STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060407	A. BUILDING: _____ B. WING _____	C 08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER HEALTHCARE CENTER	1417 BRACE ROAD CHERRY HILL, NJ 08034

(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 000	Initial Comments COMPLAINT # NJ00156717, NJ00156435 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: C/O # NJ 00156717 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 as mandated by the State of New Jersey. This was evident 4 of 21 day shifts. The deficient practice was evidenced by the following: Reference: New Jersey Department of Health	S 560	1. There was no negative outcome to residents on the shifts identified as not meeting the NJ staffing requirements during the 7:00am -3:00pm shift on the dates of 7/3/22, 7/08/22, 7/23/22, and 7/28/22. 2. All residents have the potential to be affected by the deficient practice of not meeting the NJ Staffing requirement ratios. 3. The following measures have been put into place to prevent the deficient practice from recurring. Advertisement / Job postings for CNAs have been posted on	10/22/22

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

Electronically Signed | 09/22/22

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S 560	Continued From page 1 (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. "Direct care staff member" means any registered professional nurse, licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every 8 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. As per the "Nurse Staffing Report" completed by the facility for the weeks of 07/03/22 to 07/30/22, the staffing-to-resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for four-day shifts are documented below: -07/03/22 had 14 CNAs for 117 residents on the day shift, required 15 CNAs. -07/08/22 had 13 CNAs for 115 residents on the	S 560	recruitment platforms. Facility increased CNA rates to attract more staff. Bonus incentives are offered to CNAs to work pick up shifts when needed. 4. The Administrator or designee will review the staffing schedule weekly to monitor the staffing ratio on the 7am □ 3pm shift for 90 days. The findings will be reported to the QAPI committee on a monthly basis for 3 months.	

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S 560	Continued From page 2 day shift, required 14 CNAs. -07/23/22 had 14 CNAs for 117 residents on the day shift, required 15 CNAs. -07/28/22 had 13 CNAs for 111 residents on the day shift, required 14 CNAs. During an interview with the surveyor on 08/18/22 at 2:52 PM, the Licensed Nursing Home Administrator confirmed that he was aware of the minimum staffing requirements. He stated, "We are trying" when asked if the facility is meeting the staffing requirements.	S 560		
S 830	8:39-9.3(b) Mandatory Administration (b) The facility shall make reasonable efforts to ensure that staff providing direct care to residents in the facility are in good physical and mental health, emotionally stable, of good moral character, and are concerned for the safety and well-being of residents; and have not been convicted of a crime relating adversely to the person's ability to provide care, such as homicide, assault, kidnapping, sexual offenses, robbery, and crimes against the family, children or incompetents, except where the applicant or employee with a criminal history has demonstrated his rehabilitation in order to qualify for employment at the facility. ("Reasonable efforts" shall include an inquiry on the employment application, reference checks, and/or criminal background checks where indicated or necessary.) This REQUIREMENT is not met as evidenced	S 830		10/22/22

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S 830	Continued From page 3 by: Based on interview and review of employee files, it was determined that the facility failed to obtain a Criminal Background (CB) check prior to the date of hire for new employees. This deficient practice was identified for 2 of 5 newly hired employees reviewed and was evidenced by the following: A review of the five randomly selected newly hired employee files included the following: An Activities Aide #3, who was hired on 06/15/22, had a CB ordered and reported on 6/23/22. A Physical Therapy Assistant, who was hired on 06/15/22, had a CB ordered and reported on 6/23/22. On 08/12/22 at 11:25 AM, in the presence of another survey team member, the surveyor interviewed the Director of Human Resources (DHR) regarding a newly hired employee's CB. The DHR stated that a CB was obtained when she received a potential new employee's application. The surveyor then asked the DHR why it was important to obtain a CB prior to an employee's date of hire. The DHR stated that it was important because the facility cannot hire employees with certain backgrounds. The surveyor then asked the DHR the reason why the two employees' CBs were obtained after their date of hire. The DHR stated that the employees had shown her a copy of a previous employers CB but that she did not obtain a copy for the file. She could not provide a reason why the CB was not obtained prior to the employees' date of hire. The facility could not provide documented	S 830	1.The Administrator in-serviced the Director of Human Resources regarding completing a CB (Criminal Background) prior to date of hire to prevent individuals who have been convicted of a crime against the elderly from being employed at this facility. 2.All residents have the potential to be affected by this deficient practice when a Criminal Background is not done on every employee prior to date of hire. 3.The Administrator in-serviced Director of Human Resources on the State regulation (8:39-9.3) to ensure that they were aware of the mandate for new hires to have a Criminal Background prior to date of hire. 4.New employee files will be reviewed with the Administrator weekly for 90 days to ensure that Criminal Backgrounds are being done prior to the date of hire. The findings will be reported to the QAPI committee on a monthly basis for 3 months.	

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S 830	Continued From page 4 evidence that a CB was done prior to the two employees date of hire. On 08/12/22 at 1:12 PM, in the presence of the survey team and the Vice President of Clinical Services, the surveyor told the Licensed Nursing Home Administrator (LNHA) the concern that the two newly hired employees did not have a CB prior to their date of hire and asked what the expectation was. The LNHA stated that the expectation was for the newly hired employees to have a CB prior to the date of hire. On 08/15/22 at 9:18 AM, during surveyor interview, the LNHA stated that the background checks were done late for the new hires. He added that this was a "fluke". A review of the facility provided policy titled, "Background Investigation of Employees" with a revised/reviewed date of 5/2022, included the following: Protocol. The facility will complete a criminal investigation, per State regulations, prior to employment to prevent employment of individuals who have been convicted of abuse, neglect, misappropriation and exploitation of the elderly. Procedure. 1. Prohibit the employment of individuals who have: Been found guilty in a court of law of abusing, neglecting, or mistreating individuals ...2. Complete the following process prior to offering employment: ...Obtain criminal background check.	S 830		
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	S1405		10/22/22

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S1405	Continued From page 5 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 interview and review of five recently hired employee files, it was determined that the facility failed to ensure that 2 of 5 newly hired employees had completed a health history and received an examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to employment or upon employment. This deficient practice was evidenced by the following: A review of the five randomly selected newly hired employee files included the following: A Temporary Nursing Assistant (TNA), who was hired on 04/11/22, did not have documented evidence of a health history or physical.	S1405	1.The Administrator reviewed with the Director of Human Resources the requirement to ensure that all new employees complete a screening health history within 30 days of hire. An audit was done of all new hire files in the past year to ensure that all had baseline health screens were completed. 2.All residents have the potential to be affected by this deficient practice when newly hired employees do not have a baseline health screen. 3.An in-service was done by the Administrator with Director of Human Resources regarding the mandatory requirements of new employees to have baseline health screens. 4.The Administrator will review new hire	

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S1405	Continued From page 6 A Cook #2, who was hired on 06/27/22, did not have documented evidence of a health history or physical. On 08/09/22 at 2:13 PM, in presence of another survey team member, the surveyor interviewed the Director of Human Resources (DHR) regarding the health history and physical for the TNA. The DHR stated the TNA did not have a physical and that she was being taken off the schedule. She added that the TNA should have had a physical upon hire. The DHR stated that the TNA had said that she had given the physical that she had done by her own physician to the Infection Preventionist (IP), who no longer worked at the facility. The DHR stated that she usually did not check on the "medical stuff" and that it was the IP that checked. She then added that the TNA was going to now get a copy of the physical from her doctor. On 08/12/22 at 11:25 AM, in the presence of another survey team member, the surveyor interviewed the DHR regarding the health history and physical for Cook #2. The DHR stated that Cook #2 did not have a physical but that she told the Assistant Director of Nursing (ADON) that she had one done by her own physician but that Cook #2 never provided it to the facility. The DHR stated that she never checked again to see if Cook #2 had provided the documentation of the health history and physical. On 08/12/22 at 12:01 PM, the DHR provided the surveyor a document dated 08/10/22 regarding TNA's physical, which included the following: This is to certify that [TNA] was seen in my office on 8/10/22. She completed her annual physical today.	S1405	employee files regarding health screen requirements weekly for 4 weeks and then monthly for 90 days. The findings will be reported to the QAPI committee on a monthly basis for 3 months.	

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S1405	Continued From page 7 On 08/12/22 at 12:56 PM, the surveyor interviewed the ADON regarding the health history and physical for Cook #2. The ADON stated that Cook #2 was going to email a copy of the physical. She added that no one had told her that Cook #2 did not email it so she did not follow up on it. She then stated that her expectation was that the Human Resources department would keep a list of what needs to be completed by the employee and that they would handle it. The surveyor then asked the ADON what the expectation was for having a health history and physical done for new employees. The ADON stated that the health history and physical was to be done by the date of hire. The facility could not provide documented evidence that the two newly hired employees had a health history and physical done upon hire. On 08/12/22 at 1:12 PM, in the presence of the survey team and the Vice President of Clinical Services, the surveyor told the Licensed Nursing Home Administrator (LNHA) the concern that the two newly hired employees did not have a health history and physical and asked what the expectation was. The LNHA stated that before being hired a physical should be done. On 08/15/22 at 09:18 AM, during surveyor interview, the LNHA stated that the physicals were done late for the new hires. He added that this was a "fluke." A review of the facility provided policy titled, "Employee Medical Evaluation/Physicals," with a revised date of 5/2022, included the following: The ... personnel will all be checked for baseline	S1405		

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S1405	Continued From page 8 health assessment on hire ...All new employees will complete a screening health history which will be completed and reviewed by the Medical Director of the facility within 30 days of hire.	S1405		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060407 Y1	A. Building B. Wing Y2	11/17/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER HEALTHCARE CENTER	1417 BRACE ROAD CHERRY HILL, NJ 08034

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 10/22/2022	ID Prefix S0830 Reg. # 8:39-9.3(b) LSC	Correction Completed 10/22/2022	ID Prefix S1405 Reg. # 8:39-19.5(a) LSC	Correction Completed 10/22/2022
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
8/29/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS COMPLAINT# NJ00156717, NJ00156435 THE FACILITY IS NOT IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483,SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. 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. Survey date: 08/29/22 Survey dates: 08/02/22, 08/03/22, 08/04/22, 08/05/22, 08/08/22, 08/09/22, 08/10/22, 08/11/22, 08/12/22, 08/15/22, 08/16/22, 08/17/22, 08/18/22, 08/19/22, 08/24/22, 08/25/22, and 08/29/22. CENSUS: 110 SAMPLE SIZE: 33 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities. Deficiencies were cited for this survey. The following immediate jeopardy (IJ) situations	F 000		

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

Electronically Signed | 09/22/2022

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F 000	Continued From page 1	F 000		

were identified for F689, F760, F808 and F835:

During a Standard Survey conducted 08/02/22 through 08/29/22, the survey team identified the following:

F689, s/s K
On 08/05/22, the facility failed to securely safeguard hazardous chemicals from vulnerable and independently mobile residents by ensuring the janitor door was flush with the door casing and allowing the door to close and latch securely.

The facility's Licensed Nursing Home Administrator (LNHA) and the Assistant Director of Nursing (ADON) were notified of the IJ on 08/05/22 at 3:13 PM.

A Removal Plan was received on 08/5/22, and the survey team verified the implementation of the Removal Plan on 08/05/22.

On 08/05/22 at 4:24 PM, two surveyors confirmed/verified, in the presence of the Licensed Practical Nurse Unit Manager, that the janitor door self closes and locks.

This was cited at a level K as the deficient practice was cited at the last standard survey of 11/01/21.

F760, s/s K
On 08/04/22, the surveyor observed Licensed Practical Nurse (LPN) #1 administer medications to Resident #7 while providing the resident with thin (unthickened) liquids. LPN #1 did not follow the physician's order for [redacted] documented on the Medication Administration Record (MAR).

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F 000	Continued From page 2	F 000		

This posed a serious and immediate threat for residents on a physician's ordered altered liquid consistency diet. The Immediate Jeopardy (IJ) began on 08/04/22 at 8:25 AM and continued until 08/05/22.

The Licensed Nursing Home Administrator (LNHA) and Assistant Director of Nursing (ADON) were notified of the IJ on 08/04/22 at 3:56 PM. LPN #1's failure to follow a physician's order for NTL during the medication administration pass placed residents on a physician's ordered altered liquid consistency diet at risk for choking, aspiration (when material such as food or drink enters the respiratory tract), or death.

An acceptable removal plan was received on 08/05/22 and verified by the survey team.

This IJ was cited at a level K as the deficient practice was cited at the last standard survey of 11/01/21.

F808, s/s K
On 08/04/22 during the breakfast meal, Surveyor #1 observed Resident #7 drink thin liquids from his/her breakfast tray. The facility staff did not follow the instructions on the meal ticket for [redacted] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.) and appropriately thicken the liquids prior to providing the resident with the breakfast tray.

On 08/04/22 during the lunch meal, Surveyor #2 observed Resident #99 drink a thin liquid from his/her lunch tray. The facility staff did not follow the instructions on the meal ticket for [redacted] NJAC 8:43E and appropriately thicken the liquid prior to providing the resident with the lunch tray.

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This posed a serious and immediate threat for residents on an altered liquid consistency diet who are at risk for aspiration. The Immediate Jeopardy (IJ) began on 08/04/22 at 8:25 AM and continued until 08/05/22.

The Licensed Nursing Home Administrator and Assistant Director of Nursing (ADON) were notified of the IJ on 08/04/22 at 3:56 PM. The facility's failure to ensure the appropriate liquid consistency diet was provided during meals placed residents at risk for choking, aspiration, or death.

An acceptable removal plan was received on 08/05/22 and verified by the survey team.

F835, s/s K
The facility's Licensed Nursing Home Administrator (LNHA) failed to ensure that the facility's policies and procedures were implemented to ensure resident safety and well-being, by failing to: a.) ensure safe meal delivery for Residents #7 and #99, who were at risk for aspiration, according to the physician's prescribed diet order to include [redacted] thickened liquids, b.) perform medication administration according to professional standards of practice, and c.) maintain and provide a safe environment for the residents by ensuring chemicals were locked and secured.

This posed a serious and immediate threat to the safety and well-being of all the residents who receive thickened liquids from choking, aspirating or dying and all the residents on the [redacted] Unit from ingesting chemicals and becoming seriously ill or death.

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F 000	Continued From page 4 The failure of the LNHA to ensure the facility established and maintained systems that were effective and efficient to operate the facility in a manner to safely meet resident's needs in compliance with federal, state and local requirements as outlined in the Administrator Job Description, resulted in an Immediate Jeopardy (IJ) that was identified on 08/08/22 at 2:19 PM . A Removal Plan was received on 08/10/22 at 8:48 AM and the survey team verified the implementation of the Removal Plan on 08/10/22 at 2:00 PM.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		10/22/22

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F 550	Continued From page 5 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other pertinent facility documents, it was determined that the facility failed to ensure that the resident's dining experience was provided in a manner to promote dignity and respect for the resident's when a.) all residents were not served their meal at the same time while seated at the same table (Resident #93), b.) performing housekeeping activities in the presence of a resident (Resident #93) while they were eating, c.) a staff member leaned against a resident's (Resident #10) wheelchair while the resident was seated and eating, d.) when a staff member stood over a resident (Resident #99) while assisting he/she to eat while the resident was in bed, and e.) when not engaging with the resident during the meal (Resident #93). The deficient practice was observed for 3 of 7 residents observed during meals (Residents #10, #93, and # 99) and	F 550	1.Director of Housekeeping provided individual counseling to Housekeeper # 1 and Housekeeper # 2 regarding the policy and procedure for cleaning and disinfecting during meal service. Nursing Management in-serviced Certified Nurses Aid # 6, # 15 and #18 regarding the policy and procedure of Dignified Dining with special focus on meal service. 2.All residents have the potential to be affected by this deficient practice when the policy and procedure is not followed regarding a dignified meal service experience. 3.Nursing Management conducted in-service on Dignified and Homelike environment with special focus on Meal Service with nursing and housekeeping staff.	

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F 550	Continued From page 6 who resided on 2 of 4 units [NJAC 8 43E-2.1 and] and [NJAC 8 43E-2.1 and]). This deficient practice was evidenced by the following: 1.) On 08/03/22 at 1:10 PM, Surveyor #2 observed the lunch meal on the [NJAC 8 43E-2.1 a] unit. The lunch meal tray cart arrived at the [NJAC 8 43E-2.1 and] unit at 1:10 PM and all residents had been provided their lunch meal by 1:18 PM and were eating independently or assisted to eat by staff except Resident #93. Two (2) staff were noted to assist at a table of three (3) residents and one (1) staff assisted at a table of one (1) resident. At 1:20 PM, Surveyor #2 observed Resident #93 was seated at the end of a table with seven (7) other residents. Six (6) of the residents had been provided their meal and were actively eating independently and one (1) resident required assistance and was being assisted by staff. Resident #93 had not received his/her lunch meal. At 1:22 PM, Surveyor #2 observed two (2) nurses behind the nurses' station and three (3) activity staff standing in the television room during the lunch meal. None of the activity staff or nurses were observed to assist with the lunch meal. Resident #93 still had not received his/her meal tray at 1:24 PM. Surveyor #2 observed a lunch meal tray on the counter of the activity station at 1:34 PM and was able to validate that it was Resident #93's meal tray, as evidenced by reading the meal ticket on the tray which had Resident #93's name on it. Resident #93 received his/her lunch meal tray at 1:35 PM. Resident #93 was provided a clothing protector and was assisted to eat at 1:37 PM by a Certified Nursing Assistant (CNA). Resident #93 waited 27 minutes	F 550	4.The Director of Nursing or designee will monitor the distribution of meal trays as well as the conduct of CNA's during meal service to ensure a dignified dining experience. Meals will be monitored daily for 2 weeks then, twice a week for 2 weeks thereafter. The Housekeeping Director will monitor each unit prior to meal service to ensure all housekeeping carts are secured in the housekeeping closet 3 x a week for 4 weeks and weekly thereafter for 60 days. All findings will be reviewed with the QAPI committee monthly for 3 months.	

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to receive their lunch meal tray and to be assisted with the meal.

On 08/17/22 at 1:57 PM, Surveyor #2 conducted an interview with the facility Licensed Nursing Home Administrator (LNHA) and Assistant Director of Nursing. Surveyor #2 asked what the facility policy was for serving meals to residents. The LNHA replied, "All residents should be served at the same time at the table. It's inappropriate for a resident to be served their tray a half hour after other residents received their meals at the same table."

2.) On 08/03/22 at 1:49 PM, a housekeeping staff (HK #1) was observed to take a broom and sweep around Resident #93's feet and gerichair while he/she was actively being assisted with eating their lunch meal. At the same time, another housekeeping staff (HK #2) was observed to spray the table with disinfectant spray and wipe the table afterward with a white cloth while resident #93 was actively eating his/her lunch meal and five (5) additional residents were also seated at the table after they had completed their lunch meals. Through interview, Surveyor #2 was able to determine that the product sprayed on the table was a multi-purpose disinfectant cleaner (a phosphate free, pH neutral formulation designed to provide effective cleaning, deodorization, and disinfection).

On 08/03/22 at 1:55 PM, Surveyor #2 interviewed HK #1 and HK #2. According to HK #1 when questioned whether it was appropriate to sweep around a resident while the resident was actively eating. HK #1 responded, "They said we shouldn't have our carts out during the meal but once the

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trays were removed, we could start cleaning." Surveyor #2 then asked HK #1 if it was facility policy to sweep the floor under a resident while they were actively eating. HK #1 responded, "I'm not sure." Surveyor #2 questioned HK #1 if she had ever been in-serviced concerning performing housekeeping tasks during mealtime. HK #1 responded, "We had some in-servicing, but I don't know if I was told that specifically." Surveyor #2 asked HK #2 if it was appropriate to spray a table with disinfectant while a resident was actively eating their lunch meal (Resident #93). HK #2 responded, "I thought it was ok to clean after the trays had been removed." The surveyor informed HK #2 that Resident #93 was still actively eating when she sprayed the table with disinfectant. HK #2 replied, "Oh, I thought everybody was done."

On 08/17/22 at 9:34 AM Surveyor #2 interviewed the facilities Director of Environmental Services (DEVS). The DEVS explained that "Proper procedure is that the housekeepers are not to sweep or spray any chemicals during the meal. I in serviced the staff on that. We should not clean any dining area until all residents have completed their meal."

3.) On 08/03/22 at 12:36 PM, during lunch in the dining room on Court 1, Surveyor #1 observed CNA #6 with arms crossed, leaning and supporting herself against the handles of Resident #10's wheelchair while he/she was seated in the wheelchair and eating.

4.) On 08/10/22 at 12:25 PM, Surveyor #1 observed CNA #18 standing over and feeding resident #99 while he/she was in bed.

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F 550	Continued From page 9 During an interview with the surveyor on 08/17/22 at 1:58 PM, the LNHA confirmed it was inappropriate for a staff member to support herself on a resident's wheelchair as he/she ate. Further, the LNHA confirmed that CNA #18 should have been seated while feeding a resident in bed. 5.) On 08/04/22 at 8:48 AM, Surveyor #3 observed Resident #93 in a geriatric recliner being fed by CNA #15. CNA #15 was observed with their [redacted] on Resident #93's geriatric recliner. Surveyor #3 observed, as CNA #15 assisted Resident #93 to eat, that CNA#15 repeatedly tapped the fork on the side of the plate as the resident chewed. After being assisted to consume more of the food, CNA #15 was observed pushing food around with the utensils on the resident's plate and looking around the dining area, not engaging with the resident. Surveyor #2 reviewed the facility provided document titled Creating a Homelike Dining Experience, created January 26, 2018. The following was revealed under the heading Dignity: "All residents at a table should be served at the same time. It is easier if two staff work at serving a table together to accomplish this."	F 550		
F 558 SS=D	NJAC 8:39-4.1(a)(12) Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable	F 558		10/22/22

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F 558	Continued From page 10 accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain the call bell within reach for 3 of 27 sampled residents, (Residents #84, #100 and #110). This deficient practice was evidenced by the following: 1.) On 08/02/22 at 11:31 AM, during the initial tour of the facility, a Certified Nursing Assistant (CNA) #8 offered and accompanied Surveyor #1 to Resident #110's room. CNA #8 stated that resident #110 was [NJAC 8:43E]. Upon entering Resident #110's room, the call light was observed on the floor, coiled up against the wall behind the head of the bed. On 08/03/22 at 10:43 AM, Surveyor #1 knocked on the door and entered Resident #110's room. Resident #110 was observed lying in bed under the covers. The surveyor observed Resident #110's call light coiled up on the floor in front of the wall, as previously observed on 08/02/22 during the initial tour not accessible to the resident. On 08/03/22 at 12:59 PM, Surveyor #1 observed the door was open to Resident #110's room and Resident #110 was seated in the dining room awaiting the lunch meal. The surveyor observed from the doorway that the call light was on the floor coiled up as on previous observations, adjacent to the wall in front of the head of the bed.	F 558	1.CNA #8 and CNA # 10 were in-serviced regarding accessibility of Resident Call Bells. The call bells for resident's #84, #100 and #110 were immediately checked and placed appropriately within the reach of the resident. The Unit Manager immediately did rounds in each resident room on the Unit to ensure that all resident call bells were placed within the resident's reach. 2.All residents have the potential to be affected by this deficient practice when call bells are not placed within their reach. 3.Nursing supervisors conducted an in-service with all nursing staff regarding the accessibility of Resident Call Bells. 4.All Unit Managers will check resident rooms daily for one week then weekly for 30 days to ensure all resident's call bells are within proper reach. All findings will be reported at the QAPI meeting monthly for 3 months.	

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On 08/04/22 at 1:06 PM, Surveyor #1 observed Resident #110 seated in the dining room awaiting the lunch meal. The door was opened to his/her room and the surveyor again observed the call light to be in the same position as previous observations, coiled on the floor adjacent to the wall and beyond the head of the bed.

On 08/05/22 at 10:03 AM, Resident #110 was observed lying in bed. Surveyor #1 observed the call light to be coiled on the floor and adjacent to the wall behind the head of the bed and not accessible to Resident #110.

On 08/09/22 at 11:16 AM, Surveyor #1 observed the call light to be in a coiled position and on the floor on top of the leg to the frame of the bed.

On 08/10/22 at 9:42 AM, Resident #110 was observed lying in bed. The call light was observed to be in a coiled position and on the floor on top of the leg to the frame of the bed, as previously observed on 08/09/22.

On 08/10/22 at 11:10 AM, Surveyor #1 and CNA #10 entered Resident #110's room. CNA #10 was directed to the placement of Resident #110's call light, which was coiled on the floor and on top of the upper leg of the bed. CNA #10 responded, "The call light should be accessible to the resident. It should be within reach. I will place it on his/her bed, but he/she will probably throw it on the floor." The surveyor then questioned CNA #10 if she was familiar with the facility policy for call lights. CNA #10 responded, "We are to place the resident call light within reach of the resident."

During an interview with the surveyor on 08/10/22

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at 11:30 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM) was asked what the facility policy was for call lights. LPN/UM responded, "Our facility policy is that call lights should be within reach. If a call light is observed on the floor, staff (any) should place it within reach of the resident."

2.) On 08/03/22 at 9:48 AM, Surveyor #2 observed Resident #100's call bell on the floor behind the head of bed.

On 08/04/22 at 8:37 AM, Surveyor #2 observed Resident #100's call bell on the floor behind the head of bed.

On 08/05/22 at 9:13 AM, Surveyor #2 observed Resident #100's call bell on the floor behind the head of the bed.

During an interview with the surveyor on 08/11/22 at 10:19 AM, CNA #6 reported call bells are always kept within reach of the resident.

During an interview with the surveyor on 08/11/22 at 11:50 AM, Registered Nurse Unit Manager #2 stated that call bells are to be accessible to each resident, within reach, such as clipped to the chest, gown, or blanket.

3.) On 08/05/22 at 9:48 AM, Surveyor #2 observed Resident #84's call bell on the floor underneath the foot of bed.

On 08/09/22 at 8:37 AM, Surveyor #2 observed Resident #84's call bell on the floor at the foot of bed.

On 08/15/22 at 1:02 PM, Surveyor #2 observed

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F 558	Continued From page 13 Resident #84's call bell on the floor at foot of bed. During an interview with the surveyor on 08/17/22 at 1:45 PM, the Assistant Director of Nursing stated that call bells are not to be on the floor, they are to be within reach of the resident. The surveyor reviewed the facility provided policy titled Resident Call Bells, Last Date Reviewed: 05/2022. The following was observed under the heading PROCEDURE: 7." When making beds and tidying resident rooms, call bells will be left in a standard place in all rooms: attached to a partial side rail or to the top of the bed. the Nursing Assistant leaving the room must ensure that the call bell is in place regardless of the residents' ability to use it." 9. "The Nursing Assistants will ensure that the call bell is within the resident's reach before leaving the room."	F 558		
F 582 SS=D	NJAC 8:39-31.8 (c) (9) Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be	F 582		10/22/22

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charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the

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F 582	Continued From page 15 facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide the required Skilled Nursing Facility (SNF) Notice of Medicare Non-Coverage (NOMNC) for 1 of 2 residents (Resident #51) reviewed for change in insurance coverage status and who remained in the facility. This deficient practice was evidenced by the following: On 08/11/22 at 10:21 AM, the surveyor reviewed the SNF Beneficiary Protection Notification Review (BPNR) forms for Resident #51, provided by the facility, who had a change in insurance coverage status and remained in the facility. The resident's last covered day for Medicare Part A Services was 05/03/22. Resident #51's SNF Advance Beneficiary Notice (ABN), dated [redacted] documented that the social worker call[ed] the resident's [redacted] to discuss the LCD (last covered date) of [redacted] and that the family was not interested in paying for therapy services. Resident #51's SNF NOMNC form did not have a signature from Resident #51 or the resident's representative. There was no additional documentation about communication of this form to the resident or resident's representative. During an interview with the surveyor on 08/11/22 at 1:08 PM, the Social Services Director (SSD) #1, in the presence of SSD #2, stated that the SNF NOMNC form should be issued at least 48 hours before the resident's last covered date. SSD #1 stated that if a resident had a Brief	F 582	1.The Administrator provided individual counseling to Social Service #1 and Social Service #2 regarding the policy and procedure for issuing (NOMNC) Notice of Medicare Non-Coverage in a Skilled Nursing Facility. 2.All residents who require a NOMNC notification have the potential to be affected by his deficient practice when NOMNC notification is not provided according to facility policy. 3.An audit was done by the Director of Social Services to review all residents who discharged home/or remained in the facility with remaining Medicare days within the last 6 months to ensure that all notifications met regulatory requirements. None were found to be deficient. An in-service was done by the Administrator with Social Service #1 and Social Service #2 regarding the policy for NOMNC notification. 4.The Director of Social Services will review each notification to ensure that if the resident is not able to be issued the notification is not possible then the responsible party for the resident will be notified by telephone, mail, secure fax or email. If the beneficiary fails to return the signed document, then all subsequent attempts will be documented in the electronic record. All information will be documented on the NOMNC form. Weekly audits will be completed for 4 weeks, and then monthly for 3 months	

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F 582	Continued From page 16 Interview for Mental Status (BIMS) score of [redacted] and below [redacted], the service end date, possible cost and right to appeal would be discussed with the resident's legal representative. SSD #1 added that Resident #51 had a BIMS of [redacted], which indicated that the resident was [redacted]. SSD #1 acknowledged she did not have electronic documentation or written documentation of a conversation on the SNF NOMNC form nor did she have a signed SNF NOMNC form from the resident's representative. SSD #1 and SSD #2 stated, "It was missed" and that the form was provided to the family but was not documented on the SNF NOMNC form. A review of the facility policy titled "Advance Beneficiary Notice (ABN) and Notice of Medicare Non-Coverage (NOMNC) Guidelines," revised on 05/01/22, included under section "Guidelines" revealed the following: 6. You must issue the Notice of Medicare non-coverage as required per CMS guidelines CMS-10123 form. 8. In circumstances when issuing an ABN and/or NOMNC Coverage form in person is not possible...Telephone, Mail, Secure fax machine or Email ...If the beneficiary fails to return a signed copy, document the initial contact and subsequent attempts to obtain a signature in the appropriate records.	F 582	thereafter by the Director of Social Services or Designee to ensure that NOMNC's are being provided as required. The results of these audits will be reported to the QAPI committee monthly for 3 months.	
F 584 SS=E	NJAC 8:39-4.1(a)(8) Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		10/22/22

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§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

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F 584	Continued From page 18 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: C/O # NJ 00156717 Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to provide a clean, comfortable, and homelike environment by a.) storing medical equipment within a dining/day room area, b.) not maintaining resident rooms, hallways and common areas clean and in good repair, as well as leaving soiled incontinence briefs on the floor in the communal shower, c.) serving resident meals on plastic trays and d.) failed to ensure that a complete and thorough inventory of resident (Resident #89) belongings was completed and a copy maintained on the medical record. The deficient practice was identified for 2 of 4 units observed under the Environmental Task ([redacted] and [redacted]) and 1 of 27 sampled residents, (Resident #89). This deficient practice was evidenced by the following: 1.) On 08/02/22 at 10:41 AM, during the initial tour of the facility, Surveyor #1 observed a geriatric recliner and mechanical lift placed in front of a bookcase. Another mechanical lift, a high-back wheelchair, and a stretcher were placed on the opposite wall from the bookcase in the day room in the presence of Resident #99. On 08/03/22 at 9:50 AM, Surveyor #1 observed a geriatric recliner and mechanical lift placed in front of a bookcase and a second mechanical lift, high-back wheelchair, and stretcher placed on the	F 584	1. Medical equipment was immediately removed and placed in a storage area. Resident rooms, hallways and common areas were checked again for cleanliness and cleaned as needed. Soiled briefs immediately removed, and shower room checked to prevent reoccurrence. Resident meals no longer served on plastic trays. Inventory sheet was completed for resident #89. 2. All residents have the potential to be affected by these deficient practices. Building wide rounds completed to ensure no other instances or these areas were identified. 3. Housekeeping staff will be re-educated on proper cleaning of resident rooms, hallways, shower rooms and common areas. Nursing staff re-educated about homelike dining experience. Nursing staff re-educated on inventory policy. 4. Weekly audits of 5 resident rooms, all hallways, all shower rooms and common areas on all units will be completed by housekeeping director or designee for 4 weeks, and monthly thereafter for 3 months to ensure that they are in compliance. Director of Nursing or Designee will complete audits of 3 meal service times to ensure compliance with tray removal for 4 weeks, and monthly thereafter for 3 months. DON or designee will audit 5 resident charts weekly to ensure that inventory sheets are in place. Findings will be brought to the QAPI	

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F 584	Continued From page 19 opposite wall from the bookcase in the day room. On 08/08/22 at 10:06 AM, Surveyor #1 observed a geriatric recliner and a mechanical lift placed in front of a bookcase in the day room. On 08/08/22 at 12:14 PM, Surveyor #1 observed a plastic bag with garbage inside on the floor in the hallway outside of the soiled-utility room. On the same date and time, Surveyor #1 observed a white, fabric material on the floor alongside the bed inside Resident #99's room. 2.) On 08/08/22 at 1:04 PM, Surveyor #1 observed scuff marks on the floor of room [redacted]. On 08/09/22 at 9:14 AM, Surveyor #1 observed the floor of room [redacted] was sticky upon walking on it. On 08/10/22 at 9:10 AM, Surveyor #1 observed a soiled incontinence brief, paper towel, and scuff marks on the floor of room [redacted]. On 08/10/22 at 10:29 AM, Surveyor #1 observed a soiled brief and glove on the floor of the communal shower room. The soiled brief was further observed on the floor of the shower room on 08/11/22 at 9:35 AM, 08/15/22 at 9:23 AM, 08/17/22 at 9:01 AM, and 08/18/22 at 9:00 AM. On 08/15/22 at 9:53 AM, during an interview with Surveyor #1, the Director of Environmental Services (DEVS) stated that the communal shower was cleaned twice daily. She further stated that every room was mopped daily. On 08/18/22 at 2:50 PM, during an interview with	F 584	committee monthly for 3 months.	

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Surveyor #1, the Licensed Nursing Home Administrator (LNHA) stated, "No" when asked if storing the medical equipment in a room used by a resident was considered a homelike environment.

A review of the facility document titled, "Bathroom Cleaning & Shower Rooms Procedure" under the section "Steps to Do Job" number 4; "Dust Mop. Pick up trash ..."

On 08/02/22 10:29 AM, Surveyor #2 observed the following environmental concerns on the [redacted] unit:

-Walls adjacent to the door frame of room [redacted] have peeled paint and marks all over the wall.
-The wall adjacent to the bulletin board and hallway corner appears to have rotten baseboard molding and an unidentified brown stain in front of the baseboard molding.
-The walls of the same area are missing paint and have unidentified stains on the wall.
-The corner of the door to the Central Bathing/Tub room is rotten on the bottom right corner and the door threshold is stained with an unidentified substance, brown in color.

On 08/03/22 at 10:23 AM, Surveyor #2 made the following observations on the [redacted] Unit:
-The [redacted] (near the entry door to the unit) walls are missing paint, and the door that leads to the outside is stained with an unidentified white film substance on the lower half of the glass door. In addition, the door threshold and lower frame of the door appeared to be rusted. The lower sheetrock wall to the left side, when facing the door, was cracked and peeling/separating. There was unidentified brown debris on the floor and in

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the corner of the molding on the floor. On the floor on the lower right side of the door, facing outwards, the surveyor observed unidentified brown debris on the floor and adjacent to the baseboard molding.
-General observation of the [NJAC 8:43E-2.1(a)] unit revealed walls missing paint, gouged walls/sheetrock, and brown/rust colored unidentified debris around baseboard molding throughout the unit.
-Outside of room [NJAC 8:4], Surveyor #2 observed a rust-colored stain extending approximately three feet past the hinge-side of the resident door and extending towards room [NJAC 8:4]. Upon closer inspection, Surveyor #2 was able to determine that the stain was wet with an unidentified watery substance that was rust colored.

On 08/03/22 at 11:02 AM, Surveyor #2 was granted permission to open the door to room [NJAC 8:43] Surveyor #2 had to apply significant force to open the door because the bottom of the door rubbed against the floor of the room. The resident stated, "Sometimes it's hard to open." Once inside the room, Surveyor #2 observed the lower left door frame to be rusted and unidentified brownish debris in the corner by the rusted door frame and the baseboard wall molding. On 08/05/22 at 10:57 AM, Surveyor #2 reviewed the Pavilion Maintenance Log. The log revealed that on "7/27" (staff name) commented "[NJAC 8:4] Broken Door Dragging" (as of 08/05/22 not signed off/completed by maintenance).

On 08/04/22 at 1:32 PM, Surveyor #2 observed an unidentifiable brown substance in the sink in the activities station on the [NJAC 8:43E-2.1(a)] unit. Surveyor #2 also observed what appeared to be three (3) small pieces of aluminum foil wrapper in the base of the sink.

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F 584	Continued From page 22 On 08/08/22 at approximately 10:26 AM, Surveyor #2 observed an approximate eight-by-10 inch gouge/hole in the drywall on the right-side wall as you enter room [redacted] at the baseboard floor molding level. The gouge/hole was partially obscured by the resident's dresser. Additionally, on 08/09/22 at 11:04 AM, Surveyor #2 observed broken molding surrounding the top of the clothing armoire. The molding was broken from the main body of the armoire, had exposed nails, and was not attached to the armoire but placed on top of the armoire. Surveyor #2 observed a red/rust colored stain on the floor between the bathroom door and extending to under the resident's bed in room [redacted] on 08/02/22, 08/03/22, 08/04/22, 08/05/22, 08/09/22, and 08/10/22. In addition, on the same dates, the surveyor smelled a strong odor of urine in room [redacted] On 08/10/22 at 9:43 AM, two (2) surveyors observed the left corner of the top sheet of the bed in room [redacted] to be stained with a yellow unidentified substance. There was a strong smell of urine in the room at that time. In addition, on the above-mentioned dates, Surveyor #2 observed a flush mount wall light outside the bathroom door missing its cover with the light bulb exposed. During an interview with Surveyor #2 on 08/17/22 at 9:34 AM, the Director of Environmental Services (DEVS) revealed the following: "We have two house keepers and one floor tech on the [redacted] unit. The floor tech was responsible for the unit floors. That would include all three sunrooms. Housekeeping's daily responsibility	F 584		

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was the cleanliness of resident rooms and bathrooms. Every room was cleaned daily, unless it was a troubled room, they are often cleaned more than once daily, we keep a log for those rooms, and we sign off each time we clean. Rooms [NJAC 8:43] and [NJAC 8:4] are logged and are considered troubled rooms. I monitor the unit to ensure rooms are clean. I try to do it daily and I keep a log. Those logs (Room Cleaning Log 416/418) are specifically addressing urine cleanups." Surveyor #2 revealed an observation dated [NJAC 8:43E-2.1 and], of a stain in room [NJAC 8:4], rust in color, that extended from the bathroom door to underneath the resident's bed. The DEVS responded, "That shouldn't be like that. The mopping isn't sufficient to clean that, and it should have been stripped by the floor tech."

3.) On 08/03/22 at 12:24 during lunch in the dining area, surveyor #1 observed that resident meals were served on plastic trays. The staff did not remove the plates, cups, napkins, or utensils from the tray for the residents. The observation was also observed on 08/08/22 at 12:18 PM, 08/09/22 at 12:19 PM, 08/10/22 at 12:16 PM, 08/15/22 at 12:07 PM, 08/17/22 at 12:11 PM.

On 08/17/22 01:58 PM, during an interview with Surveyor #1, the LNHA stated, "No, it is supposed to be homelike." when asked if meals should be served on trays.

Review of a facility provided document titled Creating a Homelike Dining Experience, created January 26, 2018, revealed under the heading Homelike environment:

"Do not put tray with meal in front of resident. Items must be placed on the table like someone

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would eat at home. Any garbage created from the setting up the tray cannot be left beside the resident."

4.) A review of the medical record revealed Resident # 89 was admitted to the facility with diagnosis which included, but was not limited to, NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted]

During an interview with Surveyor #4 on 08/08/22 at 10:29 AM, CNA #3 said, for a new admission, the resident was given a shower, put on clean clothes and socks. The aides help to put clothes away, set up the room, and make sure they are comfortable. We use a permanent marker pen to put the resident's name and room number on their clothes. When asked if the aides document what a resident brings with them, CNA #3 said, not that I know do we document what things they have but I think the unit manager might document. They (nurses) tell us if family does their clothes.

During an interview with the Surveyor #4 on 08/08/22 at 10:32 AM, Licensed Practical Nurse (LPN) #3, the assigned nurse for Resident #89, said for a new admission, I talk to family and ask questions of residents, do skin checks, the CNA gets the resident's weight, and we give them a meal or snack if they are hungry. Then we put up their clothes, do inventory on a piece of paper and the clothes are marked by housekeeping. LPN #3 went on to say that the CNA writes down what they brought in on a paper. Housekeeping then takes the clothes down to mark with the resident's name. LPN #3 said, the inventory form

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should go in the chart. There is sign put up in the room that family does laundry. Some residents do tear the sign down.

On 08/08/22 at 10:40 AM, Surveyor #4 reviewed Resident #89's hard medical record and the Electronic Medical Record and was unable to find the inventory sheet for Resident #89.

On 08/08/22 at 11:45 AM, Surveyor #4 reviewed the grievance logs for June, July, and August 2022. There was a documented grievance due to Resident #89 bit his/her lip. There were no documented grievances for missing items.

During an interview with Surveyor #4 on 08/08/22 at 12:17 PM, the Social Services Director (SSD) #1 said, she was the grievance officer. She said, the process for missing items was that staff or family can fill out a grievance form and the forms come to me to log. I then make a copy and give it to the housekeeping director who will go and investigate. SSD #1 said, Yes, staff is obliged to fill out a grievance form when a complaint for a missing item is brought to their attention. SSD #1 said, she will go to the laundry and look for the missing item, and will ask the resident or family if they have receipts. SSD #1 said, if we still can't find the missing items, we will discuss reimbursement with the administrator. SSD #1 said, we are supposed to have an inventory sheet on the chart. The SW said, not to my knowledge am I aware that Resident #89 had missing items. Staff keeps all his/her clothes in a three-drawer bin behind the nurses' station, as resident goes through the clothes and takes everything and throws the clothes all over. This is a request from his/her family.

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On 08/08/22 at 12:25 PM, Surveyor #4 requested Licensed Practical Nurse/Unit Manager (LPN/UM) to review the resident's chart, in the presence of the surveyor, for the resident inventory sheet of belongings. LPN/UM stated, I don't see it in here. He then said, give me one minute and left the office to the nurses' station and looked in another binder. He returned and said, "More than likely we don't have an inventory sheet, as Resident #89's family will bring things in several times a day." LPN/UM went on to say that the resident's family had been educated on the policy of telling us what he/she brings in and marking his/her clothes. LPN/UM said, he has not been able to find the missing items and still has no list of resident's missing items.

During a follow-up interview with Surveyor #4 on 08/09/22 at 11:43 AM, SSD #1 said, I put a note in resident's chart after speaking with LPN/UM and he is to cross check clothing with what is on the inventory sheet. It is a personal preference of the family to keep his/her clothes behind the nurses' station, so he/she doesn't throw them away or around his/her room.

During an interview with the surveyor, in the presence of the survey team members, on 08/17/22 at 9:34 AM, the Director of Environmental Services (DEVS) said, the process for the family bringing clothing into the facility was that the clothing was kept at the front desk, laundry was notified, and someone from laundry in the "personals department" will pick up the clothing. The clothes have an inventory sheet attached to the bag in which the clothes are placed, and the employee takes it back to laundry for labeling. The same procedure should happen whenever clothing is brought in by families. The

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DEVS said, they do get unlabeled clothing sometimes and we know what unit it came from, and we bag it up. The aide will call down and describe the clothing and the aide will come look at it, and then we will label the clothing, and the aide will take the clothing back to the unit. We are notified of the family doing laundry, and we discuss all missing items at morning meetings. We wash each nursing unit separately. We don't fill out inventory sheets whatsoever. We get a copy from the front. If we can't find the clothes, the resident or family fills out a grievance form, and we reimburse them. We look back at the inventory sheet and track what was here.

During an interview with Surveyor #4 on 08/17/22 at 2:19 PM, the Assistant Director of Nursing said the expectation was the inventory sheets were filled out upon admission for resident belongings.

On 08/18/22 at 11:25 AM, the LNHA provided the possession sheets dated 06/29/22, 08/10/22 and 08/17/22. The LNHA said the LPN/UM found them on the chart. Surveyor #4 told the LNHA that LPN/UM, in the presence of the survey team, went through the chart together and another binder for personal possessions and they were not there at that time.

A review of a progress note dated [redacted] at 15:00 (3:00 PM), revealed an inventory performed on resident clothing. The clothing sent to the laundry to be labeled and returned. The note was signed by the LPN/UM.

A review of a facility policy titled Personal Belongings, with new checked and date of 5/2022, revealed under the Purpose section: To assure safe storage and respectful handling or

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F 584	Continued From page 28 residents' personal belongings. Under the Procedure section 1. Upon admission, an inventory sheet is completed to inventory the residents' personal belongings. List all personal items, clothing list and miscellaneous items on the residents' Inventory of Personal Possessions, if applicable. NJAC 8:39-31.8 c (9) NJAC 8:39-4.1(15)	F 584		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 609		10/22/22

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F 609	Continued From page 29 Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH), a facility reportable event for a resident that sustained a serious injury of an unknown origin. This was cited at a level E as the deficient practice was cited at the last standard survey of 11/01/21. This deficient practice was identified for 1 of 27 residents reviewed (Resident #50), and was evidenced by the following: On 08/03/22 at 1:02 PM, the surveyor observed Resident #50 in the [redacted] area. The resident was seated in a chair at a table, did not want to remain seated, stood up, walked to another chair, and sat down. The resident then stood up, walked over to a table which contained, among other items, wipes, cups, and napkins and tried to overturn the table. The Licensed Practical Nurse/Unit Manager (LPN/UM) redirected the resident and asked a staff member to take the resident for a walk in the [redacted] area. According to the Admission Record, Resident #50 was admitted to the facility with diagnoses which included, but were not limited to, unspecified [redacted]	F 609	1. Investigation was completed for the resident toe fracture at the time of the incident. 2. All residents with injuries of unknown origin have the potential to be affected by the deficient practice. A review of all incidents / accidents for the last 3 months was completed and there were no other unreported injuries of unknown origin identified. 3. Nursing staff and Nursing Administration were re-educated on reporting any injury of unknown origin to their supervisor immediately. Administrator and Director of Nursing re-educated on reporting any injury of unknown origin to the NJDOH and other authorities as needed. 4. The Administrator or designee will review the nursing reports and grievance logs weekly x 90 days to ensure all injuries of unknown origin are appropriately being reported within the guidelines of the regulations. The findings will be reported to the QAPI committee monthly for 3 months.	

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F 609	Continued From page 30 NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. . Review of Resident #50's Significant Change in Status Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJAC 8:43E-2.1 and , revealed that the resident had NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. , and required Exec Order 4.b.1. and NJAC 8:43E-2.1.(d) patient confidentiality The resident was coded for Exec Order 4.b.1. and NJAC 8:43E-2.1.(d) patient confiden and walking as NJAC 8:43E-2.1 and Exec , but able to stabilize without staff assistance" when moving from seated to standing position. Review of Resident #50's individualized, comprehensive Care Plan (CP) included an entry dated NJAC 8:43E-2.1 and E which indicated that the resident had extensive behaviors which included, but was not limited to, Exec Order 4.b.1. and NJAC 8:43E-2.1.(d) patient confidentiality The CP further reflected an entry dated NJAC 8:43E-2.1 and which indicated that the resident had NJAC 8:43E-2. and Exec Order 26, 4. b. 1 NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. with an intervention to Exec Order 4 Review of the Progress Notes revealed a NJAC 8:43E-2.1 and E Note dated NJAC 8:43E-2.1 and at 4:29 PM, which reflected that NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. Will continue to monitor." The Progress Notes further revealed a Nurses Note dated NJAC 8:43E-2.1 and at 10:30 AM, which reflected	F 609		

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"It was brought to this nurses attention at 10:15 am by CNA [Certified Nursing Assistant] that resident [redacted]. I observed resident [redacted] to be [redacted] response from resident. Applied [redacted] Offered [redacted], resident tolerated meds [medications] well. Unable to keep resident off of feet." The Progress note further reflected that the Nurse Practitioner (NP) was alerted and an [redacted] was ordered.

The Progress Notes reflected a Nurses Note dated [redacted] at 12:00 PM, which reflected "After investigating incident, it was found that resident had behaviors 2 days prior; 'flipping tables and chairs.' With this information, it is determined that swelling to [redacted] was due to preexisting behaviors. Therefore abuse s [is] not a factor. We will continue to manage pain pending x-ray exams."

The Progress Notes further reflected a Health Status Note dated [redacted] at 5:09 PM, which reflected "IDC (Interdisciplinary) team met to review occurrence of [redacted] resident noted to have a [redacted]. Upon investigating incident, it was found that resident had behaviors 2 days prior; [redacted].' With this information, it is determined that [redacted] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. . Therefore abuse is not a factor. Care plan has been updated with goals and intervention, all parties were notified and order obtained from NP for x-ray. We will continue to manage pain pending x-ray exam."

Review of the x-ray report of the [redacted]

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NJAC 8 43E-2.1 and Exec Order 26, 4. b. 1. at 3:27 PM reflected that resident sustained an NJAC 8 43E-2.1 and Exec Order 26, 4. b. 1. NJAC 8 43E-2.1 and Exec Order 26, 4. b. ."

Review of the skin incident report dated NJAC 8 43E-2.1 and, provided by the facility, reflected that the resident had NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. The report further reflected that two witness statements were obtained, one from the CNA and one from the LPN/UM. The CNA's statement reflected that resident was "limping and [his/her] NJAC 8 43E-2.1 and Exec Order 26, 4 so I reported it to the nurse." The LPN/UM's statement reflected that the CNA alerted the LPN/UM that " ...resident NJAC 8 43E-2.1 and Exec O NJAC 8 43E-2.1 and Exec . Resident observed NJAC 8 43E-2.1 and Exec O NJAC 8 43E-2.1 and Exec Order 26, 4. b and tender to touch." LPN/UM contacted the NP who ordered an x-ray of the foot and ankle with further orders to continue with current pain management.

During an interview with the surveyor on 08/16/22 at 10:55 AM, the LPN/UM stated that he did not know if an injury of unknown origin needed to be reported.

The surveyor interviewed the Assistant Director of Nursing (ADON) and Licensed Nursing Home Administrator (LNHA) on 08/17/22 at 1:14 PM. The surveyor inquired what was the process to investigate abuse. The ADON stated that when nursing observes abuse, they will report it to the supervisor and she will inform the DON (Director of Nursing), ADON and Administrator. The abuse is then reported to corporate and an investigation is completed and reported to the Department of Health. The LNHA stated that for Resident #50, based on the information received at the time, with the resident's history of behaviors, and the resident's demonstrated behavior two days prior

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F 609	Continued From page 33 of flipping tables, we did not think it was abuse or an injury of unknown origin. The LNHA further stated that now, looking at the facts, we would definitely have investigated the incident further and reported it to the Department of Health. Review of the facility's Abuse Prevention policy, reviewed/revised 05/22, reflected "All reports of alleged or suspected abuse, neglect, and injuries of unknown origin shall be promptly and thoroughly investigated by the facility's Administrator." The policy further reflected that "If no cause and effect can be established for an injury, the incident will be defined as "origin unknown" and the person conducting the investigation will maintain a record of the incident, the action taken, and the outcome." The policy indicated that "When the investigation is concluded, the OOIE [Office of the Ombudsman for the Institutionalized Elderly] and the NJDHSS [New Jersey Department of Health and Senior Services] will be notified of the results of the investigation, as well as any corrective measures taken." The policy reflected that "All injuries of unknown origin will be reported to appropriate agencies as indicated in this facility's policy titled "Report and Investigation Protocols - Abuse, Neglect, Injuries of Unknown Origin." NJAC 8:39-9.4(f)	F 609		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged	F 610		10/22/22

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F 610	Continued From page 34 violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to thoroughly investigate an injury of unknown origin. This was cited at a level E as the deficient practice was cited at the last standard survey of 11/01/21. This deficient practice was identified for 1 of 27 sampled residents, (Resident #50) and was evidenced by the following: On 08/03/22 at 1:02 PM, the surveyor observed Resident #50 in the [redacted] area. The resident was seated in a chair at a table, did not want to remain seated, stood up, walked to another chair, and sat down. The resident then stood up, walked over to a table which contained, among other items, wipes, cups, and napkins and tried to overturn the table. The Licensed Practical Nurse/Unit Manager (LPN/UM) redirected the resident and asked a staff member to take the resident for a walk in the [redacted] area.	F 610	1.Resident #50 received appropriate medical treatment at the time of identification of this injury. 2.Any resident with an injury of unknown origin has the potential to be affected by a lack of investigation into the cause of the injury. A thorough review of all incidents / accidents for the last 3 months was completed and there were no other uninvestigated injuries of unknown origin identified. 3.Administrator, Director of Nursing, Nursing Administration and Nursing staff were re-educated on thoroughly investigating any injury properly, including of unknown origin. 4.The Director of Nursing and designee will audit 3 incident and accident files per week for 90 days to ensure a through and accurate investigation/documentation and follow up is done. Results of these audits will be reported to the QAPI Committee monthly for 3 months.	

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According to the Admission Record, Resident #50 was admitted to the facility with diagnoses which included, but were not limited to, unspecified [redacted]

Review of Resident #50's Significant Change in Status Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], revealed that the resident had [redacted], and required supervision of one person for transfers (how resident moves to and from surfaces including to or from bed, chair, wheelchair, standing positions) and locomotion on the unit (how resident moves between locations in his/her room and adjacent corridor on the same floor). The resident was coded for [redacted]

Review of Resident #50's individualized, comprehensive Care Plan (CP) included an [redacted] which indicated that the resident had extensive behaviors which included, but were not limited to, [redacted] The CP further reflected an entry dated [redacted] which indicated that the resident had [redacted] with an intervention to "Cue, reorient and supervise as needed."

Review of the Progress Notes revealed a Behavior Note dated [redacted] at 4:29 PM, which

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reflected that "Patient is yelling and wandering in dining room. Patient is flipping over chairs and tables screaming 'please help me.' Will continue to monitor."

The Progress Notes further revealed a Nurses Note dated NJAC 8 43E-2.1 and at 10:30 AM which reflected "It was brought to this nurses attention at 10:15am by CNA [Certified Nursing Assistant] that resident NJAC 8 43E-2.1 and Exec Order 26, 4. b. 1. I observed resident crying, stating 'it hurts.' NJAC 8 43E was noted to be NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. NJAC 8 43E-2.1 and Exec Order 26, 4. b generated a NJAC 8 43E-2.1 and Exec Order from resident. Applied cold compress to area. Offered NJAC 8 43E-2.1 resident tolerated meds [medications] well. Unable to keep resident off of feet." The Progress note further reflected that the Nurse Practitioner (NP) was alerted and an x-ray of the NJAC 8 43E-2.1 and Ex was ordered.

The Progress Notes reflected a Nurses Note dated NJAC 8 43E-2.1 and Exec Order 26, 4. b. 1. , which reflected "After investigating incident, it was found that resident had behaviors 2 days prior; 'flipping tables and chairs.' With this information, it is determined that NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. was NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. . Therefore abuse s [is] not a factor. We will continue to manage pain pending x-ray exams."

The Progress Notes further reflected a Health Status Note dated NJAC 8 43E-2.1 and Exec Order 26, 4. b. 1. which reflected "IDC (Interdisciplinary) team met to review occurrence of NJAC 8 43E-2.1 ; resident noted to have a NJAC 8 43E-2.1 and Exec Order 26, 4. b . Upon investigating incident, it was found that resident had behaviors 2 days prior; NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. ' With this information, it is determined that NJAC 8 43E-2.1 and Exec Order 2 NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. behaviors.

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Therefore abuse is not a factor. Care plan has been updated with goals and intervention, all parties were notified and order obtained from NP for x-ray. We will continue to manage pain pending x-ray exam."

Review of the x-ray report of the right ankle/right foot dated [NJAC 8:43E-2.1 and] at 3:27 PM reflected that resident sustained an "[NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] [NJAC 8:43E-2.1 and Exec Order 26, 4. b.]."

Review of the [NJAC 8:4] incident report dated [NJAC 8:43E-2.1 and], provided by the facility, reflected that the resident had [NJSA 47:1A-1 reasonable privac] [NJAC 8:43E-2.1 and Exec Order 26, 4. b.]. The report further reflected that two witness statements were obtained, one from the CNA and one from the LPN/UM. The CNA's statement reflected that resident was [NJAC 8:43E-2.1 an] and [his/her] [NJAC 8:43E-2.1 and Exec Order 26, 4] so I reported it to the nurse." The LPN/UM's statement reflected that the CNA alerted the LPN/UM that "[NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] [NJAC 8:43E-2.1 and Exec]. Resident observed [NJAC 8:43E-2.1 and Exec] [NJAC 8:43E-2.1 and Exec Order 26] [NJAC 8:43E-2.1 and Exec Order 26, 4. b] and [NJAC 8:43E-2.1 and] [NJAC 8:43E-2]" LPN/UM contacted the NP who ordered an [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] with further orders to continue with [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.].

During an interview with the surveyor on 08/16/22 at 10:55 AM, the LPN/UM and surveyor reviewed the Health Status Note dated [NJAC 8:43E-2.1 and Exec Order 26] [NJAC 8]. The surveyor inquired as to who comprised the IDC team. The LPN/UM stated that the IDC team consisted of the Director of Nursing (DON), himself and maybe the Assistant Director of Nursing (ADON) and then stated, "I can't remember." The surveyor inquired as to how was the decision made to rule out abuse. The LPN/UM stated that the resident had behaviors of flipping tables, had poor safety awareness of

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walking into things, and kicking objects to move them out of the way. It was noted that the resident was having behaviors the day before or two days prior to 05/26/22. The surveyor inquired if anyone saw the [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.]. The LPN/UM reviewed the progress note dated 05/24/22 in the presence of the surveyor. The LPN/UM stated that while not explicitly saying that the nurse observed it, "I would assume the table hit her foot." The LPN/UM and the surveyor reviewed the skin incident report, dated [NJAC 8 43E-2.1 and], and the two statements obtained on [NJAC 8 43E-2.1 and E]. The LPN/UM confirmed that he wrote the nurse statement and that the CNA assigned to the resident wrote the second statement. He further confirmed that the CNA reported to him that the resident's [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.], that the resident was [NJAC 8 43E-2.1] and he assessed the resident. The surveyor inquired if the LPN/UM was familiar with the process to rule out abuse. The LPN/UM stated that he was under the impression that witness statements would be obtained initially and then each shift 72 hours back from the date of the injury. The surveyor inquired if this should have been completed. The LPN/UM stated that based on the policy, "Yes, but I was not aware that we were investigating a potential abuse." At that time, the LPN/UM and surveyor reviewed the 05/26/22 5:09 PM Health Status Note. The LPN/UM confirmed that the Health Status Note indicated the IDC team was ruling out abuse and stated that the investigation was incomplete. The surveyor inquired of the LPN/UM if this incident was an injury of unknown origin and the LPN/UM stated, "Yes. We should have obtained 72 hours of witness statements from the date of injury."

During an interview with the surveyor on 08/17/22

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at 10:11 AM, the ADON stated that the IDC team consisted of the UM, me, the DON and maybe Social Services depending on the concern. In this case, the resident had a history of flipping tables and the LPN/UM documented a progress note two days prior that he saw the resident flipping tables and that the furniture touched her [redacted] and at that time, the resident had no complaints of pain. The surveyor and ADON reviewed the progress notes dated [redacted] and [redacted] The ADON read the progress notes and indicated that the reason abuse was ruled out was because of the resident's behaviors and the LPN/UM verbally stated the table touched the resident's [redacted]. The ADON was unaware why the LPN/UM did not write in the progress note that the table touched resident's [redacted] The ADON confirmed that the progress note dated [redacted] only says "flipping tables." The surveyor inquired what was the process to rule out abuse. The ADON replied that an investigation would be initiated and statements would be obtained a few days back from the incident and the team would decide based on the information obtained. The ADON and surveyor reviewed the skin incident report dated [redacted] and specifically reviewed the statements written by the LPN/UM and CNA. The surveyor inquired if the statements reflected the resident's [redacted] was touched with the table; and if the facility should have investigated the incident further. The ADON stated the LPN/UM verbally stated that he saw the table hit the resident's [redacted] and it was the IDC team's decision to rule out abuse based on that. The ADON stated that she was not sure why the documentation did not reflect that. Sometimes documentation was made in error. The ADON stated that we investigate every little incident that occurs in the building, this is an isolated event

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and the LPN/UM put us on the spot. The ADON reiterated that we did not do a further investigation because of the history of the resident's behaviors and what the LPN/UM said. The resident's behaviors were care planned and the LPN/UM witnessed the table touched Resident #50's toe.

The surveyor interviewed the ADON and Licensed Nursing Home Administrator (LNHA) on 08/17/22 at 1:14 PM. The surveyor inquired what was the process to investigate abuse. The ADON stated that when nursing observes abuse, they will report it to the supervisor and the supervisor will inform the DON, ADON and Administrator. The abuse is then reported to corporate and an investigation is completed and reported to the Department of Health. The LNHA stated that for Resident #50, based on the information received at the time, with the resident's history of behaviors, and the resident's demonstrated behavior two days prior of flipping tables, we did not think it was abuse or an injury of unknown origin. The LNHA further stated that now, looking at the facts, we would definitely have investigated the incident further and reported it to the Department of Health.

On 08/18/22 at 2:25 PM, the facility presented a witness statement dated [NJAC 8 43E-2.1 and] obtained by the LPN/UM from agency CNA #19 who worked on [NJAC 8 43E-2.1 and]. The witness statement reflected "Statement received via phone: written by [name, LPN/UM]. During my shift, I remember seeing [resident] flipping tables and chairs. I remember seeing the table land on [his/her [NJAC 8 43E]] I notified the nurse and she came and assessed [him/her]."

During a telephone interview with the surveyor on

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F 610	Continued From page 41 08/18/22 at 2:31 PM, agency CNA #19 confirmed that the LPN/UM called and spoke to him today. Agency CNA #19 stated that the resident was acting up, flipping stuff and he told the nurse. Agency CNA #19 stated that he did not see the table hit the resident's [NJAC 8:43E] and said, "I think the table hit her [NJAC 8:4]. I'm pretty sure it hit her [NJAC 8:43] because resident was holding her [NJAC 8:4]." The surveyor inquired if the nurse assessed the resident's [NJAC 8:43] and agency CNA #19 stated, "I believe the nurse looked at resident's [NJAC 8:43E:2] During a follow up interview with the surveyor on 08/19/22 at 8:45 AM, the LPN/UM stated that he now had a better understanding of the investigation process and he should have made more phone calls to rule out abuse at that time. He stated that he interviewed the agency CNA yesterday and left a message for the nurse who worked on 05/24/22. The LPN/UM confirmed that these interviews were part of the abuse investigation and that the telephone calls to the CNA and Nurse should have been made earlier. During a follow up interview with the surveyor on 08/19/22 at 9:34 AM, the LNHA stated that the process to investigate an injury of unknown origin was if we suspected something or if something was reported, start an investigation, interview staff, obtain statements, and review records. The surveyor inquired how far back to you obtain statements. The LNHA stated that he would check. On 08/19/22 at 10:12 AM, the surveyor conducted a follow up interview with the LNHA and ADON. The LNHA stated that the normal process was to reach out to any staff within the previous 48 hours to complete the investigation. The surveyor	F 610		

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inquired, did you follow your policy. The LNHA stated, "No, but we based the conclusion on the resident's previous behavior two days earlier." The ADON stated that the process was to obtain statements over the last 48 hours to rule out abuse. The surveyor inquired, was this done. The ADON stated, "No, it was not done. We relied on the information provided by the LPN/UM and the resident's behaviors on 05/24/22.

On 08/19/22 at 11:00 AM, the LNHA provided the surveyor with the telephone number for the DON.

During a telephone interview with the surveyor on 08/19/22 at 11:09 AM, the DON stated that her comments were based on her recollection because she did not have access to her computer. The DON stated that she observed the resident in the [redacted] area on 05/24/22. The resident was acting out and throwing furniture including chairs and tables. The resident's behavior did not cause any injury at the time, but I assume that it hit her [redacted] The DON stated that a couple days later, the resident complained of pain in the [redacted] the nurse practitioner was called, an x-ray was ordered and obtained, reflecting a fracture. We attributed it solely with the episodes of the resident's throwing furniture on 05/24/22. The DON stated that on the 24th, Resident #50's behaviors escalated, and the resident threw the furniture multiple times. The surveyor described the 05/26/22 progress note wherein the IDC team met to rule out abuse. The DON stated that she never thought of ruling out abuse because of the resident's behaviors on 05/24/22. The surveyor inquired if the DON was part of the IDC team. The DON replied, "I was not part of the IDC team and I do not know why the LPN/UM documented

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F 610	Continued From page 43 like that." The surveyor inquired if she saw any furniture hit resident's [redacted] and the DON stated, "I was there on the 24th and I truly believe that was when the injury occurred. I did not document my observations." Review of the facility's Abuse Prevention policy, reviewed/revised 05/22, reflected that "All reports of alleged or suspected abuse, neglect, and injuries of unknown origin shall be promptly and thoroughly investigated by the facility's Administrator." The policy reflected that the person conducting the investigation will "In the case of an unexplained injury, request a listing of all persons who have had contact with the resident during the previous 48 hours, including visitors, family members, consultants, volunteers, etc." The policy further reflected that "If no cause and effect can be established for an injury, the incident will be defined as "origin unknown" and the person conducting the investigation will maintain a record of the incident, the action taken, and the outcome." NJAC. 8:39-4.1(a)(5)	F 610		
F 635 SS=E	Admission Physician Orders for Immediate Care CFR(s): 483.20(a) §483.20(a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to transcribe	F 635	1. Resident #50 had no negative outcome as a result of the delay in the orthopedic appointment and staple care.	10/22/22

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F 635	Continued From page 44 hospital discharge orders upon readmission to the facility for one resident. This deficient practice was identified for 1 of 1 resident (Resident #50) reviewed for pain and was evidenced by the following: According to the Admission Record, Resident #50 was admitted to the facility with diagnoses which included, but were not limited to, NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. Review of Resident #50's Significant Change in Status Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJAC 8:43E-2.1 and revealed that the resident had NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1., and NJSA 47:1A-1 reasonable privacy ex The resident was coded for NJSA 47:1A-1 reasonable privacy expectation Review of Resident #50's individualized, comprehensive Care Plan (CP) included an entry dated NJAC 8:43E-2.1 an, which indicated that the resident was at risk for falls related to the resident's NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. NJAC 8:43E-2.1 and Exe	F 635	2. All residents readmitted to the facility are at risk for having hospital discharge orders not transcribed. An audit of all residents readmitted to the facility in the last 30 days will be conducted to ensure all hospital discharge orders had been properly transcribed. 3. The policy for Physicians Orders was reviewed and updated to include review of hospital discharge orders. Nurses, Supervisors and Unit Managers were re-educated to thoroughly review all hospital readmission paperwork and discharge orders and transcribe all to the resident's current physicians order sheet. The 11-7 shift nurses were re-educated to include the review of hospital discharge orders to ensure no omissions have occurred while doing nightly chart check. 4. The Director of Nursing or designee will review all hospital re-admission orders for 30 days, then 3 per week for 30 days, and one per week for 30 days to ensure all readmission orders were transcribed to the resident's current physicians order sheet. The result of these audits will be reported to the QAPI committee monthly for 3 months.	

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Review of the fall investigation dated [NJAC 8 43E-2.1 and] reflected that Resident #50 sustained a fall at about 10:03 PM in his/her room.

Review of the [NJAC 8 43E-2.1 and] 11:33 [NJAC 8 43E-2.1a] Incident progress note reflected the resident was [NJAC 8 43E] on the [NJAC 8 43E-2.1 and Exec Order] on his/her [NJAC 8 43E-2.1 and] Resident displayed [NJAC 8 43E-2.1 and E] t and was [NJAC 8 43E-2.1 and]. Resident #50 was sent to the emergency room to be evaluated and to rule out injury.

Review of the hospital's After Visit Summary (Summary), dated [NJAC 8 43E-2.1 and], reflected the following:
- Diagnoses: [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.]).
- Staple care: [NJSA 47:1A-1 reasonable privacy expectation] [NJAC 8 43E-2.1] [NJAC 8 43E-2.1] [Order 26, 4. b. 1.] [NJAC 8 43E-2.1] [6, 4. b. 1.] [NJAC 8 43E-2.1] [der 26, 4. b. 1.] [NJAC 8 43E-2.1] an [NJAC 8 43E-2.1 and Exec Order 26, 4. b. 1.]
- Schedule an appointment with [NJSA 47 1A-1 reasonab] as soon as possible for a visit in one day (around 07/04/22).

Review of the 07/06/22 10:15 PM Nurse Practitioner (NP) Progress Note reflected that the resident was assessed by the NP, had a recent fall and an emergency room visit for evaluation. The progress note further reflected the resident sustained an occipital scalp laceration with four staples. The progress note's Assessment/Plan reflected to continue with scalp/laceration care, monitor for healing, and monitor for signs/symptoms of infection. The Assessment/Plan further reflected to follow up

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F 635	Continued From page 46 with an ortho (NJSA 47 1A-1 reasonable privacy expectation recommended by the hospital discharge. Review of the Physician's Orders for 07/02/22 through 07/07/22 did not reflect an order for the NJAC 8 43E-2.1 and Exec Order 26 care or an appointment with the NJAC 8 43E-2.1 and Exec Order 26, 4. b. 4. During an interview with the surveyor on 08/09/22 at 11:15 AM, Licensed Practical Nurse (LPN) #4 stated that when a resident returns from the hospital, the process was to review the discharge paperwork, medications and instructions, call the physician to review the medications and instructions, transcribe orders obtained from the physician onto the physician orders and then give the hospital paperwork to the Unit Manager (UM). If a resident needs a follow up appointment, we have someone that schedules the appointment. It is important to review all of the hospital discharge paperwork so that nothing is missed. During an interview with the surveyor on 08/09/22 at 11:19 AM, the LPN/UM stated that he was familiar with Resident #50's NJAC 8 43E-2.1 and Exec Order 26. He stated that the staples had been removed by a NP and confirmed that the resident was not seen by the orthopedic surgeon. The LPN/UM stated that the process when a resident was out of the facility for 24 hours at the hospital, was that the nurse would complete the readmission process, review the documentation from the hospital and notify the physician or NP. The physician would come into the facility, review the hospital discharge summary package, and give the ok on medications that the hospital recommended and the physician would write the orders. At that time, the LPN/UM and surveyor reviewed the physician orders and the hospital Summary. The	F 635		

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LPN/UM confirmed there were no orders transcribed when the resident returned from the hospital. The LPN/UM stated that what should have been done was the hospital discharge information should have been forwarded to me or the supervisor on that particular day. We should have received orders to monitor the staple site for signs and symptoms of infection, redness, swelling, notify the physician with any changes and to apply an antibiotic ointment to the area. The LPN/UM further stated that an appointment with the orthopedic surgeon should have been scheduled. He stated that it was important to have the physician orders to make sure there was no lasting injury to the resident and to treat the resident's injury.

During an interview with the Licensed Nursing Home Administrator (LNHA) and the Assistant Director of Nursing (ADON) on 08/10/22 at 9:45 AM, the surveyor reviewed the hospital Summary and the physician orders with the LNHA and ADON. The LNHA and ADON confirmed there were no physician orders written for care of the NJSA 47 1A-1 reasonable privacy ex or the follow up for NJSA 47 1A-1 reasonab The ADON stated that the process when a resident returns from the hospital was that the admitting nurse will complete the readmission and then the manager/supervisor will follow up from there. The admitting nurse will talk to the physician to review the hospital Summary, the discharge diagnosis and the physician may agree or make changes to the medications. The admitting nurse should have transcribed the physician orders onto the physician order sheet.

During an interview with the surveyor on 08/10/22 at 10:01 AM, NP #1, in the presence of the LNHA and ADON, reviewed the physician orders and

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hospital summary with the surveyor. The surveyor inquired of NP #1 if there should have been orders transcribed to monitor the staples and NP #1 stated that this hospital documented the staple monitoring in a different place from the medications and discharge instructions. The surveyor inquired if there should have been an order to follow up with the NJSA 47 1A-1 reasonable privacy expectati and NP #1 stated that the resident should have been seen by the NJSA 47 1A-1 reasonable privacy expectati. NP #1 explained that she was a contractor of the facility and that the resident was also seen by the attending physician's NP #2.

During an interview with the surveyor on 08/10/22 at 3:41 PM, NP #2 stated that he was familiar with Resident #50's fall on 07/02/22. NP #2 stated that the admitting nurse should have reviewed the orders for the NJSA 47:1A-1 reasonable privacy expectation appointment with him and put into place the recommendation of the emergency room. He stated that he does not know what happened, as he reviewed the hospital records and assumed that the orders were written and it was probably missed.

During a follow-up interview with the surveyor on 08/16/22 at 10:55 AM, with LPN/UM, the surveyor inquired if the LPN/UM reviewed the hospital Summary and ensured that the medications were reviewed, treatments were ordered and follow up visits are ordered and scheduled. The LPN/UM stated that he expected the nurses to reach out to the physician to clarify the hospital orders and follow up appointments and transcribe the physician orders. LPN/UM stated that ultimately, it was his responsibility as unit manager to review the orders if something happened on the shift; or if he was not at the facility, then it falls on the

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supervisor in charge to review the information to ensure that everything was documented correctly. The surveyor inquired, what happened in this instance. The LPN/UM stated, "When I reviewed the hospital Summary, I did not notice the follow up appointment with the [NJSA 47 1A-1 reasonable privacy expectati]. It was my responsibility." The LPN/UM further stated that it was important for the resident to see the [NJSA 47 1A-1 reasonable privacy expectatio] so that there were no adverse reaction from not seeing the [NJSA 47 1A-1 reasonab], and that the resident had no range of motion issues, no loss of strength, and that the resident's energy levels remained stable. At that time, the surveyor reviewed with the LPN/UM the treatment recommendations for the staples in the hospital Summary and he confirmed that there should have been orders transcribed. The LPN/UM stated that Resident #50 was readmitted to the facility on [NJAC 8:43E-2.1 and] and it was my responsibility to follow up.

During a follow up interview with the surveyor on 08/16/22 at 12:11 PM, NP #2 stated that he reviewed Resident #50's orders when the resident returned from the hospital, but for some reason, the orders were not written. NP #2 stated that he believed it was an oversight at the time and confirmed that if it was not written, it was not done. NP #2 further stated that he assumed, because there were two NPs monitoring the resident, that NP #1 reviewed the orders. NP #2 stated, "It is my fault and I take responsibility that the resident did not see the [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] but pain management was always in place."

During a follow up interview with the surveyor on 8/17/22 at 9:35 AM, NP #1 stated that if an admission comes in on her shift, she will review the paperwork. She stated that it is not her

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F 635	Continued From page 50 responsibility to ensure that the admissions orders are documented but if she sees something, she will make a recommendation. During a follow up interview with the surveyor on 08/17/22 at 10:11 AM, the ADON stated that she expected the readmitting nurse to review the hospital discharge paperwork with the physician, and to transcribe the orders on the physician order sheet based on what the physician approved and ordered. Review of the facility's unnamed policy, initiated 05/2022, concerning medication orders reflected that "Each medication order is documented in the resident's medical record with the date, time, and signature of the person receiving the order." NJAC 8:39-11.2 (a), 27.1(a)	F 635		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders.	F 655		10/22/22

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F 655	Continued From page 51 (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to develop a Baseline Care Plan for a newly admitted resident who required COVID Persons Under Investigation Precautions (PUI). This deficient practice was identified for 2 of 2 residents (Residents #363 and #364) reviewed for Transmission-Based Precautions and was evidenced by the following: 1. During the initial tour of the Court 2 unit on	F 655	1. The care plan for residents #363, and #364 were immediately updated to include effective and person-centered care this included the need for isolation and a physician's order. An audit was done on all newly admitted resident charts within the past 60 days to ensure that all Baseline Care Plans were done and included the instructions needed to provide effective and person-centered care of each resident that meet	

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F 655	Continued From page 52 08/02/22 at 10:30 AM, the surveyor observed signage for droplet precautions and to "Stop and check with nurse before entering" attached to the wall outside Resident #363's door. The surveyor observed a 3-tier bin that contained Personal Protective Equipment (PPE) located outside the resident's room. At that time, the surveyor interviewed the Registered Nurse/Unit Manager(RN/UM) #1 who stated that Resident #363 was a new admission from the hospital who [redacted] and would be on PUI/Droplet precautions for [redacted] days. According to the Admission Record, Resident #363 was admitted with diagnoses which included, but were not limited to [redacted] A review of the Physician order sheet did not reveal an order for PUI or droplet isolation precautions. A review of Resident #363 immunizations did not reveal documentation that the resident had received Covid vaccinations. A review of the progress note dated [redacted] at 3:13 AM, titled "Skilled/COVID Documentation," revealed that Resident #363 was currently being monitored secondary to exposure to [redacted] (PUI). [redacted] Review of the Admission Minimal Data Set (MDS)	F 655	professional standards and quality care. 2. All residents have the potential to be affected by this deficient practice. 3. Nurses were in-serviced by the Director of Nursing on the initiation of Baseline Care plans and the content that is required within the first 24-48 hours of the resident's admission to the facility. 4. The Director of Nursing or designee will conduct weekly audit all new admissions for the initiation and completion of Baseline Care Plans for 60 days. Findings will be reviewed by the QAPI committee monthly for 3 months.	

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dated [NJAC 8 43E-2.1 and E] an assessment tool used to facilitate the management of care, revealed Resident #363 required [NJSA 47 1A-1 reaso] while a resident.

A review of Resident #363's Baseline Care Plan (BCP) did not address Resident #363's Covid PUI/Droplet isolation precaution.

2. During the initial tour of the [NJAC 8 43] Unit on [NJAC 8 43E-2.1 and Exec Order 26, 4. b. 1.], the surveyor observed signage for Contact Precautions and to "Stop and check with nurse before entering" attached to the wall outside Resident #364's [NJAC 8 43]. The surveyor observed a 3-tier bin that contained PPE located outside the resident's room.

According to the Admission Record, Resident #364 was admitted with diagnoses which included, but were not limited to, [NJAC 8 43E-2.1 and Exec Order 26] [redacted]

A review of the Physician order sheet did not reveal an order for COVID PUI or Droplet isolation precautions.

Review of the Admission MDS dated [NJAC 8 43E-2.1 and Exec Order 26, 4. b. 1.] revealed Resident #363 required [NJSA 47 1A-1 reaso] while a resident.

A review of Resident # 364 immunizations did not reveal documentation that the resident had received Covid vaccinations.

A review of the progress note dated [NJAC 8 43E-2.1 and] at [NJAC 8 43E-2.1 and] titled "Skilled/COVID Documentation" revealed that Resident #364 was a new admission on observation precautions and was to be maintained on droplet precautions.

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A review of Resident #364's BCP did not address Resident #364's Covid PUI or Droplet precaution.

During an interview with the surveyor on 08/09/22 at 12:30 PM, the Assistant Director of Nursing (ADON) stated that if the facility could not verify that the resident received up to date Covid vaccinations upon admission to the facility, then the resident would be placed on Droplet (PUI) precautions for 7 days. The ADON further stated that she would expect a baseline care plan for PUI /Droplet precautions.

During an interview with the surveyor on 08/10/22 at 8:48 AM, the Licensed Nursing Home Administrator confirmed that Resident #364 was not vaccinated for Covid and was placed on Droplet precautions when admitted.

During an interview with the surveyor on 08/10/22 at 9:52 AM, the Registered Nurse/Unit Manager (RN/UM) #2 stated that baseline care plans were completed by the admitting nurse and then updated by the Unit Manager and completed within 24-48 hours of admission. The RN/UM #2 stated that if a resident was admitted on isolation precautions, then it should be included in the BCP. RN/UM #2 confirmed that Resident #364 was admitted to the facility on Droplet and Contact precautions and did not have a BCP for PUI/Droplet precautions.

During an interview with the surveyor on 08/10/22 at 11:36 AM, the RN/UM #1 stated that when a resident was admitted to the facility, a BCP would be initiated within 48 hours of admission. The BCP would include activities of daily living (ADLs), pain, skin, falls or anything pertinent to

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F 655	Continued From page 55 the resident. If a resident was admitted to the facility and placed on PUI/Droplet precautions, then it should be included in the BCP. The RN/UM #1 further stated that it was important that the BCP was correct to "keep everyone on the same page" During an interview with the surveyor on 08/10/22 at 12:36 PM, the ADON stated that the BCP would be completed by the admitting nurse, and then updated by the unit manager within 24-48 hours of admission. The BCP would include falls, skin, pain, ADLs and any additional pertinent items for that resident. The ADON further stated the importance of the BCP was that it would be patient specific and that the staff were aware of how to take care of the resident A review of the facility's policy titled "48 Hour Baseline Care Plan", reviewed date of May 2022, indicated that a baseline plan of care to meet the resident's immediate care needs would be developed with 48 hours of admission. A review of the facility's policy titled "Transmission-based Precautions", reviewed date of 05/2022, revealed that Transmission-based Precautions are documented in the care plan. NJAC 8:39-11.2(d)	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		10/22/22

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F 656	Continued From page 56 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was	F 656	1.The care plan for resident #7 was immediately updated to include the	

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F 656	Continued From page 57 determined that the facility failed to develop a person-centered comprehensive care plan to address a.) residents' risk for [redacted] for 2 of 9 residents (Resident #7 and #99) reviewed for altered liquid consistency diets, and b.) resident's fracture of unknown origin and fall with injury for 1 of 1 resident (Resident #50) reviewed for pain. This deficient practice was evidenced by the following: 1.) On 08/04/22 at 8:25 AM, the surveyor accompanied Licensed Practical Nurse (LPN) #1 into Resident #7's room during the medication administration pass. The LPN #1 handed the resident a medicine cup and the resident put all of the oral medications into his/her mouth. The resident then took a small sip of the water from a plastic cup provided by LPN #1, but did not swallow the medications. The resident then alternated taking sips of thin liquids (coffee and orange juice) from his/her breakfast tray, but did not swallow the medications. As the resident's mouth was full of the medications and thin liquids, LPN #1 encouraged the resident to either swallow or spit out the medications, but the resident refused. At 8:45 AM, LPN #1 called LPN #2 from the hallway into Resident #7's room to assist with the medication administration. LPN #2 immediately grabbed one of the thickening packets from the resident's breakfast tray and thickened the resident's water that was brought in by LPN #1. LPN #2 also thickened the resident's coffee and orange juice on the breakfast tray. Afterwards, LPN #2 gave the resident a pre-thickened health shake from the breakfast tray and encouraged the resident to swallow the medications. As the	F 656	diagnosis of [redacted] and the interventions to prevent risk of [redacted] The care plan for resident #99 was immediately updated to include the diagnosis of [redacted] and interventions to prevent risk of [redacted]. Resident #50 the care plan was updated to include the NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1., [redacted] and need or follow up [redacted] appointment. Unit managers were given individual counseling by the Assistant Director of Nurses on the policy and procedure for Comprehensive care plans. 2.All residents have the potential to be affected by this deficient practice when care plans are not updated to include the resident care needs and person-centered care. 3.An in-serviced was done by the Assistant Director of Nurses and corporate Director of Nurses with all nurses on the policy and procedure for updating and creating Comprehensive Care Plans to include resident centered care needs. 4.The Director of Nurses, Assistant Director of Nurses and Unit managers will audit 10 charts monthly for 3 months to ensure all resident's care plans are updated to include resident care needs, appropriate diagnosis, and person -centered care. The results of these audits will be reported to the QAPI committee monthly for 3 months.	

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resident was holding the medications and liquids in his/her mouth, he/she coughed while maintaining to keep his/her mouth closed.

At 8:57 AM, Resident #7 swallowed the medications and liquids in his/her mouth.

At 9:06 AM, Surveyor #1 observed Resident #7 cough while his/her breakfast tray was in front of him/her.

According to the Admission Record, Resident #7 was admitted with diagnoses that included, but were not limited to, NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted]

Review of the Quarterly Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care, dated NJAC 8:43E-2.1 and revealed Resident #7 had a Brief Interview for Mental Status score of NJAC 8:43E-2.1 which indicated that the resident's NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. . Further review of the MDS included the resident received a 'NJSA 47:1A-1 reasonable privacy expectation [redacted]

Review of the Physician's Order Form (POF), dated NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. included a diet order, dated NJAC 8:43E-2.1 and , for NJSA 47:1A-1 reasonable privacy expectation NJAC 8:43E-2.1 NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.

Review of the Diet Requisition Form, dated NJAC 8:43E-2.1 and E- included the resident's diet was changed to NJSA 47:1A-1 reasonable privacy expectation NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.

Review of Resident #7's Breakfast Meal Ticket, dated NJAC 8:43E-2.1 and , included, " NJAC 8:43E-2.1 and Exec Order 26, 4. b

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NJAC 8 43E-2.1 an

Review of the Nutrition Progress Note, dated NJAC 8 43E-2.1 and Exec Order 26, 4. b. 1., included, "Resident is on mechanically altered diet with NJAC 8 43E-2.1 and Exec Order 26, 4. b [difficulty swallowing] and tolerates it."

Review of the Speech Therapy SLP (Speech Language Pathology) Evaluation & Plan of Treatment, dated NJAC 8 43E-2.1 and E included a diagnosis of NJAC 8 43E-2.1 and Ex, a precaution of NJAC 8 43E-2.1 and Exec Orde and a recommendation for NJAC 8 43.

Review of the Speech Therapy Discharge Summary, dated NJAC 8 43E-2.1 and, included, "Pt [patient] was educated on importance of increasing efficiency of swallow (initiation) to minimize NJAC 8 43E-2 NJAC 8 43E-2.1 and Exec and discharge recommendations for NJAC 8 43E

Review of the Care Plan (CP), initiated NJAC 8 43E-2.1 and Exec Order 26, 4. b. 1. included a focus of, "NJSA 47:1A-1 reasonable privacy expectation NJAC 8 43E-2.1 and E JAC 8 43E-2 The care plan did not address the resident's NJAC 8 43E-2.1 and Ex or include interventions to prevent the NJAC 8 43E-2 NJAC 8 43E-2.1 and Ex.

During an interview with the surveyor on 08/10/22 at 10:01 AM, LPN #2 stated that care plans are revised quarterly and when there are changes in the resident's care. The LPN further stated that care plans are updated by the Unit Manager (UM), Assistant Director of Nursing (ADON), or Director of Nursing (DON). LPN #2 then stated that it is important to keep the care plan up to date "so that the nurses know what is going on

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with the resident."

During an interview with the surveyor on 08/10/22 at 10:15 AM, Registered Nurse/Unit Manager (RN/UM) #1 stated that care plans are reviewed quarterly and updated as needed when there is a change in the resident's condition. The RN/UM further stated that nursing, dietary, therapy, social services, and activities can update the care plan, but the UM ensures that it is done. RN/UM #1 also stated that care plans should be updated upon finding a change in condition and that a risk for aspiration should be included on the care plan. RN/UM #1 then stated that it is important for the care plan to be up to date "so that staff are on the same page with the resident's care."

2.) On 08/04/22 at 12:30 PM, Surveyor #2 observed the lunch meal service on Court 1. Surveyor #2 observed a staff member enter Resident #99's room with a meal tray. The staff member set up the resident's lunch meal tray on the overbed table, exited the room and walked down the hallway. Surveyor #2 then entered Resident #99's room and observed the resident in bed with the head of bed elevated eating his/her meal. Surveyor #2 observed the resident as he/she took a spoon of the food and drank from a disposable white cup. Resident #99 then placed the cup alongside the plate after drinking from it for a third time. At which time, Surveyor #2 observed that Resident #99's disposable white cup contained clear thin liquid.

Review of Resident #99's Lunch Meal Ticket, dated [redacted] revealed documented and highlighted in yellow, "[redacted]

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[NJAC 8 43E-2.1 and Exec Order 26, 4.] Skim Milk, [NJAC 8 43E-2.1 and Exec Order 26, 4.] Apple Juice, and [NJAC 8 43E-2.1 and Exec Order 26, 4. b] Coffee." The resident's meal tray consisted of a plate with chopped green beans and chopped cheese stuffed shells with marinara sauce, [NJAC 8 43E-2.1 and Exec] milk, [NJAC 8 43E-2.1 and Exec] apple juice, a slice of bed, and a disposable cup containing thin liquid water, an unopened packet of instant thickened coffee and an unopened packet of instant food thickener.

According to the Admission Record, Resident #99 was admitted with diagnoses that included, but were not limited to, [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] [redacted].

Review of the Admission MDS, dated [NJAC 8 43E-2.1 and E] reflected that Resident #99 was moderately [NJAC 8 43E-2.1 and Exec Order 26, 4. b. 1.] and required extensive assist of staff for eating.

Review of the SLP Evaluation & Plan of Treatment (Speech therapy (ST) evaluation), dated [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.], included a diagnosis of [NJAC 8 43E-2.1 and Ex] and indicated the reason for referral was exacerbation of decreased [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] function, decreased functional activity tolerance, coughing/choking during oral intake and increased need for assistance from others. The ST evaluation included recommendations for close supervision for oral intake, mechanical soft/ground textures, and [NJAC 8:43].

Review of the POF, dated [NJAC 8 43E-2.1 and Exec Order 26, 4. b. 1.], included an order, dated [NJAC 8 43E-2.1 and Exec Ord] NJSA 47 1A-1 reasonable privacy expectation, for [NJAC 8 43E-2.1 and E] [NJAC 8 4] [NJAC 8 43E-2.1 and E] [redacted].

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SILVER HEALTHCARE CENTER	1417 BRACE ROAD CHERRY HILL, NJ 08034

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Review of the CP, initiated [redacted], included a focus of, NJSA 47:1A-1 reasonable privacy expectation [redacted].

During an interview with the surveyor on 08/10/22 at 10:46 AM, the Registered Dietician (RD) stated that she was only responsible for the nutrition care plan. The RD further stated that a care plan for aspiration precautions would be completed by the nursing department or the ST (Speech Therapist).

During an interview with the surveyor on 08/10/22 at 11:00 AM, the Director of Rehab (DOR) stated that anything related to physical, occupational, or speech therapy would be added to the care plan by the therapy department. The DOR then clarified that the therapy department started at the facility in June 2022 and currently was only responsible for updating the care plans upon a resident's discharge from therapy services.

During an interview with the surveyor on 08/10/22 at 11:27 AM, Speech Therapist (ST) #1 stated that she was not currently responsible for updating resident care plans. The ST further stated that residents with difficulty swallowing should be care planned for the risk of aspiration and include interventions such as positioning the

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resident upright, alternating food and liquids throughout meals, and feeding strategies to increase oral intake safety and reduce aspiration risk. ST #1 also stated that it is important for the care plan to be up to date so that "everyone can be on the same page."

During an interview with the surveyor on 08/10/22 at 12:04 PM, RN/UM #2 stated the CP was important because it provided the care team with the interventions needed to care for the resident. RN/UM #2 further stated that any change in the resident's status could initiate a CP update and that she expected the update to be completed within 24-48 hours. RN/UM #2 added the shift supervisors were able to update the CP; and if the CP was not updated during their shift, the UM would follow up the next morning. RN/UM #2 stated a resident with an altered diet, which includes anything other than regular texture and thin liquids, would have an at risk for aspiration CP. RN/UM #2 added that the risk for aspiration precaution was a separate CP from the nutrition CP. RN/UM #2 reviewed Resident #99's CP, in the presence of the surveyor, and stated the resident currently had an at risk for aspiration that was initiated on 08/10/22. RN/UM #2 further stated the CP should have been initiated when thicken liquids was ordered for the resident.

During an interview with the surveyor on 08/10/22 at 12:35 PM, the ADON stated that the comprehensive care plans are completed within 72 hours; but if there was a change in the resident's condition, the care plan should be updated within 24 hours. The ADON further stated that the UMs were responsible for the nursing section of the care plan; and that if the resident was not on therapy, the nursing staff

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should also update the care plan for anything therapy related. The ADON then stated that if a resident was at risk for aspiration, nursing should update the care plan, and that it's important for the care plan to be up to date in order to provide resident specific care and "so the team is aware of how to care for the resident."

3.) On 08/03/22 at 1:02 PM, the surveyor observed Resident #50 in the [redacted] area. The resident was seated in a chair at a table, did not want to remain seated, stood up, walked to another chair, and sat down. The resident then stood up, walked over to a table which contained, among other items, wipes, cups, and napkins and tried to overturn the table. The LPN/UM redirected the resident and asked a staff member to take the resident for a walk in the [redacted] area.

According to the Admission Record, Resident #50 was admitted to the facility with diagnoses which included, but were not limited to, unspecified [redacted]

Review of Resident #50's Significant Change in Status Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care, dated [redacted], revealed that the resident had [redacted], and required

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NJSA 47:1A-1 reasonable privacy expectation [redacted]

Review of Resident #50's CP included an entry dated [redacted] which indicated that the resident had extensive behaviors which included, but was not limited to, NJSA 47:1A-1 reasonable privacy expectation [redacted] " The CP further reflected an entry dated [redacted] which indicated that the resident had [redacted] with an intervention to "Cue, reorient and supervise as needed." The CP included an entry dated [redacted], which indicated that the resident was at risk for falls related to the resident's confusion, gait/balance problems, poor safety awareness, [redacted] drug use and wandering. The resident's care plan did not address the resident's fracture sustained on [redacted] or the resident's care of [redacted] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] and follow up [redacted] appointment sustained on [redacted]

Review of the skin incident report dated [redacted] reflected that Resident #50 was [redacted] and exhibited signs and symptoms of swelling of the [redacted].

Review of the Progress Notes revealed a

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Behavior Note dated [NJAC 8 43E-2.1 and] at 4:29 PM which reflected that "Patient is yelling and wandering in dining room. Patient is flipping over chairs and tables screaming 'please help me.' Will continue to monitor."

The Progress Notes further revealed a Nurses Note dated [NJAC 8 43E-2.1 and] at 10:30 AM which reflected "It was brought to this nurses attention at 10:15am by CNA that resident [NJAC 8 43E-2.1 and Exec Order 26, 4.] . I observed resident crying, stating 'it hurts.' [NJAC 8 43] was noted to be swollen with no discoloration. [NJAC 8 43E-2.1 and Exec Order 26, 4.] generated a [NJAC 8 43E-2.1 and Exec Order] from resident. Applied cold compress to area. Offered [NJAC 8 43E-2.1 a] resident tolerated meds [medications] well. Unable to keep resident off of feet." The Progress note further reflected that the Nurse Practitioner was alerted and [NJSA 47 1A-1 reas] of the [NJAC 8 43E-2.1 and E] was ordered.

The Progress Notes further reflected a Health Status Note dated [NJAC 8 43E-2.1 and Exec Order 26, 4. b. 1.] which reflected "IDC (Interdisciplinary) team met to review occurrence of 5/26/22; resident noted to have a [NJAC 8 43E-2.1 and Exec Order 26, 4. b] . Upon investigating incident, it was found that resident had behaviors 2 days prior; 'flipping tables and chairs.' With [NJAC 8] foot [NJAC 8 43E-2.1 and E] was due to preexisting behaviors. Therefore abuse is not a factor. Care plan has been updated with goals and intervention, all parties were notified and order obtained from NP for [NJSA 47 1A] . We will continue to manage pain pending [NJSA 47 1A-1 reasonable] ."

Review of the [NJSA 47 1A-1 reasonable] of the [NJAC 8 43E-2.1 and Exec Order 26] [NJAC 8 43] dated [NJAC 8 43E-2 and Exec Order 26, 4. b. 1.] reflected that resident sustained an "[NJAC 8 43E-2.1 and Exec Order 26, 4. b. 1.] [NJAC 8 43E-2.1 and Exec Order 26, 4. b] ."

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Review of the fall investigation dated [NJAC 8 43E-2.1 and] reflected that Resident #50 sustained a [NJAC] at about 10:03 PM in his/her room.

Review of the 07/02/22 11:33 PM Fall Incident progress note reflected the resident was lying on the bedroom floor on his/her left side. Resident displayed discomfort and was bleeding. Resident #50 was sent to the emergency room to be evaluated and to rule out injury.

Review of the hospital's After Visit Summary (Summary), dated [NJAC 8 43E-2.1 and], reflected the following:
- Diagnoses: [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.]
- Staple care: Clean the [NJAC 8 43E-2.1] [NJSA 47 1A-1 reasonable privacy expec] [NJAC 8 43E-2.1] [Order 26, 4. b. 1.] [NJAC 8 43E-2.1] [6, 4. b. 1.] [NJAC 8 43E-2.1] [er 26, 4. b. 1.] [NJAC 8 43E-2.1] [NJAC 8 43E-2.1 and Exec Order 26, 4. b. 1.] apply an [NJAC 8 43E-2.1 and Ex]
- Schedule an appointment with surgery as soon as possible for a visit in one day (around [NJAC 8 43E-2.1 and]).

Reviewed the [NJAC 8 43E-2.1 and] 10:15 PM Nurse Practitioner (NP) Progress Note reflected that the resident was assessed by the NP, had a recent [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] The progress note further reflected the resident sustained an [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] The progress note's Assessment/Plan reflected to continue with [NJSA 47 1A-1 reasonable privacy ex] care, monitor for healing, and monitor for signs/symptoms of infection. The Assessment/Plan further reflected to follow up

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F 656	Continued From page 68 with an NJSA 47 1A-1 reasonable privacy expectatio recommended by the hospital discharge. During an interview with the surveyor on 08/16/22 at 10:55 AM, the LPN/UM stated that it was his responsibility to update the care plan with any change in condition of the resident. During an interview with the surveyor on 08/17/22 at 10:11 AM, the ADON and surveyor reviewed Resident #50's NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. hich occurred on NJAC 8 43E-2.1 and and the resident's fall which occurred on NJAC 8 43E-2.1 and where Resident #50 sustained an NJAC 8 43E-2.1 and NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. . The ADON stated that the care plan should have been updated to reflect the resident's NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. , the staple care for the NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. and follow up appointment with the NJAC 8 43E-2.1 and Exec Order 26, 4. b. 1. . The ADON stated that the UM or the supervisor on duty were responsible to update the care plan. The ADON further stated that it was important that the care plan was updated "so that the staff knows how to care for the resident." Review of the facility's Care Plan policy, with reviewed date of 05/2022, included, "all residents admitted to the facility will have adequate person-centered care plans that provide for all their needs." Further review of the policy revealed, "They will include; initial goals, MD orders, medications treatments, dietary orders, therapy orders, social services, and PASARR recommendations," and, "Care Plans will be updated timely and necessary revisions will be made."	F 656		

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F 656	Continued From page 69 NJAC 8:39-11.2 (e)(2)	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, it was determined the facility failed to consistently follow standards of clinical practice in regard to a.) accurately documenting medication and treatment administration in the Medication Administration Record (MAR) and Treatment Administration Record (TAR) and b.) clarify and accurately transcribe a medication and treatment order for 1 of 3 residents (Resident # 113) reviewed for closed records. This was cited at a level E as the deficient practice was cited at the last standard survey of 11/01/2021. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care	F 658	1.There were no negative outcomes related to the missing signatures for resident #113, resident was discharged prior to the survey. 2.All residents have the potential to be affected by the deficient practice. The current MAR for all active residents will be reviewed for omitted signatures. Any variances identified will be reported to the Director of Nursing. All physician's orders will be audited to check for transcription or duplication errors. 3.Nurses were re-educated on the Physician's orders / Transcription policy, 24 Hour Chart Check Policy, and Medication Administration policy. 4.The Director of Nursing or Designee will audit 10 MARs, TARs, and Physician's Order sheets weekly for 4 weeks, and then monthly for 3 months. Results of these audits will be reported to the QAPI Committee monthly for 3 months.	10/22/22

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supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist."

Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist

According to the Admission Record, Resident #113 was admitted with diagnoses including but not limited to NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted]

Review of Resident #113's April and May 2022 MAR and TAR revealed the following dates and times the MAR/TAR did not have documentation that the medication was administered as ordered (blanks on the MARS and TARS):

Ordered 04/27/22 NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] Diagnosis (Dx):

NJAC 8 43E-2.1 and Exec

NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted]

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F 658	Continued From page 71 NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. Ordered NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. Ordered NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. Ordered NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. Ordered NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. Ordered NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. Ordered NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. Ordered NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. Ordered NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.	F 658		

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F 658	Continued From page 72 Ordered NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] 05/15/22 at 12PM Ordered NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] Ordered NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] Ordered NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] Ordered NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] Ordered NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] TAR Ordered NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] Ordered NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.	F 658		

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F 658	Continued From page 73 NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] Ordered NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] Ordered NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] Ordered NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] Ordered NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted]d	F 658		

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F 658	Continued From page 74 NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] During an interview with the surveyor on 08/11/22 at 1:13 PM, the Licensed Practical Nurse (LPN#5) stated that when medications or treatments were administered, the nurse would sign out (initial)the medication on the MAR as soon as it was given. If there were blanks on the MARS and TARS (no initials on the appropriate forms) could mean that the medication was not given, the treatment was not completed, or someone forgot to sign it . LPN #5 further stated that the importance of signing out the medication and treatments when administered was for the safety of documentation, "If you didn't document it, you didn't do it" During an interview with the surveyor on 08/11/22 at 1:23 PM, LPN #6 stated that when the nurses were to sign out (with your initials) the medications or treatments on the MARS and TARS as soon as they were administered. If the MARS or TARS did not have initials in the	F 658		

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dedicated lines then it meant they were not given. It is important that nurse signed out the medications and treatments when administered so they know that the medication or treatments were administered, and the medications wouldn't be administered again.

During an interview with the surveyor on 08/11/22 PM at 1:33 PM, Registered Nurse/ Unit Manager (RN/UM #2) stated that when administering medications or treatments, the nurses would sign out the medication and treatments after they are rendered or administered. If there were no initials in the MAR for a date and time the medications were to be administered, it meant the medication was not given and the treatment was not rendered. RN/UM#2 further stated that it was important to sign out medications and treatments as given to confirm that the medication was administered and the resident recieved what was ordered by the physician.

At that time the surveyor reviewed all the missing initials(blanks) of Resident #113's April and May 2022 MAR/TAR's and the RN/UM#2 stated, "If not signed I can assume it was not given or the treatment was not completed."

During an interview with the surveyor on 08/17/22 at 1:45 PM, the Assistant Director of Nursing (ADON) stated that medications and treatments were to be signed out at the time the nurses administered them as it is part of the 5 rights of medication administration. If there were no initials (blanks) on the MAR/TARs, it meant the medication or treatment was not given. The ADON further stated that "It is important to sign out the medications/treatments when administered because it is part of the 5 rights of

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medication administration and the nurses need to assess that the residents received their medications."

A review of the facility's policy titled "Med Administration," reviewed 05/2022, revealed to document necessary medication administration and treatment administration when medications/treatments are administered.

2. A Review of Resident #113's Physicians Order Sheet (POS) revealed a Physician Order (PO) dated NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. .

A review of Resident #113's NJAC 8 43E-2.1 and Exec Order 26, 4. b. 1. MARs reflected the following duplicate PO for the NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. . The NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. was not discontinued when the new PO for NJAC 8 43E-2.1 and Exec O was transcribed to the MAR on 04/28/2022.

A review of Resident #113's May 2022 MAR reflected the NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. as "duplicate" and was discontinued on NJAC 8 43E-2.1 and E

A review of the declination sheet for NJAC 8 43E-2.1 and Exec NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. for Resident #113 revealed that only NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. NJAC 8 43E-2.1 a was signed out as ordered.

A review of Resident #113's POS dated NJAC 8 43E-2.1 and revealed a physicians order for NJAC 8 43E-2.1 and Exec Order 26, 4. b NJAC 8 43E-2.1 and Exec Ord. On NJAC 8 43E-2.1 and a PO revealed to

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F 658	Continued From page 77 discontinue the [redacted] and add [redacted] to support [redacted] healing. The [redacted] PO for [redacted] order did not reflect the time and frequency the medication was to be administered. A review of Resident #113's April 2022 MAR revealed that the [redacted] order was not discontinued as ordered on [redacted] The [redacted] MAR revealed the PO for [redacted] (without a time and frequency) was transcribed on the MAR NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. with the time and frequency to be administered as [redacted] A review of Resident#113"s PO for [redacted] daily order was discontinued during the [redacted] monthly recapitulation but the PO was transcribed onto the MAR as NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] (the PO did not have the time and frequency when ordered) A review of Resident #113's April POS revealed an PO dated [redacted] to skin rash under [redacted]. The PO for [redacted] did not include the time and frequency the medication was to be administered . A review of Resident #113's [redacted] MAR revealed the transcription of the [redacted] to NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. for 11PM-7AM, 7AM-3PM and 3PM-11PM shift to be administered. A review of Resident #113's May 2022 TAR revealed that the [redacted] order was not transcribed from the [redacted] TAR onto the [redacted] TAR during the monthly [redacted]. During an interview with the surveyor on 08/11/22	F 658		

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at 1:13 PM, LPN#5 stated that the 11PM-7AM (11-7) shift performed the 24 chart check (a process to ensure all physicians orders(PO) are noted and carried out appropriately as per facility's policy) and each nurse should check that the physician's orders were transcribed correctly before administering the medications. If there was a duplicate order on the MAR or POS, the nurse should call the doctor to verify the PO and inform the unit manager. LPN #5 further stated " I would obtain an order from the doctor to discontinue one of the physician's orders so that the same medication was not administered twice. "

During an interview with the surveyor on 08/11/22 at 1:23 PM, LPN #6 stated that the 11-7 nurse completed the monthly recapitulation (recap) but was not sure if it was checked by another nurse. The recap included that the nurse would rewrite the MARS/TARS for the next month and the day shift nurse would double check the rewritten MARS/TARS but there was not a place to sign on the MAR or POS that the orders were double checked. The 24 hour chart checks were completed by the 11-7 nurse which included that the nurse would check all new physician orders were the correctly ordered and transcribed onto the MAR/TAR and then the nurse would sign their signature on the POS. LPN #6 further stated that if there was a duplicate order on the MAR or POS, then the nurse should notify the unit manager, call the physician and clarify the order.

During an interview with the surveyor on 08/11/22 PM at 1:33 PM, RN/UM #2 stated that the 11-7 nurse completed the monthly recap then the 11-7 nurse supervisor would review the recap. The nurse who completed the recap would sign their

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name on the POS as completed. The 11-7 nurses would complete the 24 hour chart checks. RN/UM #2 stated that when a new resident was admitted to the facility, the nurse would call the doctor and confirm the admitting orders with the doctor, then would transcribe the physicians' orders onto the MAR and TAR. The 11-7 nurse would then check all the new PO for correct orders and transcription and sign the POS with their signature as completed. If the POS or MAR had a duplicate order, the nurse would be to write duplicate on the MAR and discontinue the previous order. "I would confirm that the nurses who signed it out did not give the medication twice, notify the physician and write an incident report for a transcription error."

The RN/UM #2 stated that she was not made aware of any duplicate transcription errors or medication errors for Resident #113. RN/UM #2 confirmed that the duplicate physicians' orders were missed during the 24 hr. chart check and the monthly recapitulation

The facility provided the NJAC 8:43E-2.1 and Exec declination signature sheets that revealed Resident #113 received NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. as ordered.

During an interview with the surveyor on 08/17/22 at 1:45 PM, the ADON stated that the11-7 nurse completed the 24 hour chart check and the monthly recaps. If there was a duplicate physician's order the nurse should check the PO and verify if it was an actual duplication, call the doctor to clarify the PO, then discontinue one of the physician orders.

During a follow up interview with the surveyor on

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08/18/22 at 11:14 AM, the ADON stated that the 11-7 nurse would complete the monthly recap which included to verify all PO were active orders and that all PO were transcribed correctly on the current MAR and TAR as well on the next month's MAR and TAR. The 24 hr. chart check would make sure new PO and discontinued PO were reflected on the MAR and TAR.

A review if the facility's policy titled "Medication Policy", initiated 05/2022, under Elements of the Medication revealed that the medication orders specify the following: a) name of medication, b) strength of medication, c) dose of dosage form, d) time and frequency of administration, f) quantity of duration of therapy and g) diagnosis or indication for use. The prescriber is contacted by nursing to verify or clarify an order (e.g., when the resident has allergies to the medication, contraindications to the medications, significant drug interactions or the directions are confusing). Medication orders are recapped monthly when the prescriber signs the physician order summary. A designated nurse reviews the order summary before giving it to the prescriber to sign.

A review of the facility's policy titled "24 Hour Chart Check," reviewed 05/2022, reflected that each patient's chart will be reviewed daily by the 11-7 nurses assigned to that unit. The chart check will include the following:
a) Physician Orders written since last chart check are:
i. Complete (right dose, frequency, route, length of therapy, diagnosis),
ii. Put in MAR/TAR correctly with appropriate times,
iv. Corrections will be made as omissions/errors are noted,

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F 658	Continued From page 81 v. Omissions/errors that cannot be corrected immediately will be brought to the attention of the Unit Manager or Nursing Administration at the change of shift.	F 658		
F 661 SS=D	NJAC 8:39-11.2(b), 29.2(d) 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 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	F 661		10/22/22

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F 661	Continued From page 82 non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview, review of the medical record and review of other facility documentation, it was determined that the attending physician failed to document a discharge summary which included a recapitulation (recap) of the resident's stay and a final summary of the resident's status for 1 of 3 closed record's reviewed for discharge (Resident #113). This deficient practice was evidenced by the following: On 08/11/22 at 9:51 AM, the surveyor reviewed the closed medical record for Resident #113. A review of the medical record revealed that there was no documented physician discharge summary. During an interview with the surveyor on 08/22/22 at 1:33PM, the Registered Nurse/Unit Manger (RN/UM#2) stated that a doctor should write a discharge summary but was unsure of the timeframe it should be completed. During an interview with the surveyor on 08/11/22 at 9:51 AM, the Assistant Director of Nursing(ADON) stated that the doctor should write a discharge summary but was unsure of the timeframe it should be completed. During an interview with the surveyor on 08/18/22 at 11:14 AM, the Licensed Nursing Home Administrator (LNHA) and the ADON stated that the physicians have 30 days to complete the discharge summary and they would expect the physicians to complete a discharge summary	F 661	1.Resident # 113 has discharged from the facility. The physician was given individual counseling by the Administrator regarding the policy and procedure for completion of an individualized Discharge Summary. A letter was composed and sent to each physician on staff which included a review of the Federal regulation #661 and the facility policy on Discharge Summary. 2.All residents discharging have the potential to be affected by this deficient practice when a discharge summary is not completed. An audit was completed on closed records for the past 60 days to ensure that all discharge summaries were completed. None were found to be deficient. 3.An in-service was done with the Unit Managers by the Director of Nurses regarding the policy and procedure for Discharge Summary. An in-service was done by the Administrator with all Department Heads that are included in the discharge summary process; a review of the policy was done. 4.The Director of Nursing and Unit Managers will review discharge summaries with the physician prior to the resident discharging. All Department Heads, included in the discharge summary procedure will review each discharge summary for completion monthly and the results will be reported to the QAPI committee for 3 months.	

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F 661	Continued From page 83 within the 30 days. On 08/18/22 at 12:15 PM, the LNHA stated that the medical record did not contain a discharge summary. On 08/28/22 at 1:01 PM, the LNHA stated that the facility does not have a policy regarding the discharge summary but that the doctor should complete the discharge summary within 30 days. NJAC 8:39-35.2(d)(16)	F 661		
F 684 SS=D	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 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: Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to complete neurological evaluations (neuro checks) after an unwitnessed resident fall for 1 of 2 residents (Resident #63) reviewed for falls. This deficient practice was evidenced by the following: On 08/03/22 at 10:24 AM, the surveyor observed Resident #63 lying in bed with a floor mat in	F 684	1.Resident #63 had no negative outcome related to the omitted neuro checks. 2.All residents with unwitnessed falls are at risk for having their neuro checks omitted. A review of the current residents who are being monitored post fall have neuro checks ongoing as per policy. 3.Neurological Observation Policy and Fall Prevention and Management policies were reviewed and updated. Nurses and Supervisors in service initiated on 8/29/22 on the policy of performing and	10/22/22

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F 684	Continued From page 84 place. According to the Admission Record, Resident #63 was admitted with diagnoses that included, but were not limited to, [redacted] Review of the Annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], included the resident had a Brief Interview for Mental Status score of [redacted] which indicated the resident's [redacted]. Further review of the MDS revealed the resident had one fall since the prior assessment. Review of the Care Plan, dated [redacted] included the resident [redacted] Review of the Incident Report, dated [redacted] revealed the resident was found [redacted] in front of the nursing station and that there were no witnesses for the incident. The report did not include the initiation of [redacted] checks. Review of a Progress Note, dated [redacted] revealed the resident was found [redacted] in front of the nursing station and that the resident was assessed by the supervisor. Further review of the Progress Notes, dated [redacted] did not include any notes related to [redacted] checks. Review of the Assessments section in the	F 684	documenting neuro checks on any unwitnessed falls or fall with head injury. 4.The Director of Nursing or designee will audit each incident/accident report for weekly for 3 months to ensure that neuro checks are being completed. A copy of the completed neuro check assessment form will be attached to the incident/accident report. The results of these audits will be submitted to the QAPI committee monthly for 3 months.	

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Electronic Health Record (EHR), revealed there was only one [NJAC 8:43E-2] check, dated [NJAC 8:43E-2.1 and E] that was completed for the aforementioned incident.

During an interview with the surveyor on 08/11/22 at 11:51 AM, Registered Nurse/Unit Manager (RN/UM) #1 stated that when a resident falls, the resident is assessed by a RN and neuro checks are initiated if the fall is unwitnessed. RN/UM #1 further stated that neuro checks are completed every two hours for the first day, every four hours for the second day, and then every shift for the third day. The RN/UM, in the presence of the surveyor, then reviewed Resident #63's paper chart, but was unable to locate any neuro check assessments related to the unwitnessed fall on 07/30/22. RN/UM #1 stated it was important to complete neuro checks for unwitnessed falls to "monitor for changes in mental status and neurological changes."

During a follow-up interview with the surveyor on 08/12/22 at 10:23 AM, RN/UM #1 verified that he was not able to locate any neuro check assessments related to Resident #63's unwitnessed fall on 07/30/22.

During an interview with the surveyor on 08/12/22 at 12:34 PM, the Assistant Director of Nursing (ADON) stated that when a resident falls, the resident is assessed, interviewed, and placed on neuro checks if the fall is unwitnessed. The ADON further stated that neuro checks should have been completed for Resident #63's unwitnessed fall on 07/30/22 to monitor for any changes in mental status.

Review of the facility's Fall Prevention and Management Program policy, reviewed 05/2022,

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F 684	Continued From page 86 included, "A fall is any unintentional change in position where the resident ends up on the floor, ground or other lower level. It includes witnessed and unwitnessed falls," and, "Initiate neuro-check for all unwitnessed falls and witnessed falls that have resulted in a possible head injury. Follow neuro-check protocol unless otherwise specified by the MD." Review of the facility's Neurological Observation policy, revised 05/2022, included, "A. Document Physician notification, in order to determine neuro check frequency. Indicate frequency in the integrated notes and on the 24 hour report," "B. Document ordered neuro checks on Neurological Observation Record," and, "C. Active Neurological Observation Record will be maintained with current medical record." NJAC 8:39-27.1(a)	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 686		10/22/22

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F 686	Continued From page 87 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to ensure a wound treatment was transcribed into the Treatment Administration Record per the physician's order for 1 of 4 residents (Resident #102) reviewed for pressure ulcers. This deficient practice was evidenced by the following: On 08/03/22 at 11:50 AM, the surveyor observed Resident #102 in bed with the head of bed slightly elevated. The resident was on an air mattress which was set to 150 pounds, inflated, and functioning properly. When interviewed, Resident #102 was unable to provide any information about his/her [NJAC 8:43E-2.1] care treatments. According to the Admission Record, Resident #102 was admitted with diagnoses that included, but were not limited to, [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] [redacted] 4. b. 1. [redacted] [redacted] the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [NJAC 8:43E-2.1 and E], revealed Resident #7 had a Brief Interview for Mental Status score of [NJAC 8:43E-2] which indicated that the resident's NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. Further review of the MDS revealed the resident was NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1., required NJSA 47:1A-1 reasonable privacy expectation to [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.], and was	F 686	1. Resident #102 had no negative outcome related to the deficient practice. 2. All residents with pressure ulcers being followed by the wound NP are at risk for being affected by this deficient practice. An audit was completed to ensure that all current treatment orders have been transcribed correctly. 3. The Nurses were re-educated on timely and complete order transcription as well as on the 24-hour chart check policy/process. 4.The Director of Nursing or designee will do a weekly audit of 5 residents being followed by the wound NP to ensure the recommendations have been transcribed correctly to both the Physicians order sheet as well as the TAR. The audit will be done for 90 days and the results reported to the QAPI committee monthly for 3 months.	

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at risk of developing pressure ulcer.

Review of the Care Plan (CP), initiated [NJAC 8:43E-2.1 and] included a focus of [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] issue related to [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] [NJAC 8:43E-2.1 and Exec]), skin fragility and decrease in mobility as evidenced by [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] to [NJAC 8:43E-2.1 a]. The CP included interventions, initiated [NJAC 8:43E-2.1 and], for weekly [NJAC 8:43E-2.1] evaluations and wound treatment per physician order.

Review of the resident's [NJAC 8:43E-2.1] consult completed by the Advanced Practice Nurse (APN) dated [NJAC 8:43E-2.1 and] reflected that the [NJAC 8:43E-2] [NJAC 8:43E-2.1] was improving. The consult included the following treatment recommendations: cleanse the wound with [NJAC 8:43E-2.1 and Exec Order] do not scrub or use excessive force, pat dry, apply [NJAC 8:43E-2.1 an] alginate ([NJAC 8:43E-2.1] dressing) cut to size of the [NJAC 8:43E-2.1] base, cover with a border gauze/island dressing, and change dressing daily.

Review of the Physician's Order Form (POF), dated [NJAC 8:43E-2.1 and], revealed a [NJAC 8:43E-2.1 and] clarification order to NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [NJAC 8:43E-2] Do not scrub or use excessive force. Pat dry. Apply [NJAC 8:43E-2.1 and Exec Order 26, 4.], cut to size to the [NJAC 8:43E-2.1] base, cover with border gauze dressing daily."

On 08/17/22 at 10:48 AM, the surveyor observed the Licensed Practical Nurse (LPN) #2 as she prepared the supplies needed to complete Resident #102's wound treatment. LPN #2 reviewed the resident's 08/2022 Treatment Administration Record (TAR), in the presence of the surveyor. The TAR included the aforementioned order but had a start date of 08/17/22. When interviewed about the start date,

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LPN #2 stated the order was received on 08/09/22 and that she had rewritten the order onto a new TAR.

The surveyor observed the resident's pressure ulcers in the presence of the LPN #2. The resident had a healing [NJAC 8 43E-2.1 and Exec Order 26, 4. b. 1.] at a [NJAC 8 43E-2.1 and Exec Ord] hat was clean and had no foul odor from the area.

On 08/17/22 at 11:19 AM, LPN #2 reviewed the resident's chart in the presence of the surveyor and provided the surveyor with the additional TAR. Review of the complete TAR revealed an order dated [NJAC 8 43E-2.1 and E] to cleanse [NJAC 8 43E-2.1 and Exec Ord] with [NJAC 8 43E-2.1 and Exec Order 26, 4. b. 1.], apply [NJAC 8 43E-2.1 and Exec Order 26, 4. b. 1.] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. . The TAR revealed that nurses were signing the [NJAC 8 43E-2.1 and] treatment as administered from [NJAC 8 43E-2.1 and Exec Order 26, 4. b. 1.]. The TAR did not include the 08/09/22 order to [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] with [NJAC 8 43E-2.1 and Exec Ord]. NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. , cover with border gauze dressing daily. There was no documented evidence that the 08/09/22 treatment order had been transcribed into the resident's TAR from 08/09/22 - 08/16/22. When interviewed, LPN #2 stated that she was aware that the order was changed on 08/09/22 but was unable to locate the TAR with the new order. At which time, LPN #2 confirmed that the 08/09/22 order was not reflected on the TAR.

During an interview with the surveyor on 08/17/22 at 11:24 AM, the Registered Nurse/ Unit Manager (RN/UM) #1 stated the APN comes to the facility on Mondays to complete wound rounds with himself or the nurse. The APN then sends the

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wound consult report by the end of the day on Monday or Tuesday morning. The nurse would then put a call out to the physician to inform them of any recommendation. RN/UM #1 added that the nurse would obtain a verbal order, transcribe the order to the TAR, and fax it to pharmacy. RN/UM #1 stated that he expected the order to be transcribed onto the TAR as soon as the order was obtained from the physician. The RN/UM #1 further stated the 08/09/22 order should have been transcribed onto the TAR when received and that it should have included the additional instructions per the physician order.

During a follow-up interview with the surveyor on 08/17/22 at 11:33 AM, LPN #2 stated the APN would give orders during the wound rounds and that she often changed the order in the wound report. The surveyor questioned the process for following up with wound consult recommendations. LPN #2 responded that the order would be changed per the wound recommendation.

During an interview with the surveyor on 08/17/22 at 11:40 AM, the Assistant Director of Nursing (ADON) stated that wound recommendations were from an APN and that the recommendations were actual orders. The ADON further stated that she expected the nurse to transcribe the recommendations onto the POF and the TAR. The ADON added that the 24- hour chart check was completed daily to address all physician orders, and that she expected the 24-hour chart check to catch any missed orders and that it would be addressed at that time.

During a follow-up interview on 08/18/22 at 11:56 AM, the ADON stated that the order was

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F 686	Continued From page 91 transcribed onto the POF on 08/09/22 but the nurse completing the 24-hour chart check did not follow up with it. The ADON further stated that the order did not make it onto the resident's TAR. Review of the facility's 24-Hour chart check policy, reviewed 05/2022, revealed that the chart check included reviewing each resident's physician orders daily to ensure the physician orders are noted and carried out completely and accurately, NJAC 8:39-25.2 (b), (c); 27.1 (e)	F 686		
F 689 SS=K	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: An Immediate Jeopardy (IJ) was identified for F689 during the recertification survey conducted on 08/29/22. Based on observation, interview, and review of facility documents, it was determined that the facility failed to provide a safe physical environment to prevent the likelihood of serious injury, harm or death by failing to ensure a janitor closet, which contained hazardous chemicals for use by the housekeeping department, was securely closed and latched on 1 of 4 units, the	F 689	1. The housekeeping closet on the [redacted] unit was repaired immediately to ensure that it self-closes and locks. In-service was immediately started with all housekeeping staff to ensure that all housekeeping closets are securely closed and locked at all times. Any door that is found to be not closing and or locking properly will be reported to the Housekeeping Supervisor or Nursing Supervisor immediately. The door in question will be monitored by staff and not	10/22/22

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F 689	Continued From page 92 [redacted] unit, which is a secured behavior unit that included [redacted] residents, placing all residents at risk for ingestion of chemicals or death. The census on the unit was [redacted], with [redacted] residents independently ambulatory and [redacted] residents who were able to self-propel the wheelchair. No residents were in the immediate area of the janitor closet at the time it was not securely closed and latched. This deficient practice was evidenced by the following: This resulted in an IJ situation that was identified on 08/05/22 when the facility failed to securely safeguard hazardous chemicals from vulnerable and independently mobile residents by ensuring the janitor door was flush with the door casing and allowing the door to close and latch securely. The facility's Licensed Nursing Home Administrator (LNHA) and the Assistant Director of Nursing (ADON) were notified of the IJ on 08/05/22 at 3:13 PM. A Removal Plan was received on 08/5/22, and the survey team verified the implementation of the Removal Plan on 08/05/22. On 08/05/22 at 4:24 PM, two surveyors confirmed/verified, in the presence of the Licensed Practical Nurse Unit Manager, that the janitor door self closes and locks. This was cited at a level K as the deficient practice was cited at the last standard survey of 11/01/21. On 08/05/22 at 10:08 AM, the surveyor observed the janitor closet on the [redacted] unit to be ajar. The surveyor entered the closet, and the door was observed to have an automatic closure mechanism. The door, when let to close by itself, struck the door jam on the latch side of the door and would not securely close and latch. There	F 689	left unattended until repaired. Maintenance immediately repaired the door. All housekeeping closets were checked immediately to ensure that they self-close and lock. 2. All residents are at risk to be affected by the deficient practice. 3. In-service was immediately done with housekeeping staff to ensure that all housekeeping closets are securely closed and locked at all times. Inservice was started with all department staff as of 10/21/22 to ensure that all housekeeping closets are securely closed and locked at all times. Any door that is found to be not closing and or locking properly will be reported to the Housekeeping Supervisor or Nursing Supervisor immediately. The door in question will be monitored by staff and not left unattended until repaired. Daily audit tool was implemented to monitor the compliance with doors being securely closed and locked. 4. All Housekeeping closets will be audited daily by the Housekeeping Supervisor or designee to ensure that they are closed and locked for 90 days, and the results reported to the QAPI committee monthly for 3 months.	

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was a keypad lock that would require a code to open the door if the door were securely closed and latched. At that time, the surveyor observed six bottles of hand wash liquid inside the closet, one bottle of hydrogen peroxide, one opened bottle of deodorizer, four uncapped bottles of floor chemicals, and one white bottle unlabeled on the floor. There was a wall mounted chemical dispensing machine containing chemicals in separate door-type compartments. An activity staff was present in the [redacted] area but was facing away from the closet door. A housekeeper (HK #1) was in a resident room (room [redacted]) adjacent to the closet at 10:15 AM. HK #1 came out of the room, and the surveyor requested her to enter the janitor closet door and asked if the door was supposed to be open. HK #1 said, no, the door was not supposed to be open. She went on to say, that she wasn't the last one to be in and out of the janitor's closet. The surveyor requested HK #1 get her supervisor.

During an interview with the surveyor on 08/05/22 at 10:17 AM, the Floor Tech Supervisor (FTS) came to the janitor closet and, in the presence of the surveyor, confirmed the door was not securely closed and latched, and it should not be open. When asked how long it has been that the door did not shut correctly, the FTS said he doesn't know how long the door has not shut correctly. The FTS identified the unlabeled white bottle on the floor as bleach and confirmed the above identified bottles observed to be chemicals used by the housekeeping staff. The FTS said that residents would have access to the chemicals if the door was not locked or shut tightly. The FTS said he told maintenance about the problem with the door a while ago but did not fill out a maintenance request form; it was verbal.

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He confirmed the door has auto closure on it, but at this time, the door won't shut on its own without the door being pushed closed. He said staff should push on the door to ensure it closes. The FTS said this was never addressed; however, everyone (staff) knows about the door not latching correctly. The surveyor reviewed the unit maintenance logbook for the past 4 months, and there was no documentation to indicate maintenance was notified of the janitor door not closing.

During an interview with the surveyor on 08/05/22 at 10:27 AM, the maintenance staff on duty said he had been at the facility for six months. He said the process for staff to report necessary repairs was to use the logbook (on the units) or the new phone app (application) launched in the past three weeks, and requests can be submitted via the phone.

During a follow-up interview on 08/05/22 at 1:05 PM, the maintenance staff said he just became aware today that the janitor closet door on the [redacted] wasn't closing correctly. He said we worked on it a few months ago and never got the new door that his prior supervisor requested.

During an interview, in the presence of the survey team, on 08/05/22 at 03:09 PM, the LNHA said the janitor door should be kept closed and locked to prevent anyone from accessing anything inside.

During an interview in the presence of the survey team on 08/17/22 at 9:34 AM, the Director of Environmental Services (DEVS) said her expectations are the janitor closets are to be kept clean with daily checks for cleanliness and being

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F 689	Continued From page 95 put together correctly, and they should be locked. A review of a facility provided Quality Assurance folder revealed a document titled "100% Pavilion Environmental Rounds 6/13/22" that indicated that the janitors closet by room [redacted] (same closet as noted above) containing hazardous chemicals doesn't close flush (priority). A review of a facility policy titled Janitors Closet with a creation date of 9-12-14 and the last date revised 8/5/22, included under procedure section 7. Ensure that the door closes properly and is kept locked when unsupervised. Any maintenance issue with the door should be addressed with maintenance or supervisor, and the door monitored until the door can be repaired. NJAC 8:39-31.2(e)	F 689		
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	F 756		10/22/22

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F 756	Continued From page 96 during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to a.) act on or respond to, recommendations made by the Consultant Pharmacist in a timely manner. This deficient practice was identified for 1 of 8 residents reviewed for medication regimen review (Resident #114) and was evidenced by the following: According to the Consultant Pharmacist's (CP) Therapeutic Suggestions report dated [redacted] the CP made three recommendations for Resident #114 as follows: 1. NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] has a boxed	F 756	1. Resident #114 had no negative outcome as a result of the pharmacy consultant's recommendations not being acted upon. 2. All residents with Pharmacy Consultant recommendations have the potential to be affected by the deficient practice. An audit will be done of the last 3 months pharmacy recommendations to ensure that all recommendations were addressed by the MD or NP. 3. Unit Managers were re-educated on the process for timely addressing of the pharmacy consultant recommendations. The Director of Nursing will distribute the monthly report with a return by date.	

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F 756	Continued From page 97 warning indicating the possibility of serious behavior and mood-related changes. Please evaluate the risk versus benefit. 2 [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] [redacted]) increases risk of CVA (stroke), mortality in persons with dementia, exacerbation of delirium, falls, EPS (Extrapyramidal Side Effects, such as, an inability to sit still, involuntary muscle contraction, tremors, stiff muscles and involuntary facial movements), and SIADH (Syndrome of Inappropriate Antidiuretic Hormone Secretions, meaning the hormones that help the kidneys, and body, conserve the correct amount of water are produced). If continuing present therapy, please document the risk vs. benefit. 3. Please evaluate the duration of therapy for [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.]) routine. Review of the [NJAC 8:43E-2.1 and] Physician's Order Form (POF) revealed the following: - An order dated [NJAC 8:43E-2.1 and] for [NJAC 8:43E-2.1 and Exec O] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] - An order dated [NJAC 8:43E-2.1 and] for [NJAC 8:43E-2.1 and Exec O] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.). - An order dated [NJAC 8:43E-2.1 and] for [NJAC 8:43E-2.1 and Exec Order 26, 4. b.] [redacted] Review of the [NJAC 8:43E-2.1 and] Nurse Practitioner Progress Note reflected that the Nurse Practitioner did not address the [NJAC 8:43E-2.1 and] CP recommendations.	F 756	4. The Director of Nursing or designee will ensure that each units report with corrections, or needed documentation is returned by date assigned, this will be on-going. The Director of Nursing or designee with audit 2 resident pharmacy consultant reports on each unit for 3 months to ensure all recommendations were addressed. The results of this audit will be reported to the QAPI committee monthly for 3 months.	

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During an interview with the surveyor on 08/08/22 at 10:31 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated that the CP will review each resident's medications and provide a report to the facility based on his review. The Director of Nursing (DON) will then distribute the reports to the Unit Managers. The LPN/UM stated that he will then review the CP recommendations and reach out to the physician for new orders. If the physician does not want to change the orders, the physician will come into the facility and write a rationale in the medical record. The LPN/UM stated that he completed the CP recommendations as quickly as he could and then gave them back to the DON.

The surveyor interviewed the Licensed Nursing Home Administrator (LNHA) and Assistant Director of Nursing (ADON) on 08/10/22 at 9:45 AM. The ADON stated that the CP came to the facility monthly and completed rounds of the unit, checked medication carts and medication rooms, completed medication pass with the nurses, and reviewed each resident's medications. The CP will generate a report as soon as possible after the visit. The LNHA stated that the facility hired a new CP. The CP's report was emailed to the Director of Nursing, the managers, me and the ADON. The ADON further stated that the CP will prepare a report which is given to the Unit Managers to review and address the recommendations. The physician will be notified for clarification and changes are made to the Medication Administration Record and Treatment Administration Record if new orders were received.

The surveyor interviewed the LNHA and ADON

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F 756	Continued From page 99 during a follow up interview on 08/18/22 at 11:26 AM. The LNHA stated that the email from the CP was encrypted, difficult to access, and the facility did not get the June 2022 CP report until the month of July. The ADON stated that this was received after the resident was discharged from the facility. The surveyor inquired if the facility could have acquired the report in a different form other than email. The LNHA stated that he expected the staff to reach out to the CP and attempt to obtain the report. The facility did not provide a policy concerning the CP recommendations.	F 756		
F 758 SS=D	NJAC 8:39 - 29.3 (a)(1) Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		10/22/22

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F 758	Continued From page 100 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to adequately monitor the target behaviors for the use of [redacted] medications (mood altering medications) for 1 of 5 residents (Resident #63) reviewed for unnecessary medications. This deficient practice was evidenced by the following:	F 758	1. Resident #63 had no negative outcome from the inconsistent behavior monitoring. 2. All residents on [redacted] medications are at risk for the deficient practice. An audit on all residents receiving [redacted] medications will be conducted to ensure that all ordered [redacted] medications are included on the [redacted] Monitoring Form with	

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F 758	Continued From page 101 On 08/03/22 at 10:24 AM, the surveyor observed Resident #63 lying in bed. According to the Admission Record, Resident #63 was admitted with diagnoses that included, but were not limited to [redacted]. Review of the Annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] included the resident had a Brief Interview for Mental Status score of [redacted] which indicated the resident's [redacted]. Further review of the MDS revealed the resident received the following [redacted]. Review of the Care Plan, dated [redacted] included a focus that the resident "uses [redacted] medications," and [redacted] problem r/t [related to] [redacted] with an intervention to "observe for signs and symptoms of [redacted]. Review of the Physician Order Form, dated [redacted] included the resident was ordered the following [redacted]: NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted]	F 758	the targeted behaviors indicated, and documentation is occurring every shift. 3. A review of the policy Mood and Behavior Monitoring was completed, and revisions made. Nurses will be re-educated on thoroughly completing the Behavior Monitoring form, ensuring that all psychoactive meds and their associated targeted behaviors are indicated, and behavior presence or absence is documented each shift. 4. The Director of Nursing or designee will audit the [redacted] monitoring form of 5 residents per week for 90 days to ensure all [redacted] medications and their associated behaviors are complete and nurses are documenting the presence or absence of behaviors every shift. The results of this audit will be presented to the QAPI committee monthly for 3 months.	

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[redacted]

Review of the [redacted] Monitoring Form [redacted] included that the resident was on [redacted]. The [redacted] did not include the targeted behaviors for staff to monitor. Further review of the [redacted] revealed that staff did not document whether the resident had behaviors on the following shifts:
05/09/22 3p-11p Shift
05/14/22 7a-3p Shift and 3p-11p Shift
05/15/22 7a-3p Shift and 3p-11p Shift
05/16/22 3p-11p Shift
05/18/22 3p-11p Shift
05/19/22 3p-11p Shift
05/26/22 3p-11p Shift
05/31/22 11p-7a Shift

Review of the [redacted] PMF included that the resident was on [redacted]. The [redacted] did not include that the resident was on [redacted] nor did it include the targeted behaviors for staff to monitor. Further review of the [redacted] revealed that staff did not document whether the resident had behaviors on the following shifts:
06/02/22 3p-11p Shift
06/03/22 3p-11p Shift
06/04/22 3p-11p Shift
06/06/22 3p-11p Shift
06/10/22 7a-3p Shift
06/13/22 11p-7a Shift
06/16/22 11p-7a Shift
06/18/22 7a-3p Shift and 3p-11p Shift
06/21/22 3p-11p Shift
06/24/22 7a-3p Shift
06/27/22 7a-3p Shift and 3p-11p Shift
06/28/22 7a-3p Shift and 3p-11p Shift

Review of the [redacted] included that the

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resident was on [redacted]. The PMF did not include that the resident was on [redacted], nor did it include the targeted behaviors for staff to monitor. Further review of the PMF revealed that staff did not document whether the resident had behaviors on the following shifts:
07/10/22 3p-11p Shift
07/13/22 3p-11p Shift
07/15/22 3p-11p Shift
07/19/22 3p-11p Shift
07/24/22 11p-7a Shift
07/25/22 3p-11p Shift and 11p-7a Shift
07/28/22 3p-11p Shift
07/30/22 3p-11p Shift and 11p-7a Shift
07/31/22 11p-7a Shift

During an interview with the surveyor on 08/11/22 at 11:51 AM, Registered Nurse/Unit Manager (RN/UM) #1 stated that residents on [redacted] medications are monitored for behaviors and that nurses are expected to document the behaviors on the PMF prior to the end of their shift. The RN/UM, in the presence of the surveyor, reviewed Resident #63's [redacted] and stated that the form should have included all [redacted] medications ordered, the targeted behaviors, and that the nurses should have filled out the form each shift. RN/UM #1 further stated that it was important to monitor the behaviors of residents on [redacted] medications to "make sure the medications are effective."

During an interview with the surveyor on 08/12/22 at 12:34 PM, the Assistant Director of Nursing (ADON) stated that nurses are expected to document resident behaviors on the PMF prior to the end of their shift. The ADON further stated that the nurses should not be leaving omissions on the [redacted] and that the PMF should include all

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F 758	Continued From page 104 NJAC 8:43E-2.1 and Exec O medications and the targeted behaviors to "monitor if the medication is effective." Review of the facility's Mood & Behavior Monitoring policy, revised 05/2022, included, "Mood and Behavior tracking documentation will be completed by the licensed nurse every shift, based upon comprehensive assessment outcomes, to identify any mood and behavior patterns, interventions attempted, outcome of approaches and side effects of medication." Further review of the policy included, "Psychoactive Monitoring Form with behavior chart will be initiated for every resident who receives psychoactive, antianxiety, sedative or antidepressant medications as well as any patient without medical regiment but with new onset of behaviors. The form will be placed in MAR [Medication Administration Record], and targeted behaviors will be outlined on the form." NJAC 8:39-27.1(a)	F 758		
F 760 SS=K	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: An Immediate Jeopardy (IJ) was identified for F760 during the recertification survey conducted on 08/29/22. Based on observation, interview, record review, and review of pertinent facility documents, it was	F 760	1. A. Resident #7 assessed by Nurse Practitioner, and Unit Manager verified that the liquid consistency was on the Medication Administration Record. LPN #1 was immediately educated about following physician's orders for med pass,	10/29/22

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F 760	Continued From page 105 determined the facility failed to follow a physician's order for [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.], as documented on the Medication Administration Record while administering medications. This deficient practice was identified for 1 of 3 nurses (Licensed Practical Nurse #1) on 1 of 4 units (Court 2) during the medication administration pass. On 08/04/22, the surveyor observed Licensed Practical Nurse (LPN) #1 administer medications to Resident #7 while providing the resident with thin (unthickened) liquids. LPN #1 did not follow the physician's order for [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] (NTL) documented on the Medication Administration Record (MAR). This posed a serious and immediate threat for residents on a physician's ordered altered liquid consistency diet. The Immediate Jeopardy (IJ) began on 08/04/22 at 8:25 AM and continued until 08/05/22. The Licensed Nursing Home Administrator (LNHA) and Assistant Director of Nursing (ADON) were notified of the IJ on 08/04/22 at 3:56 PM. LPN #1's failure to follow a physician's order for [NJAC 8:43] during the medication administration pass placed residents on a physician's ordered altered liquid consistency diet at risk for choking, [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.]), or death. An acceptable removal plan was received on 08/05/22 and verified by the survey team. This IJ was cited at a level K as the deficient practice was cited at the last standard survey of 11/01/21.	F 760	meals, and liquid consistencies. Agency was notified about the medication error. No medications will be administered until the licensed nurse reviews the Medication Administration Record to check for altered liquid consistency orders. B. Resident #114 did not return to the facility and expired in the hospital. 2. A. Any resident with an order for an altered liquid consistency is at risk for the same deficient practice. An audit was conducted of all residents with current orders for an altered liquid consistency to ensure that proper orders are in place and indicated on the Medication Administration Record. B. An audit was conducted of all residents on PRN [NJAC 8:43E-2.1 and Exec Orde] medications to ensure that the orders did not extend beyond the 14-day period. 3. A. Facility reviewed the policy for physician's orders. All nurses were re-educated to follow the five rights of Medication Administration and to utilize the Resident Census Information sheet to find pertinent resident information (i.e. liquid consistencies). B. Nurses will be re-educated to ensure that the 14 day cutoff for PRN [NJAC 8:43E-2.1 and Exec O] medications is followed. 4. A. DON or Designee will monitor 3 med passes per week for 3 months to ensure that all physician orders are being followed correctly. The results of these audits will be reported to the QAPI committee monthly for 3 months. B. DON or Designee will audit 3 residents with new orders for PRN [NJAC 8:43E-2.1 and Exec Or] medications per week for 3 months to	

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F 760	Continued From page 106 This deficient practice was evidenced by the following: On 08/04/22 at 08:15 AM, the surveyor observed LPN #1 (an agency nurse) dispense seven oral (PO) medications into a medicine cup and pour water (a thin liquid) into a plastic cup for Resident #7. At 8:25 AM, the surveyor accompanied LPN #1 into Resident #7's room. The LPN handed the resident the medicine cup, and the resident put all seven PO medications into their mouth. The resident took a small sip of the water from the plastic cup but did not swallow the medications. The resident then alternated taking sips of thin liquids (coffee and orange juice) from their breakfast tray but did not swallow the medications. As the resident's mouth was full of the medications and thin liquids, LPN #1 encouraged the resident to either swallow or spit out the medications, but the resident refused. At 8:45 AM, LPN #1 called LPN #2 from the hallway into Resident #7's room to assist with medication administration. LPN #2 immediately grabbed one of the thickening packets from the resident's breakfast tray and thickened the resident's water that was brought in by LPN #1. LPN #2 also thickened the resident's coffee and orange juice on the breakfast tray. Afterward, LPN #2 gave the resident a pre-thickened health shake from the breakfast tray and encouraged the resident to swallow the medications. The resident coughed as they held the medications and liquids in their mouth, attempting to keep their mouth closed.	F 760	ensure that the 14 day cutoff for PRN [redacted] medications is followed. The results of these audits will be reported to the QAPI committee monthly for 3 months.	

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At 8:57 AM, Resident #7 swallowed the medications and liquids held in their mouth.

According to the Admission Record, Resident #7 was admitted with diagnoses that included, but were not limited NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted]

A review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], revealed Resident #7 had a Brief Interview for Mental Status score of [redacted] which indicated that the resident's NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] Further review of the MDS included the resident received a NJSA 47:1A-1 reasonable privacy expectation [redacted]

Review of the Care Plan, initiated 03/26/13, included a focus on NJSA 47:1A-1 reasonable privacy expectation [redacted] ."

Review of the Physician's Order Form, dated [redacted] included a diet order, dated [redacted] for NJSA 47:1A-1 reasonable privacy expectation [redacted] ."

Review of the August 2022 MAR included the aforementioned diet order but did not require nurses to sign their initials to acknowledge the order.

Review of the Diet Requisition Form, dated [redacted], included the resident's diet was

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changed to Regular, Chopped Texture, and [redacted].

Review of Resident #7's Breakfast Meal Ticket, dated [redacted], included [redacted].

Review of the Nutrition Progress Note, dated [redacted], included, "Resident is on mechanically altered diet with [redacted] for [redacted] [difficulty swallowing] and tolerates it."

Review of the Speech Therapy SLP (Speech Language Pathology) Evaluation & Plan of Treatment, dated [redacted], included a diagnosis of [redacted] a precaution of [redacted], and a recommendation for [redacted].

Review of the Speech Therapy Discharge Summary, dated [redacted], included, "Pt [patient] was educated on importance of increasing efficiency of swallow (initiation) to minimize [redacted]," and discharge recommendations for [redacted].

During an interview with the surveyor on 08/04/22 at 9:00 AM, LPN #2 stated that she was the regular nurse for Resident #7. She further stated that LPN #1 should have been made aware of the resident's NTL order during the report but that it is also included on the MAR. LPN #2 stated the importance of following a physician's order for NTL was because the resident was on aspiration precautions.

During an interview with the surveyor on 08/04/22 at 10:31 AM, LPN #1 stated that nurses are made aware of altered liquid consistencies from the MAR or the resident's chart. LPN #1

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acknowledged that Resident #7 should have received NTL to prevent the risk of aspiration.

During an interview with the surveyor on 08/04/22 at 10:36 AM, Registered Nurse/Unit Manager (RN/UM) #1 stated that nurses should know if a resident has an order for an altered liquid consistency because the diet order is included on the MAR. RN/UM #1 further stated that LPN #1 should have checked the MAR for the diet order and used the thickening powder located in the medication cart to thicken Resident #7's liquids during the medication administration pass due to the [redacted].

During an interview with the surveyor on 08/04/22 at 11:58 AM, the ADON stated that agency staff are provided a "Welcome to Orientation" packet upon working in the facility and are also required to complete a medication pass test.

A review of the "Welcome to Orientation" packet signed by LPN #1, dated [redacted], included a Medication Administration policy dated [redacted] The policy revealed, "The nurse is to prepare medications prior to medication pass. Preparation includes; (a) the review of orders ..."

Review of the Medication Pass test completed by LPN #1, dated [redacted], did not include altered liquid consistencies.

During an interview with the surveyor on [redacted] at 2:40 PM, [redacted] (ST) #1 stated that when the ST makes a recommendation for an altered diet, the ST will handwrite the order on the Physician Order Sheet, and the nurse is responsible for transcribing the order. The ST also stated giving thin liquids to Resident #7, who

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is ordered NTL, would be contraindicated and "not safe."

During a follow-up interview with the surveyor on 08/04/22 at 3:41 PM, the ADON stated that during medication administration, the nurse should know if the resident requires an altered liquid consistency and thicken the liquids based on the diet order written in the MAR. The ADON further stated that providing residents with the correct liquid consistency is essential due to the risk of aspiration.

On 08/04/22 at 3:56 PM, the LNHA and ADON were notified that LPN #1's failure to follow a physician's order for NTL, as documented on the MAR during the medication administration pass, constituted as an IJ situation that placed residents on a physician's ordered altered liquid consistency diet at risk for choking, aspiration, or death.

An acceptable Removal Plan was received on 08/05/22 and verified by the survey team.

Review of the facility's Medication Administration policy, reviewed 05/2022, included, "Follow appropriate medication administration guidelines."

Review of the facility's Thickened Liquids policy, reviewed 05/2022, included, "Facilities will serve thickened liquids to residents as ordered by the physician."

Review of the facility's Therapeutic Diet Orders policy reviewed 05/2022 included, "Therapeutic diets will be provided to residents in the appropriate form and/or the appropriate nutritive content as prescribed by the physician and/or

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assessed by the interdisciplinary team to support the treatment and plan of care."

PART B
Based on interview and record review, it was determined that the facility failed to order one PRN (as needed) [redacted] medication for a 14-day period. This deficient practice was identified for 1 of 8 residents reviewed for medication regimen review (Resident #114) and was evidenced by the following:

According to the Admission Record, the resident was admitted to the facility with diagnoses that included but was not limited to [redacted].

Review of the Physician's Order Form, dated [redacted] for Resident #114 reflected an order [redacted]. The surveyor observed that the order did not contain a duration of [redacted]

Review of the [redacted] Medication Administration Record (MAR) reflected that Resident #114 received the as needed medication on [redacted] two times on [redacted]

Review of the [redacted] MAR reflected that Resident #114 received the as needed medication on [redacted]

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F 760	Continued From page 112 During an interview with the surveyor on 08/08/22 at 10:41 AM, LPN #3 stated that if there was a [redacted] medication ordered PRN, then it should be initially ordered for 14 days and then reevaluated by the physician. LPN #3 further stated that if the resident was receiving the PRN medication regularly and it was helping the resident, she would call the physician to see if the physician would change the order to a standing order. During an interview with the surveyor on 08/08/22 at 10:43 AM, the LPN/UM stated that a [redacted] medication should be ordered initially for 14 days and then reevaluated by the physician. When the medication was evaluated, the physician either wrote a new prescription or discontinued the order. During an interview with the surveyor on 08/10/22 at 9:45 AM, the ADON, in the presence of the LNHA, stated that a new prescription for a PRN [redacted] medication should be ordered for 14 days, reviewed by the physician, and then renewed or discontinued. The ADON stated that the physician must write a rationale as to why they continued the medication and include a duration in the order. The ADON stated that it was essential to monitor a PRN [redacted] medication to see if it was needed by the resident. Review of the facility's Antipsychotic Medication Use policy, revised in December 2016, reflected that "The need to continue PRN orders for psychotropic medications beyond 14 days requires that the practitioner document the rationale for the extended order. The duration of	F 760		

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F 760	Continued From page 113 the PRN order will be indicated in the order."	F 760		
F 808 SS=K	NJAC 8:39-11.2(b); 27.1(a) Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: An Immediate Jeopardy (IJ) was identified for F808 during the recertification survey conducted on 08/29/22. Based on observation, interview, record review, and review of pertinent facility documents, it was determined the facility failed to ensure that residents at risk for aspiration (when material such as food or drink enters the respiratory tract) received the appropriate altered liquid consistency diet. This deficient practice was identified for 2 of 9 residents (Resident #7 and #99) reviewed for altered liquid consistency diets. On 08/04/22 during the breakfast meal, Surveyor #1 observed Resident #7 drink thin liquids from his/her breakfast tray. The facility staff did not follow the instructions on the meal ticket for	F 808	1. Resident #7 assessed by Nurse Practitioner, and received order for diagnostic work up, speech therapy evaluation which was carried out on 8/4/22, Registered Dietitian assessment, and ongoing vital signs monitoring. Resident care plan was also reviewed by Unit Manager and interventions remained appropriate. Resident #99 was assessed by Registered Nurse and Respiratory Therapist, and received order for diagnostic work up, speech therapy evaluation was ordered on 8/4/22, Registered Dietitian assessment, and ongoing vital signs monitoring. Resident care plans were also reviewed by Unit Managers and interventions remained appropriate. LPN#1 was immediately educated about following physician's orders for med pass, meals, and liquid	10/29/22

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F 808	Continued From page 114 NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.) and appropriately thicken the liquids prior to providing the resident with the breakfast tray. On 08/04/22 during the lunch meal, Surveyor #2 observed Resident #99 drink a thin liquid from his/her lunch tray. The facility staff did not follow the instructions on the meal ticket for NTL and appropriately thicken the liquid prior to providing the resident with the lunch tray. This posed a serious and immediate threat for residents on an altered liquid consistency diet who are at risk for aspiration. The Immediate Jeopardy (IJ) began on 08/04/22 at 8:25 AM and continued until 08/05/22. The Licensed Nursing Home Administrator and Assistant Director of Nursing (ADON) were notified of the IJ on 08/04/22 at 3:56 PM. The facility's failure to ensure the appropriate liquid consistency diet was provided during meals placed residents at risk for choking, aspiration, or death. An acceptable removal plan was received on 08/05/22 and verified by the survey team. This deficient practice was evidenced by the following: 1.) On 08/04/22 at 8:25 AM, Surveyor #1 accompanied Licensed Practical Nurse (LPN) #1 into Resident #7's room during the medication administration pass. The LPN handed the resident a medicine cup and the resident put all of the oral medications into his/her mouth. The resident then took a small sip of the water from a plastic cup provided by the LPN, but did not	F 808	consistencies. Agency was notified about the medication error. An individual in-service was completed with admissions director to ensure that any future food or fluids offered to a resident are offered in the presence of a nurse to ensure that the proper liquid consistency is provided. All orders for thickened liquid consistencies will be placed on the medication administration record. No food trays will be served to the residents until meal ticket has been checked and if necessary, liquids will be thickened prior to serving. Meal ticket will be checked by licensed nurse. All temporary nurses will receive a policy and information packet regarding following physician orders, and safely administering altered liquid consistencies. Policy packet contains therapeutic diets, thickened liquids, physician's orders, medication administration, 24-hour chart check and resident information census. 2. Any resident with an order for an altered liquid consistency is at risk for the same deficient practice. An audit was conducted of all residents with current orders for an altered liquid consistency to ensure proper thickening prior to meal intake was conducted. 3. Facility reviewed the policy for therapeutic diets, thickened liquids, physician's orders, and medication administration. Additionally, all nurses were re-educated on the 24-hour chart check policy and resident information census policy. All temporary nurses at the start of their first shift, will receive education regarding all above policies. An individual in-service was completed with	

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swallow the medications. The resident then alternated taking sips of thin liquids (coffee and orange juice) from his/her breakfast tray, but did not swallow the medications. As the resident's mouth was full of the medications and thin liquids, LPN #1 encouraged the resident to either swallow or spit out the medications, but the resident refused.

At 8:45 AM, LPN #1 called LPN #2 from the hallway into Resident #7's room to assist with the medication administration. LPN #2 immediately grabbed one of the thickening packets from the resident's breakfast tray and thickened the resident's water that was brought in by LPN #1. LPN #2 also thickened the resident's coffee and orange juice on the breakfast tray. Afterwards, LPN #2 gave the resident a pre-thickened health shake from the breakfast tray and encouraged the resident to swallow the medications. As the resident was holding the medications and liquids in his/her mouth, he/she coughed while maintaining to keep his/her mouth closed.

At 8:57 AM, Resident #7 swallowed the medications and liquids in his/her mouth.

At 9:06 AM, Surveyor #1 observed Resident #7 cough while his/her breakfast tray was in front of him/her.

According to the Admission Record, Resident #7 was admitted with diagnoses that included, but were not limited to, [redacted]

Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the

admissions director to ensure that any future food or fluids offered to a resident are offered in the presence of a nurse to ensure that the proper liquid consistency is provided. Department heads will be re-educated that non clinical staff should not deliver meal trays to residents. Food Service Staff were re-educated about thickening non-prethickened liquids prior to them leaving the kitchen.
4. Director of Nursing or Designee will observe the meal service of 5 residents per week for 90 days to ensure that those with orders for thickened liquid consistency have received the appropriate liquid consistency. The results of these audits will be reported to the QAPI committee monthly for 3 months.

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management of care, dated [redacted], revealed Resident #7 had a Brief Interview for Mental Status score of [redacted] which indicated that the resident's [redacted]. Further review of the MDS included the resident received a '[redacted]

Review of the Care Plan, initiated [redacted], included a focus of, "[redacted] ."

Review of the Physician's Order Form, dated [redacted], included a diet order, dated [redacted], for [redacted] ."

Review of the Diet Requisition Form, dated [redacted], included the resident's diet was changed to Regular, Chopped Texture, and [redacted]

Review of Resident #7's Breakfast Meal Ticket, dated [redacted], included, "[redacted]

Review of the Nutrition Progress Note, dated [redacted] included, "Resident is on mechanically altered diet with [redacted] [difficulty swallowing] and tolerates it."

Review of the Speech Therapy SLP (Speech Language Pathology) Evaluation & Plan of Treatment, dated [redacted], included a diagnosis of [redacted] a precaution of [redacted] and a recommendation for [redacted]

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Review of the Speech Therapy Discharge Summary, dated [NJAC 8 43E-2.1 and Exec], included, "Pt [patient] was educated on importance of increasing efficiency of swallow (initiation) to minimize [NJAC 8 43E-2.1 and Exec Order 26]," and discharge recommendations for [NJAC 8 43E].

During an interview with the surveyor on 08/04/22 at 9:00 AM, LPN #2 stated that she was the regular nurse for Resident #7. She further stated that during meals, the Certified Nursing Assistants (CNA) pass out and set up the meal trays for residents. LPN #2 explained that the meal trays were sent from the kitchen with thin liquids and for Resident #7, the nurse must thicken the liquids on his/her tray outside of the room otherwise the resident will get upset. The LPN then verified that when she entered Resident #7's room, she had to thicken the liquids on the resident's breakfast tray and stated that the CNA should have called the nurse to thicken the liquids on the tray prior to giving the resident his/her breakfast. LPN #2 further stated that it was important to thicken Resident #7's liquids because the resident was on [NJAC 8 43E-2.1 and E] precautions.

During an interview with the surveyor on 08/04/22 at 9:59 AM, the Director of Nutritional Services (DNS) stated that the kitchen staff are responsible for providing a thickening packet for each beverage on the meal tray and then the nursing staff are responsible for thickening the liquids when the tray arrives to the nursing unit.

During an interview with the surveyor on 08/04/22 at 10:19 AM, CNA #1 stated that CNAs are responsible for passing out the meal trays,

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checking the meal tickets for accuracy, and thickening liquids on the meal tray. CNA #1 also stated that CNAs know if the resident requires thickened liquids because it is written on the meal ticket and the meal tray comes with thickening packets. The CNA further stated that it is important to thicken liquids if the resident has swallowing issues.

During an interview with the surveyor on 08/04/22 at 10:23 AM, CNA #2 stated that CNAs are responsible for passing out the meal trays, checking the meal tickets for accuracy, and thickening liquids on the meal tray. CNA #2 also stated that CNAs know if the resident requires thickened liquids because it is written on the meal ticket and the meal tray comes with thickening packets from the kitchen. The CNA further stated it is important to thicken liquids to prevent the resident from aspirating.

During an interview with the surveyor on 08/04/22 at 10:31 AM, LPN #1 stated that any facility staff can pass out the meal trays, but that nurses are responsible for thickening the liquids on the meal tray. LPN #1 further stated that Resident #7 should have received NTL to prevent the risk for aspiration.

During an interview with the surveyor on 08/04/22 at 10:36 AM, Registered Nurse/Unit Manager (RN/UM) #1 stated that CNAs or nurses can pass out meal trays and check the meal tickets for accuracy, but that the nurse is responsible for thickening the liquids on the meal tray. RN/UM #1 further stated that the nurse should have thickened the liquids on the meal tray prior to giving Resident #7 his/her breakfast due to the [redacted].

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During an interview with the surveyor on 08/04/22 at 2:40 PM, Speech Therapist (ST) #1 stated that when the ST makes a recommendation for an altered diet, the ST will handwrite the order on the Physician Order Sheet and the nurse is responsible for transcribing the order. The ST also stated giving thin liquids to Resident #7, who is ordered NTL, would be contraindicated and "not safe."

2.) According to the Admission Record, Resident #99 was admitted with diagnoses that included, but were not limited to, NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted]

Review of the Admission MDS, dated NJAC 8 43E-2.1 and [redacted], reflected that Resident #99 was NJAC 8 43E-2.1 and Exec Order 26, 4. b. 1. [redacted] and NJSA 47:1A-1 reasonable privacy expectation [redacted]

Review of the Care Plan (CP), initiated NJAC 8 43E-2.1 and Exec Order 26, 4. b. 1. included a focus of, NJSA 47 1A-1 reasonable privacy expectation [redacted] The CP included an intervention, dated [redacted], to, NJSA 47 1A-1 reasonable privacy expectation [redacted] ."

Review of the SLP Evaluation & Plan of Treatment (Speech therapy (ST) evaluation), dated NJAC 8 43E-2.1 and Exec Order 26, 4. b. 1. included a diagnosis of NJAC 8 43E-2.1 and Ex [redacted] and indicated the reason for referral was exacerbation of decreased NJAC 8 43E-2.1 and Exe [redacted]) function, decreased functional

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activity tolerance, coughing/choking during oral intake and increased need for assistance from others. The ST evaluation included recommendations for close supervision for oral intake, mechanical soft/ground textures, and [NJAC 8:43].

Review of the POF, dated [NJAC 8:43E-2.1 and], included an order, dated [NJAC 8:43E-2.1 and] for ST evaluation and treatment for [NJAC 8:43E-2.1 and Exec] downgrade diet to ground texture [NJAC 8:43E] feeding assistance with all meals, and [NJAC 8:43E-2. and E] precautions.

Review of the Diet Requisition Form, dated [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] included the resident's diet was changed to Carbohydrate Controlled (CCD), Ground texture, and [NJAC 8:43E]

On 08/04/22 at 12:30 PM, Surveyor #2 observed the lunch meal service on Court 1. Surveyor #2 observed a facility staff enter Resident #99's room with a meal tray. She set up the resident's lunch meal tray on the overbed table, exited the room and walked down the hallway. Surveyor #2 then entered Resident #99's room and observed the resident in bed with the head of bed elevated eating his/her meal. Surveyor #2 observed the resident as he/she took a spoon of the food and drank from a disposable white cup (cup). Resident #99 then placed the cup alongside the plate after drinking from it for a third time. At which time, Surveyor #2 observed that Resident #99's cup contained clear thin liquids (water). Surveyor #2 further observed an unopened packet of instant thickened coffee and an unopened packet of instant food thickener on the resident's tray. The facility staff did not follow the instructions on the meal ticket for [NJAC 8:43E-2.1 and Exec Or] [NJAC 8:43E-2.1 and Exec Ord] and appropriately thicken the

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liquids prior to providing the resident with the lunch tray.

Review of Resident #99's Lunch Meal Ticket (meal ticket), dated [NJAC 8 43E-2.1 and], revealed documented and highlighted in yellow, "[NJAC 8 43E-2.1] Skim Milk, [NJAC 8 43E-2.1 and Exec Order 26, 4.] Apple Juice, and [NJAC 8 43E-2.1] Coffee."

On 08/04/22 at 12:33 PM, CNA #6 entered Resident #99's room and stated she was there to assist the resident with the lunch meal tray. CNA #6 immediately grabbed the instant thickened coffee packet from the resident's tray and thickened the water in the cup. When interviewed, CNA #6 stated the thin liquid in the disposable cup was water for the resident's instant coffee. CNA # 6 further stated Resident #99 required NTL and that the thin liquids in the cup should have been thickened with the instant thickened coffee prior to giving it to the resident. CNA #6 added that Resident #99 should not have been given thin liquids.

08/04/22 at 12:41 PM, Surveyor #2 interviewed the facility staff who set up Resident #99's lunch meal tray. The facility staff identified herself as the Admissions Director (AD) and stated she regularly passed trays on the units. The AD stated she looks at the resident's meal ticket and compare it to the tray for accuracy. The AD added that you would open the thickening packets and mix it with the appropriate liquids. The AD further stated the liquid consistency was documented on the meal ticket and that the person setting up the meal tray was responsible for making sure the that the resident was receiving the correct consistency. The AD stated she would remove

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the tray if she was unsure of the consistency and would follow up the nursing staff. When question about her setting up Resident #99's lunch meal tray, the AD stated she was not familiar with the resident and that she exited the room to get the CNA. The AD did not provide an explanation why she did not thicken the resident's coffee or remove the resident's tray before leaving the room.

During an interview with Surveyor #1 and #2 on 08/04/22 at 3:41 PM, the ADON stated that CNAs and nurses were responsible for passing out the meal trays, but that the nurse were responsible for checking the meal ticket for accuracy and ensuring the correct thickening packets are on the meal tray. The ADON further stated that staff should not provide a meal tray with thin liquids to a resident who is on an altered liquid consistency diet due to the risk of aspiration.

During an interview with Surveyor #2 on 08/05/22 at 8:58 AM, the ADON stated the AD was recently hired and completed the New Employee Orientation education. The ADON added that passing trays was not part of the education packet and that the AD should not have been passing trays on the units.

Review of the facility's Thickened Liquids policy, with reviewed date of 05/2022, included, "Facilities will serve thickened liquids to residents as ordered by the physician," and, "For beverages which must be thickened, such as coffee, tea, cocoa and soup, the beverage will be thickened by the Dietary staff prior to leaving the kitchen."

Review of the facility's Therapeutic Diet Orders

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F 808	Continued From page 123 policy, with reviewed date of 05/2022, included, "Therapeutic diets will be provided to residents in the appropriate form and/or the appropriate nutritive content as prescribed by the physician and/or assessed by the interdisciplinary team to support the treatment and plan of care." Review of the facility's Meal Services policy,with reviewed date of 05/2022, included, "A record of all residents' diet order and a list of those residents on thickened liquids or fluid restrictions will be kept in each unit in a manner that ensures privacy."	F 808		
F 812 SS=F	NJAC 8:39-17.4(a)(2) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		10/22/22

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F 812	Continued From page 124 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other documentation, it was determined that the facility failed to A) handle potentially hazardous foods and maintain sanitation in a safe and consistent manner. The facility also failed to B) ensure that facility staff used appropriate infection control measures during meal observation on 1 of 4 units, the [redacted] Unit. This deficient practice was evidenced by the following: A) On 08/02/22 from 9:10 to 10:16 AM, the surveyor, accompanied by the Director of Nutrition Services (DONS), observed the following in the kitchen: 1. Upon entry to the kitchen the surveyor observed a female kitchen staff member from the entrance doorway without a hair net or mask. Upon seeing the surveyor enter the kitchen, the female staff member proceeded to don (put on) a hairnet and surgical mask. When questioned whether she was required to wear a hair net while in the kitchen and handling food the staff did not answer the surveyor. When interviewed the DONS revealed, "It is a requirement that all staff don a hairnet while in the kitchen." 2. On a middle shelf of a 4-tiered wire rack used for storage outside the dietary office, the surveyor observed an open box of aluminum half pans. The aluminum half pans were removed from their plastic bag and were exposed to the air. 3. A multi-tiered can rack in the dry storage area contained a can of sweetened apple sauce that had a significant dent on the seam of the can. In addition, (6) cans of peas all had significant dents	F 812	1.The female kitchen staff member (without a hairnet) received individual counseling immediately by the Director of Nutritional Services regarding donning a hairnet when entering the kitchen. The AM and PM cooks received individual counseling by the Director of Food Services regarding temperature logs. CNA who was feeding resident with his hands was given individual counseling by the Assistant Director of Nurses regarding infection control/hand-washing procedures during meal service while assisting a resident. The aluminum half pans on the 4-tier wire rack that were exposed to the air were immediately thrown away. Dented cans and expired/undated food in the kitchen and pantries were immediately discarded. Temperature logs on the walk-in freezer and walk-in refrigerator are being recorded twice a day. 2. All residents have the potential to be affected by this deficient practice. 3. Dietary Staff were in serviced on the hairnet, beard guard and mask usage as it relates to the dietary staff. Nursing Management in-serviced nursing staff on proper dining procedures including the correct technique for assisting a resident with eating during meal service. The kitchen implemented daily department rounds which will be conducted and recorded by the FSD or designee to monitor the labeling and dating of products in the department along with cooks are responsible to check the	

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F 812	Continued From page 125 on the seams. The DONS stated, "They must have dropped that whole case." On a middle rack of a multi-tiered wire rack, a previously opened package of powdered vanilla pudding mix was wrapped in clear plastic wrap. The package had no dates. The DONS stated, "That should have a use by date." 4. A Refrigerator/Freezer Temperature Log was on the outside wall of the walk-In freezer and next to the door. The Refrigerator/Freezer Temperature Log was undated. The DONS confirmed to the surveyor that the temperature log was for July of 2022 and a new log for August 2022 had not been initiated. The log was not completed for the dates of July 30th and July 31st during the AM or PM. Upon further interview the DONS stated that the AM and PM cooks were responsible for recording temperatures in the kitchen. The DONS stated, "The temperature logs should be completed twice daily in the AM and PM. The DONS agreed that a temperature log had not been initiated for the walk-in freezer for August 22 and there were no recorded temperatures in the AM and PM for 8/1 and 8/2/22. 5. On the middle rack of a multi-tiered storage rack in the walk-in freezer, a frozen Angel Food style cake in a clear plastic bag was removed from its original container and was placed on top of a cardboard box. The bag had no dates. On an upper shelf on the opposite side of the freezer a Lemon Meringue pie was removed from its original container and was placed on a cardboard box. The pie had no dates. 6. The Refrigerator Temperature Log posted on the outside of the walk-in refrigerator revealed	F 812	refrigerators and freezer at the end of their shift for any improper labeling and dating. 4. The Director of Nutritional Services will monitor daily for 30 days all temperature logs for the walk-in freezer and walk-in refrigerator. Director of Nutritional Services will inspect all cans in the kitchen for dents. All cans found defective will be stored in a separate area, discarded, or returned. The Unit Managers will observe meal service 3x weekly to ensure that residents are assisted according to the policy and procedure for 30 days, and thereafter weekly for 60 days. Unit Managers will audit pantries 2x weekly for 30 days and once weekly thereafter for 60 days to ensure all items are properly labeled and dated. The results of these audits will be reported to the QAPI committee monthly for 3 months. The Director of Nutritional Services or designee for the next 30 days will monitor the refrigerators , freezers and food storage room for labeling and dating to ensure that staff is adhereing to standard pratices. After 30 days the Director of Nutritional Services will monitor these deficiency practices monthly and will report findings with an action plan to the QAPI committee.	

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that no refrigerator temperatures were recorded for August 1st during the AM and PM. On interview the DONS revealed that temperatures should be completed twice a day for all refrigeration and the AM and PM cooks are responsible for taking the temperatures.

7. A multi-tiered wheeled storage rack in the walk-in refrigerator contained a sheet pan with 8 vanilla puddings in single serve portion containers. The puddings had no dates. On a sheet pan beneath the puddings 3 more puddings with whipped topping in single serve portion cups had no dates. A second wheeled multi-tiered storage cart contained 2 half pans with individualized portions of angel food cake. The cakes were on individual Styrofoam plates covered with clear plastic wrap and had no dates. On interview the DONS stated, "They were left over from last night's dinner. They must have made too much. Everything should have a date."

On 08/09/22 from 9:26 to 9:42 AM, the surveyor, accompanied by the Unit Clerk and Registered Nurse/Unit Manager (RN/UM #2) observed the following on the Court 1 unit pantry:

1. In the freezer an individual piece of frozen pie on a Styrofoam plate was covered with plastic wrap had no dates. In addition, (2) clear plastic quart containers with lids contained unidentified frozen food, one orange in color and one brown in color. The containers had no name or dates. A drawer below the middle shelf of the refrigerator contained a zip lock style bag with (3) pickle spears. The bag had no name or dates. When interviewed RN/UM#2 revealed, "The 11-7 nursing and dietary staff are tasked with monitoring the refrigerator. Those foods should

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have been labeled and dated, consistent with our policy. Those foods will be thrown away."

On 08/09/22 from 9:45 to 9:52 AM, the surveyor, accompanied by the Registered Nurse/Unit Manager (RN/UM#1) observed the following on the Court 2 Unit Pantry:

1. On a middle shelf in the pantry refrigerator a sub style sandwich wrapped in [name of store] paper had no name or date. When interviewed the RN/UM#1 stated, "Everything should be dated. I check it every morning and supervisors check every shift. The policy is right on the refrigerator door."

On 08/18/22 from 11:45 AM to 12:09 PM, the surveyor, accompanied by the DONS observed the following in the kitchen:

Upon entry to the kitchen the surveyor observed a female staff member with their hair in a bun style that extended significantly above her head. The staff was also observed with a head band around her upper forehead area and the lower back/upper neck area of hair. The female staff member was not wearing a hair net. The surveyor observed the female staff member open the kitchen door and enter the hallway with the door held open. The staff then proceeded to get a hair net from the wall mounted hair net bin and place the hair net on their head to fully cover their hair and bun. On interview the staff stated, " I had a hair net on, but I went on break. I just returned from break and I'm putting one on now. The surveyor questioned the staff if you are supposed to enter the kitchen without a hairnet. The female staff did not respond to the surveyor's question and proceeded to walk away.

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B) On 08/09/22 at 1:30 PM, observed the lunch meal on the [redacted] unit. The surveyor observed Certified Nursing Assistant (CNA #8) providing 1:1 assist with the lunch meal to Resident #93. CNA #8 was not observed to perform handwashing prior to assisting Resident #93 and was not observed to be wearing gloves. CNA #8 was observed to pick up a piece of white bread from Resident #93's meal plate and tear the crust off with his bare hands. After removing the crust from the bread, CNA #8 then proceeded to tear off a small piece of bread with his bare hands and place the piece of bread into Resident #93's mouth. Resident #93 proceeded to eat the piece of bread. CNA #11 was interviewed by the surveyor on 08/09/22 at 1:33 PM, as she was standing next to the surveyor when CNA #8 was feeding Resident #93 with bare hands. The surveyor asked CNA #11 if it was appropriate for staff to handle foods with bare hands during meal service. CNA #11 responded, " No you should not handle resident food with your bare hands. It's an infection control issue. It's disgusting." The surveyor then interviewed CNA #8. CNA #8 provided the following response when asked why food should not be handled with bare hands, "I shouldn't handle the food with my bare hands because it's an infection control issue." The facility provided documentation that revealed that CNA #8 received orientation on 05/24/22, which included "Infection Control-Hand Washing Policy/Isolation Guidelines."

On 08/09/22 at 2:48 PM the surveyor asked CNA #8 if he had received in-service training on hand hygiene or proper food handling practices. CNA #8 stated, "I have not received any in-service training from the facility since I have worked here.

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My agency has provided hand hygiene in-servicing in the past. I did go through orientation when I started here, yes."

The surveyor reviewed an undated facility policy titled UNIFORM POLICY. The following was revealed under the heading PROCEDURE:

"Hair nets are worn and completely cover the hair from front to back."

The surveyor reviewed the facility policy titled DATING AND LABELING POLICY, with rev(revision).1-24-2017. The following was revealed under the heading POLICY:

"Kitchen will assure safety by maintaining proper dates and labels to all goods and ready to eat food products."

The following was revealed under the heading PROCEDURE:

1. Inspect all deliveries carefully for proper labeling and damage.
2. Label products in storage with date the package was opened.
4. Ready to eat foods must be dated with a 72 hour use by date and discarded when expired.
5. Label all goods with date received and identity of product.
6. Use printed address label or Black marker with legible writing to date and label products.
10. Discard all foods that expire immediately.

The surveyor reviewed an undated facility policy titled How to recognize unsafe cans. The policy revealed the following:

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A. Avoid using cans that have severe dents:
1. On the side and top seams 2. With sharp edges 3. That break any seal in the can 4. That break the inner body wall lining 5. Which contain any leaks or pin holes.

The surveyor reviewed an undated facility policy titled Policy- Food brought in from outside sources. The following was revealed under the heading Procedure:

2. Foods or beverages brought in from outside will be labeled with the resident's name and dated with the current date the item(s) was brought to the facility for storage.

3. Food or beverage items may be stored in facility pantries, refrigerators or freezers or resident's personal room refrigerators, if applicable.

a. Foods that do not require refrigeration may be stored in the resident's room or in the unit pantry. Food or beverage in the original container that is past the manufacturer's expiration date will be discarded by staff.

b. All cooked or prepared food brought in for resident and stored in the unit's pantry refrigerator or personal room refrigerator will be dated when accepted for storage and discards after 72 hours. Unlabeled/undated food found will be discarded immediately.

4. Staff will monitor resident's room, unit pantry, refrigerator/freezer units for food and beverage for disposal.

The surveyor reviewed the facility policy titled

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F 812	Continued From page 131 Refrigerator/Frozen Food Temperature Policy, Rev 7.2020. The following purpose was revealed: "Refrigerated and Frozen Food Storage will be used to hold potentially hazardous foods since refrigerated and frozen food storage slows the growth of microorganisms." The following was revealed under the Procedure for Refrigerated Food Temperature heading: 1. "The refrigerator temperature will be maintained at 41 F (Fahrenheit) or lower. Place hanging thermometer in the warmest part of the refrigerator. Check temperature on unit at least twice per day." The following was revealed under the heading Frozen Food Temperature: 8. "Monitor and record freezer temperatures at least twice per day." A review of a facility provided document titled Creating a Homelike Dining Experience, created January 26, 2018, revealed under the heading Infection Control: "Staff need to wash their hands before meals are served." "All food should be served with proper utensils." NJAC 18:39-17.2(g), 19.4(m)	F 812		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse	F 814		10/22/22

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F 814	Continued From page 132 properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to have a cover over the opening of 1 of 1 garbage compactors and 1 of 1 recycling dumpster's. This deficient practice was evidenced by the following: On 08/02/22 at approximately 9:45 AM, the surveyor, accompanied by the Director of Foodservice (DOFS) observed the following in the designated facility garbage area: A green compactor style garbage container had its door open, and the facility bagged garbage contents were exposed. In addition, on the ground surrounding the compactor the following items were observed: empty 4-ounce portion control beverage cups, paper, a plastic beverage lid with a plastic straw inserted in the lid, an empty 16-ounce Styrofoam beverage cup, plastic forks, plastic bags, and a used vinyl, disposable glove. The facility also had a recycling dumpster designated for cardboard, per the DOFS. The dumpster had 2 of 2 plastic lids opened and exposed bagged and un-bagged garbage, including a Styrofoam plate with what appeared to be lettuce on it and cardboard. Flies were observed on the garbage within the dumpster. When interviewed the DOFS stated, "Maintenance, housekeeping and dietary are responsible for the maintenance of the area." We share the dumpster/trash with the adjacent facility.	F 814	1.All areas surrounding the green compactor style garbage container were cleaned. The recycling dumpster was emptied of all items other than cardboard and disposed of in the compactor. An in-service was done by the Administrator with the Director of Food Services, Maintenance Director as well as the Director of Housekeeping regarding proper disposal of garbage. 2.All residents have the potential to be affected by this deficient practice when garbage is not disposed of properly. 3.An in-service was done by the Dietary Director with the dietary staff regarding the proper disposal of waste. The Housekeeping Director conducted an in-service with the housekeeping staff to ensure all waste was disposed of appropriately and in the proper containers. The Maintenance Director in-serviced the maintenance staff regarding the proper disposal of facility waste. 4.The Food Service Director, Housekeeping Director and Maintenance Director will audit the area around the compactor daily for 4 weeks, and weekly thereafter for 90 days to ensure that the area is clean, and all garbage items are placed in the appropriate containers. The results of these audits will be reported to the QAPI committee monthly for 3 months.	

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F 814	Continued From page 133 The surveyor reviewed the facility policy titled Waste Disposal, Revised: 05/2022. The following was revealed under the heading POLICY: "To maintain an odorless and safe environment that is inaccessible to insects and rodents." The following was revealed under the heading Procedure: 5. "All garbage/refuse containers in utility rooms, refuse storage rooms, and outside facility must be maintained at all times with a closed lid." 6. "Areas around the dumpster should be kept clean and orderly." NJAC 8:39-19.3(c)	F 814		
F 835 SS=K	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Reference F689K, 760K, F808K, Based on observations, interviews, review of medical records and review of facility documents, it was determined that the facility Licensed Nursing Home Administrator (LNHA) failed to ensure that the facility's policies and procedures were implemented to ensure resident safety and well-being, by failing to: a.) ensure safe meal	F 835	1. All three IJ's had removal plans submitted, accepted, and implemented. A professional development plan will be initiated for the administrator and will include but is not limited to, daily oversight by the VP of Operations, VP of Clinical Services, VP of Compliance. 2. All residents have the potential to be affected by the deficient practice.	10/26/22

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F 835	Continued From page 134 delivery for Residents #7 and #99, who were at risk for aspiration, according to the physician's prescribed diet order to include [redacted] thickened liquids, b.) perform medication administration according to professional standards of practice, and c.) maintain and provide a safe environment for the residents by ensuring chemicals were locked and secured. This posed a serious and immediate threat to the safety and well-being of all the residents who receive thickened liquids from choking, aspirating or dying and all the residents on the [redacted] Unit from ingesting chemicals and becoming seriously ill or death. The failure of the LNHA to ensure the facility established and maintained systems that were effective and efficient to operate the facility in a manner to safely meet resident's needs in compliance with federal, state and local requirements as outlined in the Administrator Job Description, resulted in an Immediate Jeopardy (IJ) that was identified on 08/08/22 at 2:19 PM . A Removal Plan was received on 08/10/22 at 8:48 AM and the survey team verified the implementation of the Removal Plan on 08/10/22 at 2:00 PM. This deficient practice was evidenced by the following: A review of the facility's policy titled "Administrator Job Description", undated, revealed that the duties of the Administrator included but not limited to: a)Operate the facility in accordance with the	F 835	3. The Licensed Administrator will receive education and support from VP of Operations, VP of Clinical Services, VP of Compliance including but not limited to: policy review, management processes, and regulation management. A weekly meeting will be held for 90 days to review topics covered and progress made. Staff were re-educated for F689 Free of Accident Hazards / Supervision / Devices, F760 Significant Medication Errors, F808 Therapeutic Diet as Prescribed by Physician, and audits were put in place to monitor compliance. 4. VP of Operations, VP of Clinical Services, VP of Compliance will complete a performance evaluation at the end of 90 days to evaluate the performance of the Administrator and will determine if additional education is required. All Housekeeping closets will be audited daily for 90 days by the Housekeeping Supervisor or designee for F689 to ensure that they are closed and locked. Director of Nursing or Designee will monitor 3 med passes per week for 3 months for F760 to ensure that all physician orders are being followed correctly. Director of Nursing or Designee will observe the meal service of 5 residents per week for 90 days for F808 Therapeutic Diet as Prescribed by Physician, to ensure that those with orders for thickened liquid consistency have received the appropriate liquid consistency. The results of these audits will be reported to the QAPI committee monthly for 3 months.	

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F 835	Continued From page 135 established policies and procedures of the governing body in compliance with federal, state and local regulations. b)Establish systems to enforce the facility policies and procedures. c)Follow facility Resident Rights policies d)Perform other related duties as directed by the governing body Refer F760K On 08/04/22, the LNHA failed to ensure the facility followed a physician's order for [redacted] as documented on the Medication Administration Record, while administering medications. This deficient practice was identified for 1 of 3 nurses (Licensed Practical Nurse #1) on 1 of 4 units (Court 2) during the medication administration pass. On 08/04/22, the surveyor observed Licensed Practical Nurse (LPN) #1 administer medications to Resident #7 while providing the resident with thin liquids. LPN #1 did not follow the physician's order for [redacted] documented on the Medication Administration Record (MAR). This posed a serious and immediate threat for residents on a physician's ordered altered liquid consistency diet. The Immediate Jeopardy (IJ) began on 08/04/22 at 8:25 AM and continued until 08/05/22. The Licensed Nursing Home Administrator (LNHA) and Assistant Director of Nursing (ADON)	F 835		

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were notified of the IJ on 08/04/22 at 3:56 PM. LPN #1's failure to follow a physician's order for NTL during the medication administration pass placed residents on a physician's ordered altered liquid consistency diet at risk for choking, aspiration (when material such as food or drink enters the respiratory tract), or death.

An acceptable removal plan was received on 08/05/22 and verified by the survey team.

This was cited at a level K as the deficient practice was cited at the last standard survey of 11/01/21.

This deficient practice was evidenced by the following:

On 08/04/22 at 08:15 AM, the surveyor observed LPN #1 (an agency nurse) dispense seven oral (PO) medications into a medicine cup and pour water (a thin liquid) into a plastic cup for Resident #7.

At 8:25 AM, the surveyor accompanied LPN #1 into Resident #7's room. The LPN handed the resident the medicine cup and the resident put all seven PO medications into his/her mouth. The resident took a small sip of the water from the plastic cup, but did not swallow the medications. The resident then alternated taking sips of thin liquids (coffee and orange juice) from his/her breakfast tray, but did not swallow the medications. As the resident's mouth was full of the medications and thin liquids, LPN #1 encouraged the resident to either swallow or spit out the medications, but the resident refused.

At 8:45 AM, LPN #1 called LPN #2 from the

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hallway into Resident #7's room to assist with the medication administration. LPN #2 immediately grabbed one of the thickening packets from the resident's breakfast tray and thickened the resident's water that was brought in by LPN #1. LPN #2 also thickened the resident's coffee and orange juice on the breakfast tray. Afterwards, LPN #2 gave the resident a pre-thickened health shake from the breakfast tray and encouraged the resident to swallow the medications. As the resident was holding the medications and liquids in his/her mouth, he/she coughed while maintaining to keep his/her mouth closed.

At 8:57 AM, Resident #7 swallowed the medications and liquids in his/her mouth.

According to the Admission Record, Resident #7 was admitted with diagnoses that included, but were not limited to, NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted]

Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJAC 8 43E-2.1 and, revealed Resident #7 had a Brief Interview for Mental Status score of NJAC 8 which indicated that the resident's NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.. Further review of the MDS included the resident received a NJSA 47:1A-1 reasonable privacy expectation [redacted]

Review of the Care Plan, initiated NJAC 8 43E-2.1 and included a focus of, "potential nutrition problem r/t [related to] need for mechanically altered diet, thickened liquids," with an intervention dated, NJAC 8 43E-2.1 and, to, "provide diet as ordered: Regular,

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chopped texture, [redacted]."

Review of the Physician's Order Form, dated [redacted] included a diet order, dated [redacted] for "[redacted] NJSA 47:1A-1 reasonable privacy expectation [redacted], [redacted]

[redacted] the [redacted] MAR included the aforementioned diet order, but did not require nurses to sign their initials to acknowledge the order.

Review of the Diet Requisition Form, dated [redacted], included the resident's diet was changed to [redacted] NJSA 47:1A-1 reasonable privacy expectation [redacted].

Review of Resident #7's Breakfast Meal Ticket, dated [redacted] included, "[redacted]"

Review of the Nutrition Progress Note, dated [redacted] included, "Resident is on mechanically altered diet with [redacted] for [redacted] and tolerates it."

Review of the Speech Therapy SLP (Speech Language Pathology) Evaluation & Plan of Treatment, dated [redacted], included a diagnosis of [redacted], a precaution of [redacted], and a recommendation for [redacted].

Review of the Speech Therapy Discharge Summary, dated [redacted], included, "Pt [patient] was educated on importance of increasing efficiency of swallow (initiation) to minimize [redacted]" and discharge recommendations for [redacted]

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During an interview with the surveyor on 08/04/22 at 9:00 AM, LPN #2 stated that she was the regular nurse for Resident #7. She further stated that LPN #1 should have been made aware of the resident's NTL order during report, but that it is also included on the MAR. LPN #2 stated the importance of following a physician's order for NTL was because the resident was on aspiration precautions.

During an interview with the surveyor on 08/04/22 at 10:31 AM, LPN #1 stated that nurses are made aware of altered liquid consistencies from the MAR or the resident's chart. LPN #1 acknowledged that Resident #7 should have received NTL to prevent the risk for aspiration.

During an interview with the surveyor on 08/04/22 at 10:36 AM, Registered Nurse/Unit Manager (RN/UM) #1 stated that nurses should know if a resident has an order for an altered liquid consistency because the diet order is included on the MAR. RN/UM #1 further stated that LPN #1 should have checked the MAR for the diet order and used the thickening powder located in the medication cart to thicken Resident #7's liquids during the medication administration pass due to the risk of aspiration.

During an interview with the surveyor on 08/04/22 at 11:58 AM, the ADON stated that agency staff are provided a "Welcome to Orientation" packet upon working in the facility and are also required to complete a medication pass test.

Review of the "Welcome to Orientation" packet signed by LPN #1, dated [redacted], included a Medication Administration policy, dated [redacted] The policy revealed, "The nurse is to prepare

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F 835	Continued From page 140 medications prior to medication pass. Preparation includes; (a) the review of orders ..." Review of the Medication Pass test completed by LPN #1, dated [redacted], did not include altered liquid consistencies. During an interview with the surveyor on 08/04/22 at 2:40 PM, Speech Therapist (ST) #1 stated that when the ST makes a recommendation for an altered diet, the ST will handwrite the order on the Physician Order Sheet and the nurse is responsible for transcribing the order. The ST also stated giving thin liquids to Resident #7, who is ordered NTL, would be contraindicated and "not safe." During a follow-up interview with the surveyor on 08/04/22 at 3:41 PM, the ADON stated that during medication administration, the nurse should know if the resident requires an altered liquid consistency and thicken the liquids based on the diet order written in the MAR. The ADON further stated it is important to provide residents with the correct liquid consistency due to the risk of aspiration. On 08/04/22 at 3:56 PM, the LNHA and ADON were notified that LPN #1's failure to follow a physician's order for NTL, as documented on the MAR during the medication administration pass, constituted as an IJ situation that placed residents on a physician's ordered altered liquid consistency diet at risk for choking, aspiration, or death. An acceptable Removal Plan was received on 08/05/22 and verified by the survey team.	F 835		

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Review of the facility's Med Administration policy, reviewed 05/2022, included, "Follow appropriate medication administration guidelines."

Review of the facility's Thickened Liquids policy, reviewed 05/2022, included, "Facilities will serve thickened liquids to residents as ordered by the physician."

Review of the facility's Therapeutic Diet Orders policy, reviewed 05/2022, included, "Therapeutic diets will be provided to residents in the appropriate form and/or the appropriate nutritive content as prescribed by the physician and/or assessed by the interdisciplinary team to support the treatment and plan of care."

Refer F808K

On 08/04/22, the LNHA failed to ensure that residents at risk for aspiration (when material such as food or drink enters the respiratory tract) received the appropriate altered liquid consistency diet.

This deficient practice was identified for 2 of 9 residents (Resident #7 and #99) reviewed for altered liquid consistency diets.

On 08/04/22 during the breakfast meal, Surveyor #1 observed Resident #7 drink thin liquids from his/her breakfast tray. The facility staff did not follow the instructions on the meal ticket for [redacted] and appropriately thicken the liquids prior to providing the resident with the breakfast tray.

On 08/04/22 during the lunch meal, Surveyor #2 observed Resident #99 drink a thin liquid from

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his/her lunch tray. The facility staff did not follow the instructions on the meal ticket for NTL and appropriately thicken the liquid prior to providing the resident with the lunch tray.

This posed a serious and immediate threat for residents on an altered liquid consistency diet who are at risk for aspiration. The Immediate Jeopardy (IJ) began on 08/04/22 at 8:25 AM and continued until 08/05/22.

The Licensed Nursing Home Administrator(LNHA) and Assistant Director of Nursing (ADON) were notified of the IJ on 08/04/22 at 3:56 PM. The facility's failure to ensure the appropriate liquid consistency diet was provided during meals placed residents at risk for choking, aspiration, or death.

An acceptable removal plan was received on 08/05/22 and verified by the survey team.

This deficient practice was evidenced by the following:

1.) On 08/04/22 at 8:25 AM, Surveyor #1 accompanied Licensed Practical Nurse (LPN) #1 into Resident #7's room during the medication administration pass. The LPN handed the resident a medicine cup and the resident put all of the oral medications into his/her mouth. The resident then took a small sip of the water from a plastic cup provided by the LPN, but did not swallow the medications. The resident then alternated taking sips of thin liquids (coffee and orange juice) from his/her breakfast tray, but did not swallow the medications. As the resident's mouth was full of the medications and thin liquids, LPN #1 encouraged the resident to either swallow

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or spit out the medications, but the resident refused.

At 8:45 AM, LPN #1 called LPN #2 from the hallway into Resident #7's room to assist with the medication administration. LPN #2 immediately grabbed one of the thickening packets from the resident's breakfast tray and thickened the resident's water that was brought in by LPN #1. LPN #2 also thickened the resident's coffee and orange juice on the breakfast tray. Afterwards, LPN #2 gave the resident a pre-thickened health shake from the breakfast tray and encouraged the resident to swallow the medications. As the resident was holding the medications and liquids in his/her mouth, he/she coughed while maintaining to keep his/her mouth closed.

At 8:57 AM, Resident #7 swallowed the medications and liquids in his/her mouth.

At 9:06 AM, Surveyor #1 observed Resident #7 cough while his/her breakfast tray was in front of him/her.

According to the Admission Record, Resident #7 was admitted with diagnoses that included, but were not limited to, NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted]

Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], revealed Resident #7 had a Brief Interview for Mental Status score of [redacted]" which indicated that the resident's NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. . Further review of the MDS included the resident received a NJSA 47:1A-1 reasonable privacy expectation

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F 835	Continued From page 144 NJSA 47:1A-1 reasonable privacy expectation Review of the Care Plan, initiated 03/26/2013, included a focus of, "NJSA 47:1A-1 reasonable privacy expectation [redacted]." Review of the Physician's Order Form, dated [redacted] included a diet order, dated [redacted] for "NJSA 47:1A-1 reasonable privacy expectation [redacted] Review of the Diet Requisition Form, dated [redacted], included the resident's diet was changed to NJSA 47:1A-1 reasonable privacy expectation, and [redacted] Review of Resident #7's Breakfast Meal Ticket, dated [redacted] included, "[redacted] Review of the Nutrition Progress Note, dated [redacted] included, "Resident is on mechanically NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] and tolerates it." Review of the Speech Therapy SLP (Speech Language Pathology) Evaluation & Plan of Treatment, dated [redacted], included a diagnosis of [redacted], a precaution of [redacted], and a recommendation for [redacted] Review of the Speech Therapy Discharge Summary, dated [redacted] included, "Pt [patient] was educated on importance of increasing efficiency of swallow (initiation) to minimize [redacted]," and discharge	F 835		

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recommendations for [redacted] NJAC 8:43E

During an interview with the surveyor on 08/04/22 at 9:00 AM, LPN #2 stated that she was the regular nurse for Resident #7. She further stated that during meals, the Certified Nursing Assistants (CNA) pass out and set up the meal trays for residents. LPN #2 explained that the meal trays were sent from the kitchen with thin liquids and for Resident #7, the nurse must thicken the liquids on his/her tray outside of the room otherwise the resident will get upset. The LPN then verified that when she entered Resident #7's room, she had to thicken the liquids on the resident's breakfast tray and stated that the CNA should have called the nurse to thicken the liquids on the tray prior to giving the resident his/her breakfast. LPN #2 further stated that it was important to thicken Resident #7's liquids because the resident was on aspiration precautions.

During an interview with the surveyor on 08/04/22 at 9:59 AM, the Director of Nutritional Services (DNS) stated that the kitchen staff are responsible for providing a thickening packet for each beverage on the meal tray and then the nursing staff are responsible for thickening the liquids when the tray arrives to the nursing unit.

During an interview with the surveyor on 08/04/22 at 10:19 AM, CNA #1 stated that CNAs are responsible for passing out the meal trays, checking the meal tickets for accuracy, and thickening liquids on the meal tray. CNA #1 also stated that CNAs know if the resident requires thickened liquids because it is written on the meal ticket and the meal tray comes with thickening packets. The CNA further stated that it is

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important to thicken liquids if the resident has swallowing issues.

During an interview with the surveyor on 08/04/22 at 10:23 AM, CNA #2 stated that CNAs are responsible for passing out the meal trays, checking the meal tickets for accuracy, and thickening liquids on the meal tray. CNA #2 also stated that CNAs know if the resident requires thickened liquids because it is written on the meal ticket and the meal tray comes with thickening packets from the kitchen. The CNA further stated it is important to thicken liquids to prevent the resident from aspirating.

During an interview with the surveyor on 08/04/22 at 10:31 AM, LPN #1 stated that any facility staff can pass out the meal trays, but that nurses are responsible for thickening the liquids on the meal tray. LPN #1 further stated that Resident #7 should have received NTL to prevent the risk for aspiration.

During an interview with the surveyor on 08/04/22 at 10:36 AM, Registered Nurse/Unit Manager (RN/UM) #1 stated that CNAs or nurses can pass out meal trays and check the meal tickets for accuracy, but that the nurse is responsible for thickening the liquids on the meal tray. RN/UM #1 further stated that the nurse should have thickened the liquids on the meal tray prior to giving Resident #7 his/her breakfast due to the risk of aspiration.

During an interview with the surveyor on 08/04/22 at 2:40 PM, Speech Therapist (ST) #1 stated that when the ST makes a recommendation for an altered diet, the ST will handwrite the order on the Physician Order Sheet and the nurse is

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responsible for transcribing the order. The ST also stated giving thin liquids to Resident #7, who is ordered NTL, would be contraindicated and "not safe."

2.) According to the Admission Record, Resident #99 was admitted with diagnoses that included, but were not limited to, NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted]

Review of the Admission MDS, dated NJAC 8:43E-2.1 and E reflected that Resident #99 was NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] required extensive NJSA 47:1A- [redacted]

Review of the Care Plan (CP), initiated NJAC 8:43E-2.1 and E included a focus of, "nutritional problem or potential nutritional problem r/t [related to] need for therapeutic diet, mechanically altered diet, thickened liquids, with history of DM and Alzheimer's. The CP included an intervention, dated NJAC 8:43E-2.1 and [redacted], to, "provide, serve diet as ordered: NAS [no added salt], CCD [carbohydrate-controlled diet], ground texture, NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted]"

Review of the SLP Evaluation & Plan of Treatment (Speech therapy (ST) evaluation), dated NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] included a diagnosis of NJAC 8:43E-2.1 and [redacted]ia and indicated the reason for referral was NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. NJAC 8:43E-2.1 and Exec Order [redacted]function, decreased functional activity tolerance, coughing/choking during oral intake and increased need for assistance from others. The ST evaluation included recommendations for close supervision for oral

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intake, mechanical soft/ground textures, and NTL.

Review of the POF, dated [NJAC 8 43E-2.1 and], included an order, dated [NJAC 8 43E-2.1 and E] for ST evaluation and treatment for [NJAC 8 43E-2.1 and Exe] downgrade diet to ground texture [NJAC 8 43E], feeding assistance with all meals, and aspiration precautions.

Review of the Diet Requisition Form, dated [NJAC 8 43E-2.1 and Exec Order 26, 4. b. 1.], included the resident's diet was changed to [NJSA 47:1A-1 reasonable privacy expectation] and [NJAC 8 43].

On 08/04/22 at 12:30 PM, Surveyor #2 observed the lunch meal service on Court 1. Surveyor #2 observed a staff member enter Resident #99's room with a meal tray. The staff member set up the resident's lunch meal tray on the overbed table, exited the room and walked down the hallway. Surveyor #2 then entered Resident #99's room and observed the resident in bed with the head of bed elevated eating his/her meal. Surveyor #2 observed the resident as he/she took a spoon of the food and drank from a disposable white cup. Resident #99 then placed the cup alongside the plate after drinking from it for a third time. At which time, Surveyor #2 observed that Resident #99's disposable white cup contained clear thin liquid. Surveyor #2 further observed an unopened packet of instant thickened coffee and an unopened packet of instant food thickener on the resident's tray.

Review of Resident #99's Lunch Meal Ticket (meal ticket), dated [NJAC 8 43E-2.1 and], revealed documented and highlighted in yellow, "[NJAC 8 43E-2.1 NJAC 8 43E-2.1 and Exec Order 26, 4. b], [NJAC 8 43E-2.1 and Exec Order 26, 4. b NJAC 8 43E-2.1 and Exec Order 26, 4.] Skim Milk, Apple Juice, and [NJAC 8 43E-2.1

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F 835	Continued From page 149 Thickened Coffee." On 08/04/22 at 12:33 PM, CNA #6 entered Resident #99's room and stated she was there to assist the resident with the lunch meal tray. CNA #6 immediately grabbed the instant thickened coffee packet from the resident's tray and thickened the water in the disposable white cup. When interviewed, CNA #6 stated the thin liquid in the disposable cup was water for the resident's instant coffee. CNA # 6 further stated Resident #99 required [redacted] and that the thin liquids in the disposable white cup should have been thickened with the instant thickened coffee prior to giving it to the resident. CNA #6 added that Resident #99 should not have been given thin liquids. 08/04/22 at 12:41 PM, Surveyor #2 interviewed the staff member who set up Resident #99's lunch meal tray. The staff member identified herself as the Admissions Director (AD) and stated she regularly passed trays on the units. The AD stated she looks at the resident's meal ticket and compare it to the tray for accuracy. The AD added that you would open the thickening packets and mix it with the appropriate liquids. The AD further stated the liquid consistency was documented on the meal ticket and that the person setting up the meal tray was responsible for making sure the that the resident was receiving the correct consistency. The AD stated she would remove the tray if she was unsure of the consistency and would follow up the nursing staff. When question about her setting up Resident #99's lunch meal tray, the AD stated she was not familiar with the resident and that she exited the room to get the CNA. The AD did not provide an explanation why she did not thicken the resident's coffee or remove the resident's tray	F 835		

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before leaving the room.

During an interview with Surveyor #1 and #2 on 08/04/22 at 3:41 PM, the ADON stated that CNAs and nurses were responsible for passing out the meal trays, but that the nurse were responsible for checking the meal ticket for accuracy and ensuring the correct thickening packets are on the meal tray. The ADON further stated that staff should not provide a meal tray with thin liquids to a resident who is on an altered liquid consistency diet due to the risk of aspiration.

During an interview with Surveyor #2 on 08/05/22 at 8:58 AM, the ADON stated the AD was recently hired and completed the New Employee Orientation education. The ADON added that passing trays was not part of the education packet and that the AD should not have been passing trays on the units.

Review of the facility's Thickened Liquids policy, with reviewed date of 05/2022, included, "Facilities will serve thickened liquids to residents as ordered by the physician," and, "For beverages which must be thickened, such as coffee, tea, cocoa and soup, the beverage will be thickened by the Dietary staff prior to leaving the kitchen."

Review of the facility's Therapeutic Diet Orders policy, with reviewed date of 05/2022, included, "Therapeutic diets will be provided to residents in the appropriate form and/or the appropriate nutritive content as prescribed by the physician and/or assessed by the interdisciplinary team to support the treatment and plan of care."

Review of the facility's Meal Services policy,with

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reviewed date of 05/2022, included, "A record of all residents' diet order and a list of those residents on thickened liquids or fluid restrictions will be kept in each unit in a manner that ensures privacy."

NJAC 8:39-17.4(a)(2)

Refer F689K

An Immediate Jeopardy (IJ) was identified for F689 during the recertification survey conducted on 08/25/22.

On 08/05/22, the LNHA failed to provide a safe physical environment to prevent the likelihood of serious injury, harm or death by failing to ensure a janitor closet, which contained hazardous chemicals for use by the housekeeping department, was securely closed and latched on 1 of 4 units, the [redacted] unit, which is a secured behavior unit that included cognitively impaired residents, placing all residents at risk for ingestion of chemicals or death. The census on the unit was [redacted] with [redacted] residents independently ambulatory and [redacted] residents who were able to self-propel the wheelchair. No residents were in the immediate area of the janitor closet at the time it was not securely closed and latched. This deficient practice was evidenced by the following:

This resulted in an IJ situation that was identified on 08/05/22 when the facility failed to securely safeguard hazardous chemicals, from vulnerable and independently mobile residents by ensuring the janitor door was flush with the door casing and allowing the door to securely close and latch. The facility's Licensed Nursing Home

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Administrator (LNHA) and the Assistant Director of Nursing (ADON) were notified of the IJ on 08/05/22 at 3:13 PM. A Removal Plan was received on 08/5/22 and the survey team verified the implementation of the Removal Plan on 08/05/22. On 08/05/22 at 4:24 PM, two surveyors confirmed/verified, in the presence of the Licensed Practical Nurse Unit Manager, the janitor door self closes and locks.

This was cited at a level K as the deficient practice was cited at the last standard survey of 11/01/21.

On 08/05/22 at 10:08 AM, the surveyor observed the janitor closet on the [NJAC 8 43E-2.1 a] unit to be ajar. The surveyor went into the closet and the door was observed to have an automatic closure mechanism. The door, when let to close by itself, struck the door jam on the latch side of the door, and would not securely close and latch. There was a keypad lock that would require a code to open the door if the door were securely closed and latched. At that time, the surveyor observed inside the closet were six bottles of hand wash liquid, one bottle of hydrogen peroxide, one opened bottle of deodorizer, four uncapped bottles of floor chemicals and one white bottle unlabeled on the floor. There was a wall mounted chemical dispensing machine with chemicals contained in separate door type compartments. There was an activity staff in the [NJAC 8 43E-2.1 and b] [NJAC 8 43E-2.1 and] area but was facing away from the closet door. There was a housekeeper (HK #1), in a resident room (room [NJAC 8 43E] adjacent to the closet. At 10:15 AM, HK #1 was in the room next to the closet, and when she came out of the room, the surveyor requested her to come to the janitor closet door and asked if the door was

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supposed to be open. HK #1 said, No, the door was not supposed to be open. She went on to say, I wasn't the last one to be out the door. The surveyor requested HK #1 get her supervisor.

During an interview with the surveyor on 08/05/22 at 10:17 AM, the Floor Tech Supervisor (FTS) came to the janitor closet and, in the presence of the surveyor, confirmed the door was not securely closed and latched and it should not be open. When asked how long it has been that the door did not shut correctly, the FTS said he doesn't know how long the door has not shut correctly. The FTS identified the unlabeled white bottle on the floor to be bleach, and confirmed the above identified bottles observed to be chemicals used by the housekeeping staff. The FTS said that if the door was not locked or shut tightly, residents would have access to the chemicals. The FTS said, he told maintenance about the problem with the door a while ago but did not fill out a maintenance request form, it was verbal. He confirmed the door has auto closure on it; but at this time, the door won't shut on its own without the door being pushed closed. He said staff should be pushing on the door to make sure it closes. The FTS said, this was never addressed and everyone knows about the door not closing correctly. The surveyor reviewed the unit maintenance logbook for the past 4 months and there was no documentation to indicate maintenance was notified of the janitor door not closing.

During an interview with the surveyor on 08/05/22 at 10:27 AM, the maintenance staff said he has worked at the facility for six months. He said the process for staff to report necessary repairs was to use the logbook or use a new phone app

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(application) in place for the past three weeks and requests can be submitted via the phone

During an interview with the surveyor on 08/05/22 at 10:27 AM, the maintenance staff on duty said he had been at facility for six months. He said the process for staff to report necessary repairs was to use the log book (on the units) or to use the new phone app (application) started in the past three weeks and requests can be submitted via the phone.

During a follow up interview on 08/05/22 at 1:05 PM, the maintenance staff said he just became aware today that the janitor closet door on the [redacted] wasn't closing properly. He said we worked on it a few months ago and never got a new door that his prior supervisor requested.

During an interview, in the presence of the survey team, on 08/05/22 at 03:09 PM, the LNHA said the janitor door should be kept closed and locked to prevent anyone from accessing anything inside.

During an interview, in the presence of the survey team, on 08/17/22 at 9:34 AM, the Director of Environmental Services (DEVS) said her expectations are the janitor closets are to be kept clean with daily checks for cleanliness and being put together in proper way, and they should be locked.

A review of a facility policy titled Janitors Closet with a creation date of 9-12-14 and last date revised of 8/5/22, included under the procedure section 7. Ensure that the door closes properly and is kept locked when unsupervised. Any maintenance issue with the door should be

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F 835	Continued From page 155 addressed with maintenance or supervisor and the door monitored until the door can be repaired. NJAC 8:39-31.2(e)	F 835		
F 880 SS=E	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	F 880		10/22/22

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F 880	Continued From page 156 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §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, record review, and review of other pertinent documents, it was determined that the facility failed to ensure staff wore appropriate Personal Protective Equipment (PPE) upon entering a resident's room who were	F 880	1. Resident #263 had no negative outcome as a result of the deficient practice. Activities aide #1 received re-education on facility PPE policy. 2. All residents on isolation have the	

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F 880	Continued From page 157 on Covid-19 Person Under Investigation (PUI) Precautions for one resident. This was cited at a level E as the deficient practice was cited at the last standard survey of 11/01/21. This deficient practice was observed for 1 of 2 Residents (Resident # 363) reviewed for Transmission Based Precautions and was evidenced by the following: During an interview with the survey team on 08/02/22 at 8:45 AM, the Assistant Director of Nursing (ADON) stated that Person Under Investigation (PUI) rooms required staff to wear full PPE which included N95 mask, gown, gloves, and eye protection. The PUI rooms would have signage indicating the isolation and a bin that contained PPE outside the resident's room. At that time, PUI rooms included residents that were newly admitted to the facility and were not vaccinated (or not up to date) for COVID 19. During the initial tour of the Court 2 Unit on 08/02/22 at 10:30 AM, the surveyor observed signage for droplet precautions and to "Stop and check with nurse before entering" attached to the wall outside Resident # 363's door. The surveyor observed a 3-tier bin that contained Personal Protective Equipment (PPE) located outside the resident's room. At that time the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM#1) who stated that Resident #363 was a new admission from the hospital who refused the Covid vaccinations and would be on Persons Under Investigation (PUI/Droplet) precautions for 7 days.	F 880	potential to be affected by this deficient practice. 3. Rounds were done immediately to ensure all other staff were wearing proper PPE. Facility staff re-educated on proper use of PPE when entering isolation rooms. 4. Infection Preventionist or Designee will complete rounds 2x weekly for 4 weeks to ensure all staff entering isolation rooms are using proper PPE, and weekly thereafter for 90 days. The results of these audits will be reported to the QAPI committee monthly for 3 months.	

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On 08/02/22 at 10:40 AM, the surveyor observed an Activities Aide (AA #1) enter Resident #363's room wearing only a surgical mask and not a N-95 mask, gown, gloves or eye protection as required. The surveyor observed AA #1 talking with Resident #363 and attaching an activity calendar to the resident's wall. AA #1 then exited Resident#363 room into the hallway. At that time the surveyor interviewed AA #1 who stated that the isolation signage outside the resident's rooms meant that the staff would need to ask the nurse before entering the resident's room. When asked if a resident was on isolation what would the staff do and AA #1 stated, " They need to ask the nurse". When asked if there was any other PPE she was to wear besides the surgical mask upon entering Resident # 363's room, AA #3 stated " No" and that "No one told me"

During an interview with the surveyor on 08/02/22 at 10:57 AM, the RN/UM #1 stated that Resident # 363 was on PUI precautions which meant the staff needed to wear a gown, gloves, N-95 mask and goggles before entering the room. RN/UM #1 further stated that staff needed to wear the proper PPE anytime entering the isolation room because Resident #363 was on PUI/Droplet precautions because he/she was new admission who was not vaccinated for Covid 19. RN/UM#1 stated that it was important to wear the proper PPE when entering a PUI/Droplet room so you don't transmit Covid or other droplets from patient to patient. RN/UM#1 confirmed that AA #1 should have worn the proper PPE when entering a PUI/ Droplet precaution room.

During an interview with the surveyor on 08/09/22 12:30 PM, the ADON and the Regional/Acting Infection Preventionist(R/AIP) stated that the

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required PPE for PUI rooms included a gown, N-95 mask, gloves and goggles or face shield. The staff should know that someone was on droplet precautions because of the signs outside the door indicating droplet precautions and to stop and ask the nurse before entering the room. There would also be a bin that contained PPE outside the door of the PUI room. The ADON stated that it was her expectation that the staff would wear the appropriate PPE prior to entering a PUI room. The ADON further stated that it was important to wear the proper PPE in a PUI room to prevent the possible spread of infection to other residents and to also protect themselves.

A review of the facility's policy titled" Outbreak Plan" with reviewed date of 05/2022, revealed under Cohorting for COVID-19 that new or readmitted asymptomatic residents who are not up to date with all recommended COVID 19 vaccine doses and have a viral test negative for SARS-COV-2 upon admission or readmission should be placed on quarantine and care for using full PPE (gowns, gloves, eye protection that covers the front and sides of face, and NIOSH-approved N95 or equivalent or higher-level respirator) even if they have a negative test upon admission.

A review of the facility's policy titled" Infection Prevention and Intervention Plan- Coronavirus (COVID-19)", with reviewed date of 05/2022, revealed under the PPE section that the PPE recommended when caring for a resident with known or suspected COVID-19 includes gowns, N-95, eye protection and gloves.

NJAC 8:39-19.4(a)

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F 881	Continued From page 160	F 881		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interviews and review of facility documents, it was determined that the facility failed to conduct ongoing review for their Antibiotic Stewardship Program. This deficient practice was evidenced by the following: During an interview with the surveyor on 08/08/22 at 1:08 PM, the Regional/Acting Infection Preventionist (R/AIP) said her role was just to help the Assistant Director of Nursing(ADON) at this facility since the ADON was by herself. Her first time at this facility was on Tuesday 08/02/22. That was the only time she was here prior to today. She stated we didn't discuss how often she's supposed to come in as she was still learning about the building. On 08/09/22 at 9:42 AM, the surveyor requested from the nurse consultant (NC) the policy and procedure for the facility antibiotic stewardship program (ASP) and to speak with the person who was responsible for the ASP. She stated that she did not know who was responsible for it but would	F 881	1.There was no negative outcome related to antibiotic stewardship program. 2.All residents will benefit from initiation and follow-up of antibiotic stewardship program. 3.Infection preventionist will ensure the initiation documentation and follow up of the antibiotic stewardship program in conjunction with the medical director as per regulation. 4.Infection preventionist will ensure monthly antibiotic stewardship meetings and minutes are presented to the QAPI program monthly for the next 90 days.	10/22/22

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find out for the surveyor.

During an interview with the survey team on 08/09/22 at 12:02 PM, the R/AIP stated she was not responsible for the ASP for the facility.

On 08/09/22 at 12:23 PM, the surveyor again requested the policy and procedure and to speak with the person who was responsible for the ASP from the Licensed Nursing Home Administrator (LNHA). He stated the R/AIP was responsible for the ASP. The surveyor told the LNHA that the R/AIP stated she was not responsible for the ASP. The surveyor again asked for the ASP information.

On 08/09/22 at 12:29 PM, the ASP binder was brought to the surveyor for review. At 12:54 PM, the surveyor asked the LNHA who was going to review the APS process with the surveyor, and he stated he would check and get back to the surveyor. At 1:18 PM, the LNHA stated that corporate personnel were doing the APS and he would find out who could review it with the surveyor.

During an interview with the surveyor on 08/10/22 at 10:30 AM, the Vice President of Clinical Services (VCS) stated that they have been unable to find anything on the ASP since the current company took over the facility in April. She stated that the Infection Preventionist resigned when the new company took over and may have taken the records with them. The VCS stated a new Infectious Disease doctor and pharmacy consultant was hired. She further stated that her team requested reports for antibiotics from the pharmacy from the beginning of the year and they were in the process of

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reviewing them. She confirmed that the information in the ASP binder that was given to the surveyor was obtained from the pharmacy and had been put together by her team when the current company took over. The VCS stated that there had not been a Quality Assurance and Performance Improvement Plan (QAPI), (a written plan containing the process that will guide the nursing home's efforts in assuring care and services are maintained at acceptable levels of performance and continually improved.) She also stated that the ASP was important to avoid overuse of antibiotics in the elderly because it could be detrimental to them, to monitor side effects, and for quality of life.

The Director of Nursing was not on site during the survey nor available for interview during the survey.

During a meeting with the survey team on 08/11/22 at 01:52 PM, the above concerns were presented to the LNHA and the Assistant Director of Nursing (ADON.) The LNHA stated he was aware that the ASP reviews were not being done. He stated that the Infection Preventionist (IP) would be responsible for the ASP to prevent unnecessary antibiotic use. The ADON stated the importance of the ASP was to monitor that the antibiotics were prescribed as necessary, to treat actual infections, make sure residents were getting the total dose, was followed by an Infectious Disease doctor and that education was done.

A review of the facility's policy, "Antibiotic Stewardship Program" dated 8/20/21, revealed under the Policy section: The Antibiotic Stewardship Program (ASP) at the [facility

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F 881	Continued From page 163 name]is part of the facility-wide Infection Prevention and Control Program. It is designed to promote the appropriate use of antibiotics and includes monitoring to 1) promote prudent use and management of antibiotics 2) reduce the development of antibiotic resistant organisms and 3) improve resident outcomes. Procedure:1) ASP leadership will consist of the LNHA, Medical Director, Director of Nursing, IP, pharmacy consultant, lab representative and Infectious Disease Specialist. 3) The Infection Preventionist (IP) is responsible for facility-wide antibiotic surveillance to identify, investigate, monitor, and report on infections ...Lab culture and sensitivity reports will be reviewed to determine whether the prescribing practitioner has been made aware. Antibiotic orders will tracker for indication or need of adjustment, dose, and duration of the drug. 7) IP Surveillance reports, pharmacy and laboratory reports will be reviewed at quarterly HOGs Quality Assurance Committee meetings. Reports will summarize trends of antibiotic use and resistance data. NJAC 8:39-19.4 (d)	F 881		
F 882 SS=E	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field;	F 882		10/22/22

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F 882	Continued From page 164 §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. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to hire a designated Infection Preventionist (IP) who worked at least part-time and had completed specialized training in infection control and prevention. The deficient practice was evidenced by the following: On 08/02/22 at 10:30 AM, an entrance conference was conducted with the License Nursing Home Administrator (LNHA), Vice President of Clinical (VCS) and Vice President of Clinical of Compliance (VC). The LNHA stated the Director of Nursing (DON) was currently away for two months and the Assistant Director of Nursing (ADON) was covering for the DON during her absence. The LNHA further stated the DON was also the Infection Preventionist (IP). The LNHA	F 882	1.The facility hired an Infection Preventionist during survey and the IP started on August 22. 2.No residents were negatively affected by this deficient practice. 3.All residents have the potential to be affected by this deficient practice. The facility has hired an IP. 4.Administration will monitor the IP for 90 days as per facility process for new hires.	

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stated that the ADON was responsible for tracking the vaccinations for employees in the facility in the absence of the DON.

On 08/03/22 at 10:25 AM, The LNHA and VCS stated they used an Infectious Disease (ID) physician, who came onsite and provided guidance for the facility. They further stated a Regional/Acting Infection Preventionist (R/AIP) was present daily and covered for the DON as the IP.

On 08/08/22 at 1:08 PM, the surveyor interviewed the R/AIP, who identified herself as an Assistant Director of Nursing (ADON) for another facility. She stated that her role at this facility was to assist the ADON "since she was by herself." The R/AIP stated her first day was on Tuesday, 08/02/22, and today (08/08/22) was her second day. She further stated the LNHA and the VCS didn't discuss with her how often she was supposed to come to this facility but revealed that she didn't come daily and wasn't sure the next time she was scheduled to come back. When the surveyor questioned her about her role as IP, she stated she hasn't had any formal infection control training except for the Centers for Disease Control and Prevention (CDC) training. She stated that she had not fulfilled any of the other requirements for the role of Infection Preventionist. The R/AIP stated that she did not have any responsibility with tracking staff vaccination in the facility.

On 08/08/22 at 1:16 PM, the ADON stated the facility had a full-time IP until about April of 2022. She further stated the facility was in the process of hiring an IP but so far, the facility had no success. The ADON stated that the DON had

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been in the role as the IP and took the CDC training. The ADON stated the DON was responsible for tracking the COVID-19 (a contagious respiratory infection) vaccination status but was currently away and that she took responsibility for tracking the vaccination status of the new hires. The ADON stated she was not certified in infection control and did not follow up with the employee vaccination status. This included staff that were due for their boosters or if an exemption letter for vaccination was needed for staff.

On 08/08/22 at 2:36 PM, the LNHA stated that the previous IP left in May of 2022 when the new company took over the facility. He further stated that they had an Infectious Disease (ID) physician but did not have any individuals that were Certified in Infection Control (CIC). The LNHA stated they are actively searching for an IP and the job was posted. He added that they had two potentials IPs, but they did not accept the position.

On 08/08/22 at 2:56 PM, the LNHA stated that since May of 2022, the DON had taken on the role as the IP. In addition, he stated that in the DON's absence, he along with the Staffing Coordinator (SC), and ADON assisted with tracking the vaccination status of employees. The LNHA stated he actively worked with the SC, the ADON and the DON to make sure they followed up with the employee's vaccination status. He confirmed that the facility did not have a CIC but had an ID physician that came in as needed and was always available by telephone. The LNHA further stated the R/AIP came in as needed but was always available when they reached out to her.

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On 08/08/22 at 3:13 PM, the surveyor interviewed the SC who stated she assisted with tracking the COVID-19 vaccination status of staff since May of 2022 after the IP left.

On 08/09/22 at 11:57 AM, the LNHA stated the SC did the COVID-19 testing for all the staff which included agency staff and contracted staff.

On 08/09/22 at 12:22 PM, the surveyor interviewed the ADON and the R/AIP. The R/AIP stated that today (08/09/22) was her third time at the facility. When the surveyors inquired as to what type of infection control duties she was responsible for, she stated that she assisted the facility with making rounds by herself to make sure everything was in place. She stated that she checked the refrigerators and made sure items were dated and she checked to make sure that staff were wearing their masks appropriately. When asked if she made rounds on all the units, the R/AIP replied that she didn't have chance to check all the units yet. The surveyor asked the ADON if the DON could perform her duties as a DON/IP. The ADON then stated she was unaware if the DON had additional infection control training and could not answer for the DON regarding her ability to perform the dual roles of DON and IP and that "she would be the only one that could answer for herself."

On 08/09/22 at 3:13 PM, the surveyor interviewed the SC who stated she performed COVID-19 rapid test during the 7:00 AM to 3:00 PM shift. She further stated the supervisors for the 3:00 PM to 11:00 PM shift and 11:00 PM to 7:00 AM shift conducted the COVID-19 rapid test for the employees on their shifts.

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F 882	Continued From page 168 On 08/10/22 at 12:38 PM, the SC stated she had no infection control training besides in-services and was never told to take any additional training courses. The surveyor showed the SC a document that was provided from the LNHA which reflected an in-service conducted by the SC dated 08/09/22 with a topic titled: "All employees that are not fully boosted or have [an] exemption have to wear an N95 at all times." The SC stated the LNHA told her to "go around and get signatures" of the staff that were supposed to wear the N-95 mask because they had an exemption not to receive the COVID-19 vaccination or were not fully vaccinated for COVID-19. The SC stated that when she obtained the signatures, she informed the staff that they were required to always wear their N95 mask until they became fully vaccinated to prevent the potential spread of COVID-19. On 08/10/22 at 1:24 PM, the R/AIP in the presence of the survey team, acknowledged that she was not a full-time employee for this facility and was only here to assist as needed. She reiterated that she was still the ADON for her facility. A review of the IP job description reflected it was associated with the ADON/Staff educator/IP which revealed the following: - Monitor and keep records of all staff COVID testing and results. - In collaboration with the Director of Nursing and other supervisory personnel, in-services staff on new infection control policies and procedures, plans educational programs on infection control techniques for all disciplines.	F 882		

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A review of the DON job description reflected the following:
-Assume responsibility for nursing service compliance with federal, state and local regulations.
-Observe infection control procedures.

A review of the CDC infection control training dated 02/03/20, indicated the DON had successfully completed the 19.3 hours Nursing Home Infection Preventionist Training Course.

A review of the CDC infection control training dated 02/07/21, indicated the R/AIP had successfully completed the 19.3 hours Nursing Home Infection Preventionist Training Course.

Review of the Certificate of Training CDC Train, dated 02/18/22, indicated that the ADON/IP had successfully completed Module 1 - Infection Prevention & Control Program from the Nursing Home Infection Preventionist Training Course.

Review of the Certificate of Training CDC Train, dated 02/18/22, indicated the R/AIP had successfully completed Module 4 - Infection Surveillance.

Review of the Certificate of Training CDC Train, dated 02/18/22, indicated the R/AIP had successfully completed Module 5 - Outbreaks.

Review of the Certificate of Training CDC Train, dated 02/18/22, indicated the R/AIP had successfully completed Module 6A - Principles of Standard Precautions.

Review of the Certificate of Training CDC Train,

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F 882	Continued From page 170 dated 02/18/22, indicated the R/AIP had successfully completed Module 6B - Principles of Transmission-Based Precautions. Review of the SC's Antigen Test Competency dated 04/12/22 which reflected the SC "had assisted [the] IP in the past." Review of the facility's Outbreak Response Plan reviewed and revised on 05/2022 did not indicate the required background, education, or training required for the designated Infection Preventionist working at the facility. Review of the CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes updated 02/02/22 reflected the following: Infection Prevention and Control Program- assign one or more individuals with training in Infection Prevention and Control [IPC] to provide on-site management of the IPC Program. This should be a full-time role for at least one person in facilities that have more than 100 residents or that provide on-site ventilator or hemodialysis services.	F 882		
F 883 SS=D	NJAC 8:39-19.1(b) Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and	F 883		10/22/22

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F 883	Continued From page 171 potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 883		

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F 883	Continued From page 172 was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to obtain written consent for the administration of an [redacted] for 1 of 5 residents (Resident #63) reviewed for immunizations. This deficient practice was evidenced by the following: According to the Admission Record, Resident #63 was admitted to the facility with diagnoses that included, but were not limited to [redacted] Review of the Annual Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care, dated [redacted], included the resident had a Brief Interview for Mental Status score of [redacted] which indicated the resident's [redacted]. Further review of the MDS revealed the resident received the flu vaccine at the facility on [redacted] Review of the Care Plan, dated [redacted] included a focus of [redacted] function or impaired thought processes r/t [related to] [redacted]." Review of the Physician Orders Sheet, dated	F 883	1. Resident #63 had no ill effects due to the consent for the flu vaccine not being obtained last influenza season. The responsible party for resident #63 will be contacted for consent prior to this season's influenza vaccine administration. 2. All residents had the potential to be affected by the deficient practice of missing immunization consents. An audit will be conducted to ensure that all residents have consents in their medical record for all administered vaccinations. 3. The Resident Influenza policy was reviewed. Nurses, Unit Managers, and Supervisors were reeducated on the need to have a signed consent from either the resident or responsible party prior to administering any immunization. 4. The Infection Preventionist or designee will audit the medical record of 5 residents per week for 90 days to ensure all administered vaccinations have signed consent forms. The results of these audits will be reported to the QAPI committee monthly for 3 months.	

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F 883	Continued From page 173 [redacted], included an order, dated [redacted] for "Annual influenza vaccination administer as directed." Review of the November 2021 Medication Administration Record (MAR) included the resident received the "Annual Influenza Vaccination" on [redacted] on the 3:00 PM - 11:00 PM shift. Review of the Electronic Health Record (EHR) and paper chart revealed there was no written consent for the flu vaccine administered on [redacted] Review of the Progress Notes, dated [redacted] through [redacted] did not include any mention of the resident's flu vaccine or that written consent for the vaccine was obtained by the resident's responsible party. During an interview with the surveyor on 08/11/22 at 11:51 AM, Registered Nurse/Unit Manager (RN/UM) #1 stated that residents are offered the flu vaccine during flu season and consent was obtained from the resident or their family. RN/UM #1 further stated that after the consent form was signed, it was kept in the resident's paper chart. The RN/UM then stated that it was important to obtain consent prior to the administration of a vaccine because the resident/responsible party is "in charge of the resident's care and entitled to consent to the care being provided." At that time, RN/UM #1, in the presence of the surveyor, reviewed Resident #63's paper chart, but was unable to locate the flu vaccine consent for 2021.	F 883		

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F 883	Continued From page 174 During a follow-up interview with the surveyor on 08/12/22 at 9:00 AM, RN/UM #1 stated he found a flu vaccine consent in the resident's thinned medical record. The flu consent was dated [redacted] and did not indicate that it provided consent to administer the flu vaccine annually. During an interview with the surveyor on 08/12/22 at 12:34 PM, the Assistant Director of Nursing (ADON) stated the flu vaccine is offered to residents during the flu season and consent was obtained from the resident or the resident's responsible party. The ADON further stated that the vaccine consents are in paper form and are kept in the resident's paper chart. The ADON then stated that it was important to obtain consent for vaccines because "residents have the choice to get the vaccine or not." When asked about Resident #63's flu vaccine consent, the ADON stated the staff should have obtained consent from the resident's responsible party prior to administering the flu vaccine and documented the consent in the resident's progress notes. Review of the facility's Resident Influenza Immunization policy, reviewed 05/2022, included, "A signed or witnessed telephone informed consent must be obtained from resident or the responsible party if the resident is unable to make decision." NJAC 8:39-19.4(h)	F 883		
F 888 SS=E	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and	F 888		10/22/22

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procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.

§483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in

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paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;
(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;
(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;
(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed

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and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and
(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

Effective 60 Days After Publication:
§483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and

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F 888	Continued From page 178 considerations; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation it was determined that the facility failed to ensure a.) there was a consistent process for tracking and securing accurate documentation for the vaccination status of facility staff and contracted staff for Covid-19, a contagious respiratory infection b.) that mitigation strategies were in place and followed to prevent the potential spread of Covid-19 for staff that were not fully vaccinated or had exemptions for the Covid-19 vaccination. This deficient practice was identified for 6 of 6 not fully vaccinated staff and 15 of 15 exempted staff, and was evidenced by the following: 1.) On 08/08/22 at 1:08 PM, Surveyor #1 interviewed the Regional/Acting Infection Preventionist (R/AIP) who identified herself as an Assistant Director of Nursing (ADON) for another facility. She stated that her role at this facility was to assist the ADON since she was by herself. When the surveyor questioned her about her role as the Infection Preventionist (IP), she stated she hasn't had any formal infection control training except for Centers for Disease Control and Prevention (CDC) training. She further stated that she did not have any responsibility with tracking the staff COVID-19 (a contagious respiratory infection) vaccination status in the facility. On 08/08/22 at 1:16 PM, the ADON stated the Director of Nursing (DON) was responsible for tracking the COVID-19 vaccination status but was currently away and that she was responsible for tracking the vaccination status of only the new	F 888	1.No residents were affected by the deficient practice. Facility immediately initiated contact with vendors/contracted staff companies to obtain updated vaccination information. Housekeeper # 3 no longer employed at this facility Registered Dietician received booster on 8/10/22 CNA #18 provided her religious exemption form on 9/16/22. CNA # 18 returned to work on 9/21/22 and is required to wear a N95 mask at all times and is tested 2x week. CNA #17 has not returned to work. Admissions Liaison received booster on 8/19/22 Respiratory Therapist #1 received booster 8/17/22 FACILITY IS CURRENTLY ONGOING VACCINATION WITH BIVALENT BOOSTER TO STAFF AND RESIDENTS(Bivalent Booster received on 9/30/22 by the facility) Any employee without an approved exemption is required to wear an N-95 mask at all times and to receive testing twice a week. 2.All residents have the potential to be affected by the deficient practices. 3.Staff re-educated on the screening kiosk. Facility initiated vaccination and booster tracking log for	

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F 888	Continued From page 179 hires. The ADON stated she was not certified in infection control (IC) and does not follow up with the employee vaccination status which included staff that were due for their boosters or if an exemption letter for vaccination was needed. On 08/08/22 at 02:56 PM, the Licensed Nursing Home Administrator (LNHA) stated that since May of 2022, the DON had taken on the role as the IP. In addition, he stated that in the DON's absence that himself, the Staffing Coordinator (SC), and the ADON assisted with tracking the vaccination status of employees. The LNHA stated he actively worked with the SC, the ADON and the DON to make sure they followed up with the employee's vaccination status. On 08/08/22 at 03:13 PM, Surveyor #1 interviewed the SC who stated she assisted with tracking the COVID-19 vaccination status of staff since May of 2022 after the IP left. She further stated that she had a spreadsheet and followed up with staff that were due for their boosters or if an exemption letter for vaccination was needed. Surveyor #1 inquired about the tracking of the contracted staff vaccination status. The SC stated that she only tracked the agency staff. She stated that she didn't track the contracted staff such as hospice and the lab technicians because there were "too many people coming in." The SC further stated that she was not sure who tracked the other contracted staff but sometimes she would get random vaccination cards and was not sure who they belonged to. A review of the facility's COVID-19 Staff Vaccination Status for Providers reflected there was not a consistent process for tracking and securing accurate documentation for the	F 888	vendors/contracted staff. INSERVICES ONGOING RE: COID VACCINATION STATUS OF BEING UP TO DATE VERSUS BEING NOT UP TO DATE, PPE TO WEAR AND ALL FACILITY POLICY AND PROCEDURES. 4.Human Resources or Designee will complete weekly audit of screening kiosk to ensure that all staff and contracted staff are using the screening kiosk for 90 days. Infection Preventionist will monitor vaccination and booster compliance ongoing. The results of these audits will be reported to the QAPI committee monthly for 3 months.	

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vaccination status of facility staff and contracted staff for Covid-19.

A review of the facility's COVID-19 vaccination tracking revealed six (6) out of 17 employees were past due for their boosters.

- Housekeeper #3 (HK) - booster due 02/28/22.
-Registered Dietitian (RD) - booster due 02/28/22
- Certified Nursing Assistant (CNA) #18 on leave of absence (LOA) - booster due 02/28/22
-CNA #17 on (LOA) - booster due 02/28/22.
-Admissions Liaison (AL) - booster due 02/28/22
-Respiratory Therapist (RT) #1 - booster due 06/20/22.

On 08/09/22 at 10:31 AM, the LNHA stated that there was no formal vaccination tracking of the contracted staff. He stated the contracted staff were required to check in at the designated COVID-19 screening kiosks and if they were not fully vaccinated it would be flagged and a notification would be sent out to the supervisor and that they would follow up with that person to be tested prior to entry into the facility. He further stated between himself, the SC, the DON and the ADON they worked collectively to track the vaccination status of staff.

On 08/09/22 at 12:08 PM, Surveyor #1 interviewed the ADON regarding the monitoring of the designated COVID-19 screening kiosks. The ADON stated staff was able to be monitored at the designated COVID-19 screen kiosks and that the kiosks were connected to one (1) supervisor phone that received all the notifications which was handed off from shift to shift.

On 08/09/22 at 12:15 PM, the ADON stated the

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SC and the DON kept track of the vaccination status of all staff. She further stated that when the previous IP was here all department heads received an email and were aware of the vaccination status in their departments. The ADON stated that they needed to recreate that process as it was stopped back in May of 2022.

On 08/09/22 at 12:54 PM, the LNHA stated for the tracking of staff, all staff were required to check in at the designated COVID-19 screening kiosks. He stated that he received all notifications via email if someone was flagged during check-in.

On 08/09/22 at 03:13 PM, Surveyor #1 interviewed the SC who stated she also had the responsibility of monitoring the COVID-19 screening kiosks. The SC stated the supervisor's phone which she had in her pocket received all notifications from the kiosks via text message. She stated the LNHA also received the notifications. The SC stated that all staff were required to check in prior to their shift at the kiosk. She confirmed that it was only the one (1) phone that she passed between herself and the evening and night supervisors. Surveyor #1 continued to interview the SC regarding the tracking at the facility. The SC stated she was "never told" that she had to send out the tracking spreadsheet to the managers regarding the vaccination status of the employees. The SC stated that the LNHA informed her today (08/09/22) that she was required to send out the notifications to all the department heads.

On 08/09/22 at 4:15 PM, the LNHA confirmed in the presence of the two surveyors (Surveyors #1 and #2) that CNA #5 was not fully vaccinated and

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had an exemption letter and did not check-in at the designated COVID-19 screening kiosk. The LNHA also provided another exemption letter for Speech Therapist #2 (ST) who utilized the designated COVID-19 screening kiosk but was not documented on the COVID-19 Staff Vaccination Status for Providers.

On 08/10/22 at 12:45 PM, the two surveyors (Surveyors #1 and #2) interviewed the Hospice Registered Nurse (HRN) who stated she was screened at the designated COVID-19 screening kiosk. She further stated at her company she had to provide her COVID-19 vaccination status and believed it was faxed to this facility but could not confirm. She concluded most facilities "would not let you in the facility if you were not fully vaccinated".

On 08/10/22 at approximately 2:00 PM, during a phone interview with another surveyor, CNA #15 who was fully vaccinated tested positive for COVID-19 on 08/09/22 stated he failed to utilize the designated COVID-19 screening kiosk prior to his shift that day because he was "in a hurry."

On 08/12/22 at 9:19 AM, the LNHA in the presence of the survey team acknowledged prior to surveyor inquiry there was no formal tracking system in place for the vaccination status of facility staff and contracted staff for Covid-19.

2.) On 08/08/22 at 1:16 PM, Surveyor #1 observed the ADON wearing a surgical mask. Surveyor #1 interviewed the ADON regarding the measures that were in place and followed to prevent the potential spread of Covid-19, for staff that were not fully vaccinated or had exemptions for the Covid-19 vaccination. The ADON revealed

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that she was exempt from receiving the Covid-19 vaccination and based on the COVID-19 Activity Level report for the county they were required to wear a surgical mask for low to moderate activity level and an N-95 mask (filtering facepiece which prevents the transmission of microorganisms) for high county activity level. She stated that since they were considered moderate, she was able to wear the surgical mask. She further stated the LNHA informed her of the moderate levels as he was in contact with their local health department. She concluded that staff were tested twice per week for Covid-19.

On 08/08/22 at 2:36 PM, Surveyor #1 observed that the LNHA was wearing a surgical mask. The LNHA indicated that he on the exemption list and was not fully vaccinated for Covid-19.

On 08/08/22 at 2:56 PM, the LNHA stated he was in contact with the local health department and stated that according to the COVID-19 Activity Level report they were considered high.

On 08/08/22 at 3:39 PM, Surveyor #1 observed the LNHA still wearing a surgical mask. The surveyor followed up with the LNHA regarding measures that were to be followed to prevent the potential spread of Covid-19, for staff that were not fully vaccinated or had exemptions for the Covid-19 vaccination. The LNHA stated if staff provided direct care to a resident, and they were not fully vaccinated and had exemptions they wore an N-95 mask. He further stated if staff did not provide direct care, then they were required to wear a surgical mask. The LNHA emphasized that he "believed" it was the latest guidance from the CDC.

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On 08/09/22 at 8:46 AM, Surveyor #1 observed the ADON wearing a surgical mask.

On 08/09/22 at 10:24 AM, Surveyor #1 interviewed the Registered Dietitian (RD) who was not fully vaccinated and had no exemption letter. The RD stated she went around to residents and perform assessments and evaluations. She stated she was required to wear an N-95 mask because she was not fully vaccinated. The RD stated she was not getting the booster and did not have an exemption letter. She stated the LNHA informed her she needed an exemption letter but could not remember when she was informed. The RD stated the LNHA did not inform her of a specific timeframe that she needed to obtain an exemption letter. The RD concluded she did get tested twice per week by the SC.

On 08/09/22 at 10:31 AM, Surveyor #1 observed the LNHA now wearing an N-95 mask. The LNHA clarified that staff who were not fully vaccinated and had an exemption were required to wear an N-95 mask regardless of if they were considered direct care staff. The LNHA stated there was no timeframe to ensure that staff received their booster or had an exemption letter, but the staff was followed up to ensure they complied. The LNHA stated there were no disciplinary actions taken and reiterated they followed up with the staff. He further stated the SC does "regularly" follow up with the staff to make sure they received their booster or an exemption. The LNHA acknowledged there was nothing in their COVID-19 Staff Vaccination Policy created 01/2021 and last reviewed 05/2022 to address staff who refused their booster and had no exemption.

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On 08/09/22 at 10:01 AM, Surveyor #2 interviewed Licensed Practical Nurse (LPN) #2 for Court 2 Unit who stated that she had two doses of Covid-19 vaccination and was not fully vaccinated. She stated that she was scheduled to get the booster shot tomorrow 08/10/22 at her family physician. She then added that because she was not fully vaccinated, she received the Covid-19 test weekly. She further added that she was not required by the facility to wear any special Personal Protective Equipment (PPE) beside a surgical mask while in the facility or near resident care areas. She then stated she was not told by the facility Administration that she needed to wear a N95 mask or eye protection. The surveyor observed the LPN was wearing a surgical mask. The LPN stated she provided direct patient care to residents while wearing a surgical mask.

On 08/09/22 at 10:06 AM, Surveyor #2 interviewed CNA #2 who worked on the Court 2 Unit. CNA #2 explained to the surveyor that she was exempt from receiving the Covid-19 vaccination due to religious reasons. She stated that she checked in at the front entrance kiosk and answered the Covid-19 exposure questions. CNA #2 stated that she answered "no" to the questions on the kiosk that she was fully vaccinated. The surveyor inquired as what the facility Administration explained to her about the PPE she was required to wear. "I was told I had to wear a N95 due to not being vaccinated however there were N95 mask downstairs today and I asked the receptionist for a N95, and she told me that I didn't have to wear it." CNA #2 then stated that the receptionist stated that they no longer offered employees a N95 mask. The

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surveyor observed that the CNA was currently wearing a surgical mask. The CNA stated that she was tested for Covid-19 weekly and that she provided direct resident care and had an assignment of residents today. She also indicated that she was told by administration that she did not need to wear eye protection.

On 08/09/22 at 10:12 AM, Surveyor #2 interviewed the Registered Nurse Unit Manager (RN/UM) on Court 2 Unit. The surveyor asked the RN/UM how he would know if an employee that worked on his unit was exempt from the Covid-19 vaccination or was not fully vaccinated for Covid-19. "I would know if a staff member was exempt from Covid-19 vaccination or was not fully vaccinated by a list that the nursing scheduler holds in her office." He stated that those employees were supposed to be wearing N95 mask. He added that he didn't think they were supposed to wear any other special PPE like goggles or eye protection but was not sure. He stated that the nursing managers and the IP were supposed to monitor these employees to assure they were wearing the appropriate PPE. The RN/UM explained that when employees come into the front on the building that they were supposed to fill out the kiosk in the front and answer the Covid-19 questionnaire. He added that if the employee answered the questions that they were not fully vaccinated then the manager or supervisor would be notified on their phones and would respond immediately to kiosk. He admitted that he did not know the process after that. He stated that in order to work here you have to wear the appropriate PPE and if you refuse the Covid-19 vaccination you are not allowed to work in the facility. He stated that he was not aware of any employee on the Court 2

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unit that was exempt from vaccination or was not fully vaccinated. He stated that it would be important to know that information so that he could monitor that they were wearing the appropriate PPE. He further added that whoever was monitoring or tracking the vaccination of staff should let all management know what employees were not fully vaccinated or exempt from vaccination so that they were monitored for wearing appropriate PPE to keep the residents safe. He admitted that he was not aware that LPN #1 or CNA #1 were not fully vaccinated and were not wearing N95 mask. He stated that he would obtain the appropriate PPE for them to wear.

On 08/09/22 at 10:56 AM, Surveyor #2 the interviewed the LNHA who stated that there was not a process in place to monitor employees or visitors at the kiosk when they are not vaccinated or exempt from Covid-19 vaccination to assure that they are wearing the correct personal protective equipment (PPE). He further stated that he was going to investigate it. He stated that he could pull up the list of employees and visitors that checked in at the kiosk and would provide to the surveyors.

On 08/09/22 at 12:04 PM, two (2) surveyors (Surveyors #1 and #2) observed the ADON wearing a surgical mask. During an interview with the two surveyors (Surveyors #1 and #2), the ADON stated she needed clarification on if she was required to wear an N-95 mask since she was exempt from receiving the Covid-19 vaccination. The ADON in the presence of the R/AIP and the two surveyors stated the importance of having the appropriate PPE when not fully vaccinated or had an exemption was to

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"protect the residents and yourself" from the potential spread of COVID-19.

On 08/09/22 at 12:07 PM, the R/AIP in the presence of the ADON and two surveyors stated that if staff were not fully vaccinated, they were required to wear an N-95 mask and were tested twice weekly per the regulations. She further stated that if staff were not fully vaccinated or had an exemption at her facility, they could not enter the building.

On 08/09/22 at 1:19 PM, 01:28 PM, and 02:06 PM Surveyor #1 observed the ADON still wearing a surgical mask.

On 08/09/22 at 3:13 PM, during an interview with Surveyors #1 and #2, the SC stated the ADON was responsible for educating staff on what PPE was required to be applied for the staff that was not fully vaccinated and had an exemption for the Covid-19.

On 08/09/22 at 3:17 PM, the two surveyors (Surveyors #1 and #2) observed the ADON still wearing a surgical mask.

On 08/09/22 at 4:11 PM, Surveyor #1 observed the LNHA wearing an N95 mask and the ADON was still wearing a surgical mask.

On 08/10/22 at 9:55 AM, Surveyor #1 observed the ADON now wearing an N95 mask.

On 08/10/22 at 10:10 AM, the ADON stated she was informed that since she had an exemption letter and not fully vaccinated, she was required to wear an N95 mask regardless of if she was in contact with residents.

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On 08/10/22 at 12:38 PM, Surveyor #1 showed the SC a document that was provided from the LNHA which reflected an in-service conducted by the SC dated 08/09/22 with a topic titled: "All employees that are not fully boosted or have [an] exemption have to wear an N95 at all times." The SC stated in the presence of the two surveyors (Surveyors #1 and #2) that the LNHA told her on 8/9/22 to "go around and get signatures" of all staff that were required to wear an N95 mask because they were not fully vaccinated and had an exemption letter. The SC stated that when she obtained the signatures, she informed the staff that they were required to always wear their N95 mask until they became fully vaccinated.

On 08/12/22 at 9:16 AM, the LNHA in the presence of the survey team acknowledged prior to surveyor inquiry the facility did not have an audit system in place to ensure staff utilized the designated COVID-19 screening kiosks prior to their shift.

Review of the facility's Outbreak Response Plan reviewed and revised on 05/2022 .... Facility Access: "Facility shall screen and log all persons entering the facility and all staff at the beginning of the shift."

Review of the facility's COVID-19 Vaccination of Staff created 01/2021 and last reviewed 05/2022 reflected ....."The Infection Control Preventionist (ICP) and HR [Human Resource] will track and securely document ....each staff member's vaccination status ... ...requirements by the facility ... .Requiring staff who have not completed their primary vaccination series to use a NIOSH approved N95 or equivalent or higher-level

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F 888	Continued From page 190 respirator for source control, regardless of whether they are providing direct care to or otherwise interacting with patients." NJAC 8:39-5.1(a)	F 888		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to maintain a resident room's call bell system in safe operating condition. This deficient practice was identified on 1 of 4 nursing units ([redacted]) and was evidenced by the following: On 08/02/22 at 10:47 AM, 08/03/2022 at 10:27 AM, 08/04/22 at 12:10 PM, and 08/05/22 at 10:25 AM, the surveyor observed the resident room on [redacted] belonging to Resident #107 and #109. Resident #107 was not in the room and Resident #109 was sitting in a chair next to his/her bed. The call bell system was not secured to the wall and was hanging with wires exposed. During an interview with the surveyor on 08/05/22 at 10:32 AM, Certified Nursing Assistant (CNA) #20 stated that when resident equipment needs to be repaired, staff call the maintenance department as soon as possible to fix the	F 908	1. Regarding the facility□s failure to maintain a resident room's call bell system in safe operating condition. Maintenance immediately secured the call bell system to the wall in the areas identified. 2. All residents have the potential to be affected by the deficient practice. 3. Maintenance conducted an audit of all call bell boxes on the occupied nursing units to ensure that they were properly affixed to the wall with no wires exposed. Nursing staff re-educated to utilize maintenance log system to report any maintenance related requests. 4. The Maintenance Director of designee will conduct weekly audits of all call bell boxes to ensure that they are properly affixed to the wall for 4 weeks, and monthly for 90 days thereafter. The findings will be reported to the QAPI committee on a monthly basis for 3 months.	10/22/22

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equipment. The CNA further stated that Resident #109 uses the call bell when he/she needs staff assistance.

On 08/05/22 at 10:37 AM, after surveyor inquiry, the surveyor observed staff in Resident #107 and #109's room attempting to secure the call bell system to the wall.

During an interview with the surveyor on 08/05/22 at 10:39 PM, Licensed Practical Nurse (LPN) #2 stated that when resident equipment needs to be repaired, if the repair is urgent, staff call the maintenance department to immediately fix the equipment. The LPN further stated that if the repair is not urgent, staff will report the issue in the maintenance department's electronic log. LPN #2 also stated that she was unaware of any issues with the call bell system in Resident #107 and #109's room and that it is important to repair a call bell system that is not secured to the wall because of the exposed wires.

During an interview with the surveyor on 08/05/22 at 10:44 AM, Registered Nurse/Unit Manager (RN/UM) #1 stated that when resident equipment needs to be repaired, staff will notify the maintenance department by phone, through the electronic maintenance log, or through the maintenance binder on the nursing unit. The RN/UM further stated that issues are reported to maintenance as soon as possible. RN/UM #1 also stated that he was not aware of any call bell system issues on Court 2 and that it is important to repair a call bell system that is not secured to the wall because it is a safety hazard.

During an interview with the surveyor on 08/05/22 at 10:50 AM, the maintenance employee stated

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he knows when resident equipment needs to be repaired because he checks the maintenance binder on the nursing units and the electronic maintenance log. The maintenance employee further stated that urgent issues are repaired on the same day it is reported. When asked about Resident #107 and #109's call bell system, the maintenance employee stated he was unaware of the issue, but that he would consider the issue urgent because of the exposed wires.

Review of the Maintenance Log Binder for Court 2, dated [redacted], did not include any report for Resident #107 and #109's room call bell system. RN/UM #1 verified that there were no reports for the month of [redacted] in the Maintenance Log Binder.

Review of the Electronic Maintenance Log, dated [redacted], did not include any report for Resident #107 and #109's room call bell system.

During an interview with the surveyor on 08/05/22 at 1:09 PM, the Assistant Director of Nursing (ADON), stated that when resident equipment needs to be repaired, staff will notify the maintenance department using the maintenance log on the nursing unit or the electronic maintenance log and that maintenance checks the logs throughout their shift. The ADON further stated that the timeframe for maintenance repairs depends on the urgency of the issue and that urgent issues should be addressed "right away." When informed about the call bell system in Resident #107 and #109's room, the ADON stated that the staff should have reported the unsecured call bell system because the exposed wires "could be a safety issue for the residents."

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F 908	Continued From page 193 Review of the facility's Resident Call Bells policy, reviewed 05/2022, included, "Call bell functioning will be checked on a regular basis by Nursing and Maintenance." Review of the facility's Maintenance policy, reviewed 05/2022, included, "The Maintenance Department will operate the facility in compliance with current federal, state and local laws, regulations and guidelines that may include, maintaining: The building in good repair and free from hazards ... Paging and nurse call systems in good working order." NJAC 8:39-31.2(e)	F 908		