/05/23 had 13 CNAs for 117 residents on the day shift, required at least 15 CNAs.

On 9/5/23 at 12:38 PM, the surveyor telephonically interviewed CNA #4 who recalled being scheduled to the Resident's unit on 8/03/23 with 55 Residents. The CNA informed the surveyor that there were times that she worked and there were only three CNAs and at times a fourth nurse came in later. The CNA also stated it was very hard when we have a call out to get the job done with three nurses, but the job gets done. It is hard with the diaper changes, call bells and residents who need total assistance and every Resident's needs varies.

7. The surveyor reviewed the closed records for Resident #312

A review of the AR revealed the resident was admitted with diagnoses that included [redacted] *Ex Order 26. 4B1*, *Ex Order 26. 4B1* and [redacted] *Ex Order 26.* [redacted].

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F 725	Continued From page 73 According to the aMDS with an ARD of 7/05/22, Resident #312 was documented as having a BIMS score of [redacted] out of 15, indicating that the resident had a [redacted]. Further review of the MDS, section M Skin Conditions revealed the resident had [redacted]. The resident had [redacted] for the chair and bed [redacted] and [redacted] were present to manage [redacted] were applied. A review of the requested staffing for the weeks of 7/17/22 to 7/30/22 showed that the NJDOH Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows: -07/17/22 had 7 CNAs for 115 residents on the day shift, required at least 14 CNAs. -07/18/22 had 12 CNAs for 111 residents on the day shift, required at least 14 CNAs. -07/19/22 had 9 CNAs for 109 residents on the day shift, required at least 14 CNAs. -07/21/22 had 12 CNAs for 109 residents on the day shift, required at least 14 CNAs. -07/22/22 had 12 CNAs for 109 residents on the day shift, required at least 14 CNAs. -07/23/22 had 8 CNAs for 115 residents on the day shift, required at least 14 CNAs. -07/24/22 had 9 CNAs for 115 residents on the day shift, required at least 14 CNAs. -07/26/22 had 12 CNAs for 116 residents on the day shift, required at least 14 CNAs. -07/27/22 had 10 CNAs for 113 residents on the	F 725		

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F 725	Continued From page 74 day shift, required at least 14 CNAs. -07/28/22 had 11 CNAs for 113 residents on the day shift, required at least 14 CNAs. -07/29/22 had 7 CNAs for 111 residents on the day shift, required at least 14 CNAs. -07/30/22 had 5 CNAs for 111 residents on the day shift, required at least 14 CNAs. On 9/8/23 at 8:35 AM, during an interview with the surveyor CNA #5 stated she had worked in facility for about 6 years. She could not recall Resident #312 who was in the facility over a year ago. CNA#4 stated she cared for 24 to 28 residents with another CNA although sometimes there was three CNAs in the unit. CNA#4 admitted to knowing the mandated ratio and that the supervisors and administrator were aware of the staffing shortages *Ex Order 26. 4B1* [redacted]. A review of the facility provided Staffing, Sufficient and Competent Nursing Policy that was provided by the LNHA with a revised date of August 2022 included our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. Included in the Policy Interpretation and Implementation that minimum staffing requirements imposed by the state, if applicable, are adhered to when determining staff ratios but are not necessarily considered a determination of sufficient and competent staffing. A review of the facility provided Facility Assessment Tool with a QA (Quality Assurance)	F 725		

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F 725	Continued From page 75 committee reviewed January 2023 that was provided by the VPoSCP included that a staffing plan has been developed to meet the professional, technical, and administrative needs of the center. The plan is informed by historical experience and projected changes. The approach takes into consideration both the type of staff (licensure or other credential) and the number required. The attachment included the Daily Staffing Schedule Week #1 for [redacted] with approximately a census of 61 residents for 11-7 shifts for two nurses and four CNAs. On 9/08/23 at 01:32 PM, the survey team met with the LNHA, DON, and VPoSCP. There was no additional information provided by the facility management, and the facility did not refute findings.	F 725		
F 732 SS=D	N.J.A.C. 8:39-27.1(a) Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.	F 732		9/19/23

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F 732	Continued From page 76 §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that the 24-hour staffing report that was posted was up to date and provided an accurate information. This deficient practice was evidenced by the following: On 8/23/23 at 8:56 AM, the survey team entered the facility and observed that the 24-hour staffing report that was posted was dated 8/18/23. The staffing report was not up to date. On 8/28/23 at 6:30 AM, two surveyors entered the facility and observed that the 24-hour staffing	F 732	Direct care staffing numbers with correct census were immediately updated and posted in the reception area. All residents have potential to be affected. The staffing coordinator and receptionist were educated on daily Posting Requirements of staffing data. An audit of direct care staffing numbers was conducted for an including the dates of 8/18/23 through 9/6/23. Census was corrected, if needed. Director of nursing (or designee) will conduct an audit the posting of the daily direct care numbers for the Center, daily x	

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F 732	Continued From page 77 report that was posted was dated 8/25/23 and that the census listed was 118. The staffing report was not up to date. On 8/28/23 at 7:35 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) to provide a copy of Resident Census from Friday, Saturday, Sunday, and Monday. On 8/28/23 at 8:11 AM, the LNHA provided a copy of the facility census from Friday through Monday as follows: Date: 8/25/23; Census: 121 Date: 8/26/23; Census: 121 Date: 8/27/23; Census: 122 Date: 8/28/23; Census: 122 The 24-hour staffing report that was posted on 8/23/23 that was dated 8/18/23 had an inaccurate census listed. On 8/28/23 at 9:50 AM, the surveyor interviewed Staffing Coordinator (SC) regarding the posting of the 24-hour staffing report. The SC stated that she does the posting on Friday for the weekend and Monday and that she tried to project the census. She added that the receptionist would try to help out and would update the census number. The surveyor asked the SC if the 24-hour staffing report that was posted should be up to date. The SC stated that the expectation was for the posting to be up to date. On 8/31/23 at 01:21 PM, in the presence of the survey team, the surveyor notified the LNHA, Assistant Director of Nursing/Infection Preventionist Nurse (ADON/IPN) and the Vice President of Special Clinical Projects (VPoSCP) the concern that the 24-hour staffing report that was posted on 8/23/23 and 8/28/23 was not up to	F 732	1 week, then weekly x 4 weeks, and monthly x 3 months. Report to QAPI monthly x 3 months.	

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F 732	Continued From page 78 date and that the 24-hour staffing report that was posted on 8/25/23 was not accurate. On 9/06/23 at 10:48 AM, the survey team met with the LNHA, ADON/IPN, Director of Nursing and VPoSCP. The VPoSCP stated that they would audit and check the posting and provided copies of corrected census. She added that she educated the receptionist and SC regarding the importance of reporting the correct number. A review of the facility provided policy titled, "Posting Direct Care Daily Staffing Numbers" with a revised date of August 2022 included the following: Policy Statement Our facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents. Policy Interpretation and Implementation 1. Within two (2) hours of the beginning of each shift, the number of Licensed Nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs and NAs) directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. 2 ....Shift staffing information is recorded on a form for each shift. The information recorded on the form shall include the following: a. The name of the facility; b. The current date (the date for which the information is posted); c. The resident census at the beginning of the shift for which the information is posted; d. Twenty-four (24)-hour shift schedule operated by the facility; e. The shift for which the information is posted;	F 732		

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F 732	Continued From page 79 f. Type (RN, LPN, LVN, or CNA) and category (licensed or non-licensed) of nursing staff working during that shift who are paid by the facility (including contract staff); g. The actual time worked during that shift for each category and type of nursing staff; and h. Total number of licensed and non-licensed nursing staff working for the posted shift. 3. Within two (2) hours of the beginning of each shift, the charge nurse or designee computes the number of direct care staff and completes the Nursing Staffing Information form. The charge nurse completes the form and posts the staffing information in the location(s) designated by the administrator. 4. The form may be typed or handwritten ... N.J.A.C. 8:39-41.2 (a)(b)(c)	F 732		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a 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	F 756		9/20/23

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F 756	Continued From page 80 separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of the facility provided documents, it was determined that the facility failed to act upon the recommendations in the monthly Medication Regimen Reviews (MRR) identified irregularities of the Consultant Pharmacist's (CP's) for one (1) of three (3) residents, (Resident #110) reviewed for closed records. This deficient practice was evidenced by the following: The surveyor reviewed Resident #110's medical records. The resident's Admission Record (or face sheet; admission summary) reflected that the resident	F 756	Resident #110s medical record was reviewed. Resident is no longer at the facility. All residents with recommendations on the drug regimen review to act on irregularities have potential to be affected. Resident #110 is no longer in the facility. All residents with orders for Ex Order 26. 4B1 medications have been audited for a 14 day limit on all as needed/PRN Ex Order 26. 4B1 orders. All residents with as needed (prn) orders for Ex Order 26. 4B1 have been audited to clarify sequencing for as needed PRN Ex Order 26. 4B1 orders. Hospice nurses educated on appropriate	

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F 756	Continued From page 81 was admitted to the facility and had diagnoses that were not limited to *Ex Order 26. 4B1* [redacted]. A review of the resident's Minimum Data Set (MDS), an assessment tool used to facilitate the management of care showed that the resident had no most recent admission MDS (aMDS) and quarterly MDS (qMDS) because the resident was in the facility for a total of 6 (six) days and did not require to have an aMDS and qMDS. The electronic medical records dated 7/07/23 showed that the MDS 3.0 Brief Interview for Mental Status (BIMS) assessment revealed that Resident #110's BIMS score was [redacted] which indicated that the cognitive status was *Ex Order 26. 4B1* [redacted]. The Order Summary Report (OSR) active orders as of 7/06/23 showed that the resident had an order of *Ex Order 26. 4B1* [redacted] *Ex Order 26. 4B1* [redacted] to give *Ex Order 26. 4B1* sublingually every 6 (six) hours (hrs) as needed (PRN) for [redacted] and may repeat dose x 1 (one) in 30 minutes (mins), *Ex Order 26. 4B1* with an order date of 7/05/23. The OSR also included an active order for *Ex Order 26. 4B1* [redacted] to give *Ex Order 26. 4B1*	F 756	recommendation for sequencing as needed/PRN medication orders. The Director of Nursing (or designee) will conduct 3 audits per week x 4 weeks of Intermediate Medication Review Recommendations from the consulting pharmacist, then monthly x 3 months, with report to QAPI.	

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F 756	Continued From page 82 sublingually every 1 (one) hr PRN for Ex Order 26. 4B1 [redacted], Ex Order 26. 4B1, may repeat dose x 1 (one) in 30 mins if ineffective. The above order for NJ Exec. Order 26:4.b.1 was transcribed to the electronic Medication Administration Record (eMAR) for July 2023 with no stop date. The above order for NJ Exec. Order 26:4.b.1 was transcribed to the July 2023 eMAR and signed by nurses that it was administered on 7/08/23 one time, 7/09/23 twice, and 7/10/23 twice. A review of the CP's MRR dated 7/07/23 revealed that the CP recommended the following: A. To re-evaluate the resident's PRN Ex Order 26. 4B1 order. CMS (Centers for Medicare and Medicaid Services) phase two regulations required a 14 day limit on all PRN Ex Order 26. 4B1 orders regardless of the indication of use. If this medication should continue please specify the rationale and its duration. B. To clarify the sequencing of Ex Order 26. 4B1 every one hour indicated for PRN Ex Order 26. 4B1. Further review of the medical records of the resident showed that the above CP's MRR recommendations were not followed and there was no documentation why the recommendations were not followed. On 8/30/23 at 10:22 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM). The RN/UM informed the surveyor that it was the nurse's responsibility to notify the physician of the CP's recommendations, obtain orders from the physician according to the CP's	F 756		

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F 756	Continued From page 83	F 756		

recommendations, transcribe the orders to the eMAR and/or electronic Treatment Administration Record (eTAR), and document in the progress notes the reason why the physician did not agree with the CP's recommendations.

At that same time, the surveyor notified the RN/UM of the above concerns and findings. The RN/UM informed the surveyor that Resident #110 was a resident in Ex Order 26. 4B1 and remembered the resident as a Ex Order 26. 4B1 resident in the facility. The RN/UM stated that the order for Morphine PRN for Ex Order 26. 4B1 should have been separated and followed the recommendation of the CP. He further stated that the nurse should have clarified and notified the doctor to put a separate order for PRN Ex Order 26. 4B1 for Ex Order 26. 4B1.

On 8/30/23 at 11:16 AM, the surveyor in the presence of another surveyor met with the Licensed Nursing Home Administrator (LNHA) and Vice President of Special Clinical Projects (VPoSCP) and were notified of the above findings. The VPoSCP stated that as a facility practice, it was the responsibility of the nurse, specifically the Unit Manager to review the monthly MRR of the CP, follow up with the recommendations, call the physician, and document if the physician declined the recommendations. She further stated that there should be a 14 day stop date for all Ex Order 26. 4B1 medications including Ex Order 26. 4B1 residents. The VPoSCP stated that the recommendation for sequencing PRN Ex Order 26. 4B1 for Ex Order 26. 4B1 should have been followed.

On 8/30/23 at 12:49 PM, the surveyor interviewed Licensed Practical Nurse #1 (LPN#1). The LPN confirmed that she was the nurse who

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F 756	Continued From page 84	F 756		

administered PRN [redacted] to the resident on 7/10/23 at 11:35 AM for [redacted]. She further stated that there should be a separate order written for PRN [redacted] for [redacted]. The surveyor then asked the LPN if she called the physician at the time she administered the PRN [redacted] to clarify the order, and LPN#1 stated that she could not remember, [redacted] She further stated that it was not her responsibility to respond to CP's monthly MRR and that it was the Unit Manager's or the Supervisor's responsibility.

On 8/31/23 at 12:29 PM, the survey team met with the VPoSCP and the [redacted] Nurse (IPN), and later on, the LNHA joined the meeting. The VPoSCP stated that the RN/UM was not aware that the resident on [redacted] with PRN [redacted] medications should also have a 14 days stop date. She further stated that PRN [redacted] of Resident #110 should have separated the order for [redacted] as recommended by the CP. The VPoSCP acknowledged that the CP's recommendations on 7/07/23 should have been acted upon for Resident #110's PRN [redacted] to have a stop date on day 14 and to sequence the PRN [redacted] for [redacted].

On 9/05/23 at 01:32 PM and 9/06/23 at 8:22 AM, the surveyor called and left a message to the Registered Nurse (RN), the RN who administered the PRN [redacted] on 7/09/23 at 02:07 AM and 7/10/23 at 01:07 AM. The RN did not call back.

A review of the facility provided MRR Policy with a revised date of May 2019 that was provided by the VPoSCP included that the CP reviews the medication regimen of each resident at least

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CAREONE AT ORADELL	**600 KINDERKAMACK ROAD ORADELL, NJ 07649**

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F 756	Continued From page 85 monthly. 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: incorrect medications, administration times or dosage forms; or other medication errors, including those related to documentation. A review of the facility provided *Ex Order 26. 4B1* Medication Policy with a revised date of 9/06/18 that was provided by the VPoSCP included that the CP shall regularly review and assess the *Ex Order 26. 4B1* of residents on these medications and will compile, analyze, and present data related to *Ex Order 26. 4B1* medication use in the facility. The need to continue PRN orders for *Ex Order 26. 4B1* medications beyond 14 days requires that the practitioner document the rationale for the extended order. The duration of the PRN order will be indicated in the order. On 9/06/23 at 10:48 AM, the survey team met with the VPoSCP, IPN, Director of Nursing, and Licensed Nursing Home Administrator. The facility management had no additional information about the concern above.	F 756		
F 759 SS=D	NJAC 8:39- 29.3 (a)(1) Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced	F 759		9/19/23

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F 759	Continued From page 86 by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication observation conducted on 8/28/23, the surveyor observed four nurses administer medications to sixteen residents. There were 25 opportunities, and two errors were observed which resulted in a medication error rate of 8%. This deficient practice was identified for one (1) of three (3) residents, that was administered by one (1) of three (3) nurses. This deficient practice was evidenced by the following: A review of the manufacturer's specifications for *Ex Order 26. 4B1* reflected that the medication was to be administered with or immediately following a meal. A review of the manufacturer's specifications for *Ex Order 26. 4B1* reflected "should be taken with meals and with glass of water or other liquid. This product should not be taken on an empty stomach because of its potential for *Ex Order 26. 4B1*. During the initial tour on 8/23/23 at 10:16 AM, the surveyors interviewed the Assistant Director of Nursing (ADON)/ Registered Nurse/Infection Preventionist (IPN) who stated she was filling in as the charge nurse on the second floor. The surveyors asked the ADON/IPN for the mealtimes on the floor, The ADON/IPN stated the mealtimes were from 8:00 AM to 8:30 AM. On 8/28/23 at 8:25 AM, the surveyor observed	F 759	It is the policy of Care One at Oradell that all residents are free from medication error. Resident #64's medications were administered as soon as the breakfast tray was provided to the resident. All residents who take *Ex Order 26. 4B1* have potential to be affected. The nurse was educated to read the cautionary prior to administration of the medication. All nurses were educated to read cautionaries and acknowledge manufacturer specifications prior to administration of medication. Pharmacy consultant will conduct three medication competency per month for nursing staff. DON/ADON (or designee) will conduct audits of all residents who are taking *Ex Order 26. 4B1* to ensure cautionaries are included in the order, weekly x 4 weeks, then monthly x 3 months with report to QAPI. DON/ADON (or designee) will conduct audits for 3 nurses per week to ensure cautionaries are being carefully read and adhered to, weekly x 4 weeks, then monthly x 3 months with report to QAPI.	

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F 759	Continued From page 87 the Licensed Practical Nurse (LPN) prepare medications for Resident #64. The medications included the following: -Ex Order 26. 4B1, 1 tablet by mouth two times a day for heartburn for Ex Order 26. 4B1 administer 30 minutes before meals. Start date of 5/19/23. -Ex Order 26. 4B1, 2 tablet s by mouth one time a day for NJ Exec. Order 26:4.b.1. Start date of 8/28/23 Ex Order 26. 4B1, 1 capsule by mouth one time a day for Ex Order 26. 4B1. Start date of 5/19/23. -Ex Order 26. 4B1, 1 tablet by mouth two times a day for Ex Order 26. 4B1, monitor for NJ Exec. Order 26:4.b.1, and NJ Exec. Order 26:4.b.1. Start date of 5/19/23. -Ex Order 26. 4B1, 1 tablet by mouth one time a day for Ex Order 26. 4B1. Start date of 5/19/23. -Ex Order 26. 4B1, give 1 tablet by mouth two times a day for Ex Order 26. 4B1. Start date of 5/19/23. -Ex Order 26. 4B1, 1 tablet by mouth one time a day for Ex Order 26. 4B1. Do not crush or chew. Take with a meal. Take with plenty of water. Start date of 5/19/23. At 8:34 AM, the LPN confirmed she had eight (8) medications in the cup and was ready to administer the medications to Resident #54. At 8:36 AM, the surveyor did not observe the breakfast trays in the resident's room. In the presence of the LPN, the resident informed the	F 759		

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F 759	Continued From page 88	F 759		

surveyor that he/she had not received breakfast that morning. The LPN proceeded towards the resident to administer the medications to the resident. The surveyor stopped the LPN and asked to speak with the LPN outside the resident's room.

At 8:37 AM, during an interview with the surveyor, the LPN stated, "the meal truck for this hallway is not here".

At that time, the surveyor, and the LPN reviewed the resident's electronic Medication Administration Record (eMAR) and the bingo card (a multidose card containing individually packaged medications) together.

The eMAR revealed that Ex Order 26. 4B1 was scheduled to be administered at 9:00 AM and 5:00 PM.

The bingo card had an affixed cautionary label that indicated *Ex Order 26. 4B1* .

The eMAR also revealed that Ex Order 26. 4B1 was scheduled to be administered at 9:00 AM and had instructions for administration that included Ex Order 26. 4 .

The bingo card for the Ex Order 26. 4B1 had an affixed cautionary label *Ex Order 26. 4B1*

At that time, after reviewing the eMAR and the bingo cards with the surveyor, the LPN stated that *Ex Order 26. 4B1* should not be taken on an empty stomach because of stomach irritation could occur and that she was unsure if taking a medication on an empty stomach affected the

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absorption of the medication. The LPN confirmed her medication administration error could have been prevented by reading the cautionary on the eMAR and the bingo card.

At 8:43 AM, in the presence of the surveyor the LPN removed the *Ex Order 26. 4B1* from the cup and disposed of the medication in the liquid drug disposal system and proceeded to continue the medication pass.

The surveyor reviewed the medical record for Resident #64.

A review of the resident's Admission Record (an admission summary) reflected that Resident #293 was admitted to the facility with diagnoses that included but were not limited to *Ex Order 26. 4B1* .

According to the admission Minimum Data Set, an assessment tool used to facilitate management of care dated, 8/9/23, Resident #293 was documented as having a Brief Interview for Mental Status score of [redacted] out of 15, indicating the resident was *Ex Order 26. 4B1* .

On 8/29/23 at 11:01 AM, in the presence of the survey team, Vice President of Special Clinical Projects (VPoSCP), ADON/IPN and Licensed Nursing Home Administrator (LNHA), the surveyor discussed the concerns regarding the medication pass errors observed.

On 8/31/23 at 12:29 PM, in the presence of the survey team, the LNHA, and the ADON/IPN, the VPoSCP stated the nurse was educated to read

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F 759	Continued From page 90 the cautionary prior to administration. The VPoSCP stated the meal truck arrived at 8:40 AM. The VPoSCP acknowledge that manufacturer specifications should be considered. A review of the facility provided policy, edited 5/21/19 included the following: Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: 4. medications are administered in accordance with prescriber orders, including any required time. 5. Medication Administration times are determined by resident need and benefit not staff convenience. Factors are considered include: a. enhancing optimal therapeutic effective medication b. preventing potential medication or food interaction. 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, comma before and after meal orders). 8. If a dosage is believed to be inappropriate or excessive for a resident or a medication has been identified as having potential adverse consequences for the resident or suspected of being associated with an adverse consequences, the person preparing or administering the medication will contact the prescriber, the residents attending physician or the facilities medical director to discuss the concerns. N.J.A.C. 8:39-29.2 (d)	F 759		

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F 880	Continued From page 91	F 880		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		9/18/23

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F 880	Continued From page 92 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility provided documents, it was determined that the facility failed to ensure: a) appropriate use of personal protective equipment (PPE) for two (2) of four (4) staff observed during meal observation and b) appropriate hand hygiene practice for one (1) of two (2) staff observed during treatment observation according to facility policy and Centers for Disease Control	F 880	It is the policy of the Care One at Oradell that Infection control and prevention are sustained for the safety and wellbeing of all residents. Residents #22 and #31 were not negatively affected using personal protective equipment (PPE) in the dining room.	

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F 880	Continued From page 93 and Prevention (CDC) guidelines. This deficient practice was evidenced by the following: According to the CDC, Hand Hygiene in Healthcare Settings, last reviewed on January 30, 2020, Hand Hygiene Guidance, The Core Infection Prevention and Control Practices for Safe Care Delivery in All Healthcare Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) include the following strong recommendations for hand hygiene in healthcare settings. Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a patient Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices Before moving from work on a soiled body site to a clean body site on the same patient After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal. 1. On 8/23/23 at 9:05 AM, the survey team entered the facility and was instructed by the Receptionist to use the alcohol-based hand rub (ABHR) for hand hygiene and to sign in the paper log. The Receptionist informed the surveyors that there were Ex Order 26. 4B1 residents in the building in Ex Order 26. 4B1 There were posted signs for Ex Order 26. 4B1 etiquette, Ex Order 26. 4B1 information, and area for hand hygiene.	F 880	Resident #79 had no untoward effects related to the nurse's hand hygiene practice during treatment. All residents eating meals in the dining room have potential to be affected. All residents receiving wound care have potential to be affected. The Recreation Director was educated to not wear gloves in the dining room while residents are eating. The Activity Assistant was educated to not wear gloves in the hallway. All staff were educated on the proper use of personal protective equipment (PPE). The nurse was educated on Hand Hygiene Guidance for hand hygiene in healthcare settings. All staff were educated on Hand Hygiene guidance including the use of alcohol-based hand rub or washing with soap and water. The Infection Preventionist (or designee) will conduct random hand hygiene audits of five staff, three times per week x 4 weeks, then monthly x 3 months, with report to QAPI monthly x 3 months. The hand hygiene audits will be conducted randomly during treatment observation, in the dining room, during medication and care observations.	

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F 880	Continued From page 94 On that same date and time, the Director of Nursing (DON) accompanied the survey team in the conference room. The DON informed the surveyors that two residents in Ex Order 26. 4B were hospital-acquired *Ex Order 26. 4B1* . On 8/30/23 at 8:30 AM, the surveyor observed the 1st-floor Private Dining room with residents assisted by staff for breakfast. Table two with two residents (Residents #22 and #31) assisted by the Recreation Director (RD) with gloves in use. The two residents were eating breakfast with food and drinks on their table. The surveyor and the RD went outside the dining area. While in the hallway, both the surveyor and the RD observed the Activity Assistant (AA) with both gloves in use. During an interview, both the RD and AA informed the surveyor that they (RD and AA) received an infection control education including appropriate use of PPE included use of gloves. The RD stated that gloves should not be used in the hallway. On 8/30/23 at 8:35 AM, the surveyor interviewed the RD in the conference room. The RD informed the surveyor that she was educated and forgot the name who told her that she could use gloves while clearing tables, that was why "I have the gloves on." On 8/30/23 at 9:48 AM, the surveyor interviewed the Infection Preventionist Nurse (IPN) in the presence of another surveyor regarding hand hygiene and the use of gloves in the dining area and hallway. The surveyor notified the IPN of the above findings regarding dining observation during breakfast.	F 880		

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On that same date and time, the IPN stated that the RD should not wear gloves while residents are being served and still eating. She further stated that staff should not wear gloves in the hallway according to facility practice.

On 8/30/23 at 11:16 AM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and Vice President of Special Clinical Projects (VPoSCP) in the presence of another surveyor. The surveyor also notified the facility management regarding the concern with the 1st floor Private Dining Room during breakfast observation.

On 8/31/23 at 12:29 PM, the survey team met with the VPoSCP and IPN, later on, the LNHA joined the meeting. The VPoSCP stated that gloves should not be worn in the dining area while residents were eating and in the hallway.

A review of the provided Assistance with Meals Policy by the VPoSCP with a revised date of March 2022 included that all employees who provide resident assistance with meals will be trained and shall demonstrate competency in the prevention of foodborne illness, including personal hygiene practices and safe food handling.

2. On 8/31/23 at 10:49 AM, the surveyor observed Ex Order 26. 4B1 NJ Exec. Order 26 4.b.1 being performed by the Licensed Practical Nurse (LPN). During the Ex Order 26. 4B1 NJ Exec. Order 26:4.b.1, she removed the NJ Exec. Order 26:4.b.1 [redacted], NJ Exec. Order 26:4.b.1 [redacted] support pillow that was previously on the resident's bed. There was no Ex Order 26. 4B1 applied to the pillow top to stop

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F 880		F 880		

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contamination from used pillow to clean [redacted].

The surveyor reviewed Resident #79's medical record.

The resident's Admission Record (or face sheet; an admission summary) reflected that the resident was admitted to the facility with a diagnosis that included but were not limited to [redacted]

The most recent admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date of 7/20/23 and with a brief interview for mental status (BIMS) score of [redacted] of 15 which reflected that the resident's cognitive status was [redacted].

A review of the care plan, dated 5/04/23, had a focus for [redacted]

A review of the order summary report, dated August 2023, revealed: [redacted]

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F 880	Continued From page 97 On 09/07/23 at 12:24 PM the surveyor interviewed the IPN in presence of another surveyor. The IPN stated, *Ex Order 26. 4B1* [redacted] On 9/08/23 at 01:32 PM, the survey team met for an Exit Conference with LNHA, DON, and VPoSCP. The facility management had no additional information provided and did not refute the findings.	F 880		
F 882 SS=D	NJAC 8:39-19.4 (a)(1) 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; §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.	F 882		9/18/23

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	315339	A. BUILDING _____ B. WING _____	C 09/08/2023

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F 882	Continued From page 98 This REQUIREMENT is not met as evidenced by: Based on the interview and review of pertinent facility documents, it was determined that the facility failed to ensure: a) the designated Infection Preventionist (IP) dedicated solely to the infection prevention and control program (IPCP) for one (1) of one (1) staff and b) the IP participated in Quality Assurance Performance Improvement (QAPI) for two (2) of three (3) quarters reviewed QAPI in accordance with the facility policy and Centers for Medicare and Medicaid Services (CMS) and New Jersey (NJ) guidelines. This deficient practice was evidenced by the following: According to the NJ Executive Directive 21-012 (revised 12/22/22) included "ii. The facility's designated individual(s) with training in infection prevention and control shall assess the facility's IPCP by establishing or revising the infection control plan, annual infection prevention and control program risk assessment, and conducting internal quality improvement audits." According to the CMS QSO-22-19-NH Memo dated 6/29/22 and Fact Sheet, Updated Guidance for Nursing Home Resident Health and Safety dated 6/29/22, effective date on October 24, 2022 Overview of New and Updated Guidance, Summary of Significant Changes, included that in Infection Control, requires the facilities to have a part-time IP. While the requirement is to have at least a part-time IP, the IP must meet the needs of the facility. The IP must physically work onsite and cannot be an off-site consultant or work at a separate location. IP's role is critical to mitigating	F 882	No residents were identified as being negatively affected by this practice. All residents have potential to be affected. The Infection Preventionist (IP) was educated on the primary functions of her role. The IP provided the QAPI reports for the quarterly meetings including: 2/2/23 and 7/20/23. The Director of Nursing's date of hire was 8/17/23; the IP returned to her primary role as Infection Preventionist on that date. The Director of Nursing (or designee) will ensure the duties of the Infection Preventionist are in accordance with CFR(s): 483.80(b)(1)-(4). The Director of Nursing (or designee) will conduct an audit of the IP role and duties weekly x 4 weeks, then monthly x 3 months with report to QAPI monthly x 3 months.	

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F 882	Continued From page 99	F 882		

infectious diseases through an effective infection prevention and control program. IP specialized training is required and available.

On 8/23/23 at 10:11 AM, the surveyor met with the Licensed Nursing Home Administrator (LNHA), and the Director of Nursing (DON) during an entrance conference. The DON informed the surveyor that the facility had a full-time Infection Preventionist Nurse (IPN) and completed the required training and certificate of an IP. He further stated that the IPN was a Registered Nurse.

A review of the signed job description of the IPN that was provided by the LNHA showed that she was hired on 3/31/21 and started as IPN on 01/01/23.

A review of the facility provided QAPI Meeting Attendance sign-in sheet by the LNHA for the last three (3) quarters revealed the following:

-02/02/23=there was no IP in the meeting
-4/20/23=IP was present in the meeting
-7/20/23=the IPN was the designated DON and there was no IP in the meeting

Further review of the 7/20/23 QAPI Meeting Attendance sign-in sheet showed that there were no Unit Managers (UMs) and ADON in the meeting.

On 8/29/23 at 8:23 AM, the surveyor interviewed the Registered Nurse/Supervisor (RN/S) for the 11-7 shift. The RN/S informed the surveyor that the IPN had multiple job responsibilities at the facility that included "deals with narcotic (controlled medications) stuff, audit orders of

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F 882	Continued From page 100	F 882		

residents, and she does infection control." The RN/S stated that the IPN also provided education about infection control, and other mandatory in-services "like" abuse, pain, and falls. He further stated that the IPN had been performing the responsibility of a UM in 2 South because "we lost the UM." The RN/S stated that "approximately a month ago" when the previous UM left and the IPN took over to help.

On 8/29/23 at 8:59 AM, the surveyor in the presence of another surveyor interviewed the IPN. The IPN informed the surveyors that she started as a UM in the 2 South unit on 8/31/21 and as an IPN on January 2023. The IPN stated that the previous DON (pDON) left the facility on June 2023 and she was the acting DON when the pDON left. She further stated that when she was the acting DON at that time (June 2023) there was no covering IP. The IPN also stated that the previous Assistant Director of Nursing (pADON) left July 2023 and that when she (IPN) was the acting DON there was no ADON.

On that same date and time, the IPN informed the surveyors that the previous IPN (pIPN) left the facility in August 2021 and "I think" it was the pDON who took the responsibility of an IP (pDON) until she (IPN) started to be the new IP on January 2023.

At that same time, the IPN informed the surveyors that the UM in the 2 South unit left in July this year (unable to state the exact date), and "everyone was pitching in," to help. The IPN acknowledged that as an IP, she was doing more responsibilities other than as an IP.

Furthermore, the IPN informed the surveyors that

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F 882	Continued From page 101	F 882		

it was her responsibility to attend the QAPI meeting and that she was aware that she was one of the key person who should be present in the meeting according to CMS regulations. The IPN confirmed that there was no IP on 02/20/23 in the QAPI meeting because she was on vacation at that time. She further confirmed that on 7/20/23 there was no IP in the QAPI meeting because she was the acting DON at that time. She acknowledged that there was no ADON in the 7/20/23 meeting as well.

On 8/29/23 at 11:01 AM, the survey team met with LNHA, IPN, and VPoSCP and were made aware of the above findings. The VPoSCP acknowledged the above findings. The VPoSCP further stated that she was aware of the regulation that the IP should be dedicated solely to the IPCP, and did not refute the findings regarding the IPN.

A review of the facility provided Infection Preventionist Policy that was provided by the LNHA with a revised date of September 2022 did not include the requirement that based upon the assessment, facilities should determine if the individual functioning as the IP should be dedicated solely to the IPCP.

On 8/30/23 at 12:10 PM, The VPoSCP informed the surveyor that the pDON's last day of work was on 6/14/23.

A review of the provided last two weeks Time & Attendance-Employee Punch History of the pDON and pADON showed the following:

From 5/29/23 through 6/14/23=the pDON did not work on 6/02/23, 6/08/23, and 6/14/23

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F 882	Continued From page 102 From 6/26/23 through 7/07/23=the pADON (also the facility's Wound Care Nurse) did not work on 6/26/23 and 6/30/23 Further review of the above Time & Attendance-Employee Punch History showed that the pDON last day of work week was on 6/14/23 and the pADON's last day of work week was on 6/30/23. On 9/08/23 at 01:32 PM, the survey team met for an Exit Conference with LNHA, DON, and VPoSCP. The facility management had no additional information provided and did not refute the findings.	F 882		
F 944 SS=D	NJAC 8:39-19.1(b) QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure facility staff had mandatory training that outlined and informed staff of the elements and goals of the facility's QAPI (quality assurance and performance improvement) program for two (2) of five (5) Certified Nurse Assistants (CNAs) reviewed for mandatory education.	F 944	No residents were identified as being negatively affected by this practice. All residents have potential to be affected. CNA#1 and CNA#2 have received education on the facility□s QAPI program. All staff have been educated on the facility□s QAPI program. Audit conducted of CNA□s mandatory annual education requirements.	10/5/23

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F 944	Continued From page 103 This deficient practice was evidenced by the following: On 9/01/23 at 9:09 AM, the surveyor reviewed the annual in-service education hours for five randomly selected CNA files, which were provided by the facility. The Staff In-service Logs showed the following: CNA #1 had a hire date of 3/14/18. According to the "Training Hours" Transcripts, CNA #1 did not have QAPI training. CNA #2 had a hire date of 7/22/19. According to the "Training Hours" Transcripts, CNA #1 did not have QAPI training. On 9/01/23 at 10:45 AM, the surveyor interviewed the Facility Educator/Registered Nurse (FE/RN) regarding the process for CNA education. The FE/RN stated that they have 12 hours of mandatory continuing education. She stated that some was done every month on site but that they also have some assigned in a computer system but that some are listed as offline. On 9/06/23 at 10:48 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Assistant Director of Nursing/Infection Preventionist Nurse (ADON/IPN) and the Vice President of Special Clinical Projects (VPoSCP) and notified the facility administration of the concern that two (2) of the five (5) CNAs did not have education for the topic of QAPI. On 9/08/23 at 12:21 PM, in the presence of the survey team, the VPoSCP stated that the two CNAs did not have QAPI in-services and that they should have had the in-services. A review of the facility provided policy titled,	F 944	The Administrator (or designee) will monitor on-going education on the facility□s QAPI program, weekly x 4 weeks, then monthly x 3 months, with report to QAPI monthly x 3 months.	

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F 944	Continued From page 104 "In-Service Training, Nurse Aide" with a revised date of August 2022, included the following: Policy Interpretation and Implementation 1. All personnel are required to participate in regular in-service education ... 4. Annual in-services: ... 9. Required training topics for all staff (including nurse aides) include: ... d. quality assurance and performance improvement (QAPI); ... N.J.A.C. 8:39-33.1	F 944		

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint # NJ00154889, NJ00155283, NJ00156726, NJ00157351, NJ00163185, NJ00166154 Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift and evening shift as mandated by the State of New Jersey. The facility was deficient in CNA (Certified Nursing Aide) staffing for the following weeks as follows: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for	S 560	Nursing leadership team met and continues to meet on an on-going basis and continues to identify staffing challenges and areas of improvement and recruitment for certified nursing assistants necessary to maintain the required minimum direct care to staff rations as required. All residents have potential to be affected. Residents #4, #32, #233 and #235 were assessed and found to be NJ Exec. Order 26:4.b.1 during Ex Order 26. 4B1 rounds by the surveyor and LPN#1. All Ex Order 26. 4B1 residents were assessed by nursing and found to be NJ Exec. Order 26:4.b.1	9/18/23

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

Electronically Signed | 09/28/23

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S 560	Continued From page 1 nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. As per the "Nurse Staffing Report" completed by the facility for the week of staffing from 5/29/2022 to 6/04/2022, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows: -05/29/22 had 14 CNAs for 121 residents on the day shift, required at least 15 CNAs. -06/02/22 had 13 CNAs for 114 residents on the day shift, required at least 14 CNAs. -06/03/22 had 10 CNAs for 114 residents on the day shift, required at least 14 CNAs. -06/04/22 had 13 CNAs for 114 residents on the day shift, required at least 14 CNAs. 2. As per the "Nurse Staffing Report" completed	S 560	To ensure that the problem of staffing does not recur: *CNA class approved for this facility and commenced on 9/12/23 with goal to offer 10 candidates free Certified Nursing Assistant courses in preparation to sit for the PSI Certified Nursing Assistant examination. The 5-week course will continue to be offered every 6 weeks, on-going. As an encouragement, students that signed up for the class, will be paid on hourly basis to complete the class. *Nursing agency usage as needed to assist in filling open positions. * The facility has implemented a significant above-market rate increase for nurses and certified nursing assistants. Incentives are offered which include tuition reimbursement, sign-on bonus, employee referral program. The facility continues to offer job fairs with on-the-spot interviews as well as walk-in applicants and could expedite contingency offers at the time of interview. Staffing plan developed to meet the professional, technical, and administrative needs of the center. The plan is based on historical experience and projected changes. Director of Nursing (or designee) and Administrator (or designee) will review staffing ratios daily and document a weekly review of the daily staffing x 4 weeks, then twice monthly x 3 months. Staffing audits will be presented to the	

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S 560	Continued From page 2 by the facility for the two weeks of staffing from 7/17/2022 to 7/30/2022, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows: -07/17/22 had 7 CNAs for 115 residents on the day shift, required at least 14 CNAs. -07/18/22 had 12 CNAs for 111 residents on the day shift, required at least 14 CNAs. -07/19/22 had 9 CNAs for 109 residents on the day shift, required at least 14 CNAs. -07/21/22 had 12 CNAs for 109 residents on the day shift, required at least 14 CNAs. -07/22/22 had 12 CNAs for 109 residents on the day shift, required at least 14 CNAs. -07/23/22 had 8 CNAs for 115 residents on the day shift, required at least 14 CNAs. -07/24/22 had 9 CNAs for 115 residents on the day shift, required at least 14 CNAs. -07/26/22 had 12 CNAs for 116 residents on the day shift, required at least 14 CNAs. -07/27/22 had 10 CNAs for 113 residents on the day shift, required at least 14 CNAs. -07/28/22 had 11 CNAs for 113 residents on the day shift, required at least 14 CNAs. -07/29/22 had 7 CNAs for 111 residents on the day shift, required at least 14 CNAs. -07/30/22 had 5 CNAs for 111 residents on the day shift, required at least 14 CNAs. 3. As per the "Nurse Staffing Report" completed by the facility for the week of staffing from 8/14/2022 to 8/20/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -08/14/22 had 8 CNAs for 122 residents on the day shift, required at least 15 CNAs. -08/15/22 had 11 CNAs for 122 residents on the	S 560	Administrator for review at QAPI monthly on an on-going basis.	

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S 560	Continued From page 3 day shift, required at least 15 CNAs. -08/16/22 had 12 CNAs for 122 residents on the day shift, required at least 15 CNAs. -08/17/22 had 9 CNAs for 120 residents on the day shift, required at least 15 CNAs. -08/18/22 had 10 CNAs for 119 residents on the day shift, required at least 15 CNAs. -08/19/22 had 12 CNAs for 119 residents on the day shift, required at least 15 CNAs. -08/20/22 had 9 CNAs for 119 residents on the day shift, required at least 15 CNAs. 4. As per the "Nurse Staffing Report" completed by the facility for the week of staffing from 3/12/2023 to 3/18/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -03/12/23 had 7 CNAs for 116 residents on the day shift, required at least 14 CNAs. -03/13/23 had 9 CNAs for 115 residents on the day shift, required at least 14 CNAs. -03/14/23 had 10 CNAs for 115 residents on the day shift, required at least 14 CNAs. -03/15/23 had 11 CNAs for 114 residents on the day shift, required at least 14 CNAs. -03/16/23 had 8 CNAs for 114 residents on the day shift, required at least 14 CNAs. -03/17/23 had 10 CNAs for 114 residents on the day shift, required at least 14 CNAs. -03/18/23 had 10 CNAs for 114 residents on the day shift, required at least 14 CNAs. 5. As per the "Nurse Staffing Report" completed by the facility for the week of staffing from 4/02/2023 to 4/08/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -04/02/23 had 7 CNAs for 112 residents on the	S 560		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT ORADELL	600 KINDERKAMACK ROAD ORADELL, NJ 07649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 4 day shift, required at least 14 CNAs. -04/03/23 had 8 CNAs for 111 residents on the day shift, required at least 14 CNAs. -04/04/23 had 8 CNAs for 109 residents on the day shift, required at least 14 CNAs. -04/05/23 had 10 CNAs for 109 residents on the day shift, required at least 14 CNAs. -04/06/23 had 8 CNAs for 109 residents on the day shift, required at least 14 CNAs. -04/07/23 had 6 CNAs for 109 residents on the day shift, required at least 14 CNAs. -04/08/23 had 5 CNAs for 109 residents on the day shift, required at least 14 CNAs. 6. As per the "Nurse Staffing Report" completed by the facility for the week of staffing from 7/30/2023 to 8/05/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -07/30/23 had 7 CNAs for 114 residents on the day shift, required at least 14 CNAs. -07/31/23 had 10 CNAs for 112 residents on the day shift, required at least 14 CNAs. -08/01/23 had 10 CNAs for 112 residents on the day shift, required at least 14 CNAs. -08/02/23 had 13 CNAs for 112 residents on the day shift, required at least 14 CNAs. -08/03/23 had 13 CNAs for 112 residents on the day shift, required at least 14 CNAs. -08/04/23 had 10 CNAs for 112 residents on the day shift, required at least 14 CNAs. -08/05/23 had 13 CNAs for 117 residents on the day shift, required at least 15 CNAs. 7. As per the "Nurse Staffing Report" completed by the facility for the two weeks of staffing from 8/06/2023 to 8/19/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060234	A. BUILDING: _____ B. WING _____	C 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT ORADELL	600 KINDERKAMACK ROAD ORADELL, NJ 07649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 5 -08/06/23 had 8 CNAs for 115 residents on the day shift, required at least 14 CNAs. -08/07/23 had 11 CNAs for 115 residents on the day shift, required at least 14 CNAs. -08/08/23 had 10 CNAs for 115 residents on the day shift, required at least 14 CNAs. -08/09/23 had 12 CNAs for 115 residents on the day shift, required at least 14 CNAs. -08/10/23 had 13 CNAs for 115 residents on the day shift, required at least 14 CNAs. -08/11/23 had 13 CNAs for 118 residents on the day shift, required at least 15 CNAs. -08/12/23 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs. -08/13/23 had 11 CNAs for 117 residents on the day shift, required at least 15 CNAs. -08/14/23 had 12 CNAs for 117 residents on the day shift, required at least 15 CNAs. -08/15/23 had 12 CNAs for 117 residents on the day shift, required at least 15 CNAs. -08/16/23 had 11 CNAs for 117 residents on the day shift, required at least 15 CNAs. -08/17/23 had 14 CNAs for 123 residents on the day shift, required at least 15 CNAs. -08/18/23 had 12 CNAs for 121 residents on the day shift, required at least 15 CNAs. -08/19/23 had 9 CNAs for 120 residents on the day shift, required at least 15 CNAs. On 8/28/23 at 9:53 AM, the surveyor interviewed the Staffing Coordinator (SC)regarding the CNA staffing. The SC stated that she was aware of the staffing ratios and that she tried to staff per unit not by the whole building. She added that most of the time she met the ratio by using agency staff but that she did not always meet the ratio. A review of the facility provided policy titled,	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060234	A. BUILDING: _____ B. WING _____	C 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT ORADELL	600 KINDERKAMACK ROAD ORADELL, NJ 07649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 6 "Staffing, Sufficient and Competent Nursing", with a revised date of August 2022, included the following: Policy Statement Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. Policy Interpretation and Implementation Sufficient Staff 1. Licensed nurses and certified nursing assistants are available 24 hours a day, seven (7) days a week to provide competent resident care services including: a. assuring resident safety; b. attaining or maintaining the highest practicable physical, mental and psychosocial well-being of each resident; c. assessing, evaluating planning and implementing resident care plans; and d. responding to resident needs ... 5. "Nurse aides/nursing assistants" are individuals providing nursing or related services to resident in the facility, including those who provide services through an agency or under a contract with the facility. Licensed health professionals, registered dieticians, paid feeding assistants and individuals who volunteer to provide nursing or related services without pay are not considered nursing assistants and are not posted or reported as "direct care" staff ... 8. Minimum staffing requirements imposed by the state, if applicable, are adhered to when determining staff ratios but are not necessarily considered a determination of sufficient and competent staffing ...	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060234	A. BUILDING: _____ B. WING _____	C 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT ORADELL	600 KINDERKAMACK ROAD ORADELL, NJ 07649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1405	Continued From page 7	S1405		
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This REQUIREMENT is not met as evidenced by: Based on the interview and review of pertinent facility documents, it was determined that the facility failed to ensure that all newly hired employees had required physical examination (exam) by the physician within two weeks prior to the first date or upon employment. This deficient practice was identified for one (1) of ten (10) newly hired employees whose personnel records were reviewed and was evidenced by the following: On 9/05/23 at 11:36 AM, the surveyor reviewed	S1405	Staff member #9 had last day of employment with the center on 9/1/23. No residents were negatively affected by this practice. All residents have potential to be affected. Staff member #9's last day of employment was 9/1/23. H&P could not be obtained. Audit conducted of 10 recent newly hired employees to verify health records, including a history and physical (H&P) were complete.	9/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060234	A. BUILDING: _____ B. WING _____	C 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT ORADELL	600 KINDERKAMACK ROAD ORADELL, NJ 07649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1405	Continued From page 8 ten (10) employee files which revealed that Staff #9 was hired on 12/23/22 and there was no physical exam by the physician that was done. On 9/05/23 at 01:33 PM, the surveyor notified the Vice President of Special Clinical Projects (VPoSCP) in the presence of the Director of Nursing (DON) of the concern that there was no physical exam by a physician done on Staff #9. On 9/05/23 at 02:07 PM, the VPoSCP confirmed that Staff #9 did not have the physical exam by the physician and did not comply with the facility's new hire requirement. On 9/06/23 at 10:48 AM, the survey team met with the Licensed Nursing Home Administration (LNHA), DON, Infection Preventionist Nurse (IPN), and VPoSCP and were made aware of the above finding. On 9/07/23 at 12:24 PM, the surveyor in the presence of the survey team interviewed the IPN regarding the facility's practice with the new hires. The IPN informed the surveyors that it was not her responsibility to review and verify if the medical of the new employee was complete including the physical exam of the physician because as an IPN she was responsible for residents and not the facility staff. The IPN stated that the facility's employees including new employees were the responsibility of the Facility Educator. On that same date and time, the IPN stated that at the time Staff #9 was hired, the assigned Facility Educator who was supposed to check Staff #9's physical exam of the physician was no longer at the facility.	S1405	Infection Preventionist educated on responsibilities including employee health. DON/ADON (or designee) to conduct an audit of newly hired staff to ensure completeness of the health record including a history and physical (H&P). Report to QAPI monthly, on-going.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060234	A. BUILDING: _____ B. WING _____	C 09/08/2023

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S1405	Continued From page 9 A review of the facility's Employee Health Records Policy with a revised date of November 2011 provided by VPoSCP included that health records will be maintained for all employees. A health record for each employee will contain, at a minimum: ...b. history of immunization status and any related medical information; c. associate TB screening record;...i. a copy of any results of examinations, medical testing, and follow-up procedures related to employee health and infection control issues... On 9/08/23 at 01:32 PM, the survey team met for an Exit Conference with LNHA, DON, and VPoSCP. The facility management had no additional information provided and did not refute the findings.	S1405		
S1410	8:39-19.5(b)(1) Mandatory Infection Control and Sanitation (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Ex Order 26. 4B1 test with five Ex Order 26. 4B1 units of Ex Order 26. 4B1. The only exceptions shall be employees with documented Ex Order 26. 4B1 two-step Ex Order 26. 4B1 within the last year, employees with a documented Ex Order 26. 4B1, employees who have received appropriate medical treatment for Ex Order 26. 4B1, or when medically contraindicated. Results of the Ex Order 26. 4B1 administered to new employees shall be acted upon as follows: 1. If the first step of the Ex Order 26. 4B1 result is less than Ex Order 26. 4B1 of	S1410		9/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060234	A. BUILDING: _____ B. WING _____	C 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1410	Continued From page 10 induration, the second step of the two-step Ex Order 26. 4B1 shall be administered one to three weeks later. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to perform a two-step Ex Order 26. 4B1 Ex Order 26. 4B or equivalent for Ex Order 26. 4B1 Ex Order 26 for infection and disease screening as required for newly hired employees. This deficient practice was identified for one (1) of ten (10) employee files (Staff #9) reviewed and was evidenced by the following: On 9/05/23 at 11:36 AM, the surveyor reviewed ten (10) employee files which revealed that Staff #9 was hired on 12/23/22 and had the first Ex Order 26. test done on 12/22/22 with a Ex Order 26. 4B1 result. There was no evidence that a two-step Ex Order 26. Ex Order 26. 4B1 or equivalent test was performed for Ex Orde. On 9/05/23 at 01:33 PM, the surveyor notified the Vice President of Special Clinical Projects (VPoSCP) in the presence of the Director of Nursing (DON) of the concern regarding Staff #9's PPD test. On 9/05/23 at 02:07 PM, the VPoSCP confirmed that Staff #9 did not have the second Ex Order 26. test and did not comply with the facility's new hire requirement.	S1410	Staff member #9 had last day of employment with the center on 9/1/23. No residents were negatively affected by this practice. All residents have potential to be affected. Staff member #9s last day of employment was 9/1/23. 2nd step Ex Order 26. was unable to be administered. Audit conducted of 10 recent newly hired employees to verify health records, including a 2 step Ex Order 26. were complete. Infection Preventionist educated on responsibilities including employee health. DON/ADON (or designee) to conduct an audit of newly hired staff to ensure completeness of the health record including a 2 step Ex Order 26.. Report to QAPI monthly, on-going.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060234	A. BUILDING: _____ B. WING _____	C 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT ORADELL	600 KINDERKAMACK ROAD ORADELL, NJ 07649

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S1410	Continued From page 11 On 9/06/23 at 10:48 AM, the survey team met with the Licensed Nursing Home Administration (LNHA), DON, Infection Preventionist Nurse (IPN), and VPoSCP and were made aware of the above finding. On 9/07/23 at 12:24 PM, the surveyor in the presence of the survey team interviewed the IPN regarding the facility's practice with the new hires. The IPN informed the surveyors that it was not her responsibility to review and complete the new employee Ex Order 26 test because as an IPN she was responsible for residents and not the facility staff. The IPN stated that the facility's employees including new employees were the responsibility of the Facility Educator. On that same date and time, the IPN stated that at the time Staff #9 was hired, the assigned Facility Educator who was supposed to check Staff #9's Ex Order 26 was no longer at the facility. A review of the facility's Employee Health Records Policy with a revised date of November 2011 provided by VPoSCP included that health records will be maintained for all employees. A health record for each employee will contain, at a minimum: ...b. history of immunization status and any related medical information; c. associate Ex Orde screening record;...i. a copy of any results of examinations, medical testing, and follow-up procedures related to employee health and infection control issues... On 9/08/23 at 01:32 PM, the survey team met for an Exit Conference with LNHA, DON, and VPoSCP. The facility management had no additional information provided and did not refute the findings.	S1410		

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
315339 Y1	A. Building B. Wing Y2	10/18/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT ORADELL	600 KINDERKAMACK ROAD ORADELL, NJ 07649

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 F0585	Correction	ID Prefix F0641	Correction	ID Prefix F0658	Correction
Reg. # 483.10(j)(1)-(4)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	09/19/2023	LSC	09/25/2023	LSC	09/27/2023
ID Prefix F0661	Correction	ID Prefix F0684	Correction	ID Prefix F0725	Correction
Reg. # 483.21(c)(2)(i)-(iv)	Completed	Reg. # 483.25	Completed	Reg. # 483.35(a)(1)(2)	Completed
LSC	09/22/2023	LSC	09/22/2023	LSC	09/18/2023
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?
9/8/2023	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315339 Y1	A. Building B. Wing Y2	10/18/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT ORADELL	600 KINDERKAMACK ROAD ORADELL, NJ 07649

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 F0585	Correction	ID Prefix F0641	Correction	ID Prefix F0658	Correction
Reg. # 483.10(j)(1)-(4)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	09/19/2023	LSC	09/25/2023	LSC	09/27/2023
ID Prefix F0661	Correction	ID Prefix F0684	Correction	ID Prefix F0689	Correction
Reg. # 483.21(c)(2)(i)-(iv)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	09/22/2023	LSC	09/22/2023	LSC	09/20/2023
ID Prefix F0690	Correction	ID Prefix F0695	Correction	ID Prefix F0725	Correction
Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.35(a)(1)(2)	Completed
LSC	09/20/2023	LSC	09/27/2023	LSC	09/18/2023
ID Prefix F0732	Correction	ID Prefix F0756	Correction	ID Prefix F0759	Correction
Reg. # 483.35(g)(1)-(4)	Completed	Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.45(f)(1)	Completed
LSC	09/19/2023	LSC	09/20/2023	LSC	09/19/2023
ID Prefix F0880	Correction	ID Prefix F0882	Correction	ID Prefix F0944	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.80(b)(1)-(4)	Completed	Reg. # 483.95(d)	Completed
LSC	09/18/2023	LSC	09/18/2023	LSC	10/05/2023

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?
9/8/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060234 Y1	A. Building B. Wing Y2	10/18/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT ORADELL	600 KINDERKAMACK ROAD ORADELL, NJ 07649

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 09/18/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
9/8/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: 361E12

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060234	A. Building B. Wing	10/18/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT ORADELL	600 KINDERKAMACK ROAD ORADELL, NJ 07649

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 09/18/2023	ID Prefix S1405 Reg. # 8:39-19.5(a) LSC	Correction Completed 09/20/2023	ID Prefix S1410 Reg. # 8:39-19.5(b)(1) LSC	Correction Completed 09/20/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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?
9/8/2023	☐ ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315339	A. BUILDING **01** B. WING _____	**09/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT ORADELL	**600 KINDERKAMACK ROAD** **ORADELL, NJ 07649**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 08/24/2023. 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 Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/24/23 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. CareOne at Oradell is a two-story building that was built in 1992. It is composed of Type II protected construction. The facility is divided into 14 - smoke zones. The generator does approximately 70 % of the building as per the Regional Maintenance Director. The current occupied beds are 118 of 154.	K 000		
K 918 SS=F	. Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying	K 918		9/21/23

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

Electronically Signed | 09/28/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315339	A. BUILDING **01** B. WING _____	**09/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT ORADELL	**600 KINDERKAMACK ROAD** **ORADELL, NJ 07649**

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K 918	Continued From page 1 service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: . Based on record review and interview, the facility failed to ensure the three year load bank test was completed on the existing emergency generator in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 4.9.1 This deficient practice had	K 918	The three-year load bank test was completed on the existing emergency generator in accordance with NFPA 110 standard for Emergency and standby system. All residents living in the facility have	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315339	A. BUILDING **01** B. WING _____	**09/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT ORADELL	**600 KINDERKAMACK ROAD** **ORADELL, NJ 07649**

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K 918	Continued From page 2 the potential to affect all 118 residents. Findings include: A document review of the generator reports for 2022 and 2023 provided by the Maintenance Director revealed a three year load bank test had not been completed for the emergency generator. During an interview at 12:20 PM on 08/24/23 the Regional Maintenance Director confirmed the three year load bank test had not been completed for the emergency generator. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	potential to be affected The facility will maintain a maintenance log book and audit the compliance every year in the month of August. The Director of Maintenance will complete an audit of the log book every year and yearly report to QAPI.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315339 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	10/18/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT ORADELL	600 KINDERKAMACK ROAD ORADELL, NJ 07649

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 Reg. # NFPA 101 LSC K0918	Correction Completed 09/21/2023	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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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	
9/8/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO