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	315280	A. BUILDING _____ B. WING _____	C 11/01/2021

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

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F 000	INITIAL COMMENTS COMPLAINT # NJ149075, NJ149176 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: 11/01/21 Survey dates: 10/8, 10/12, 10/18, 10/19, 10/20, 10/21, 10/22, 10/24, 10/25, 10/26, 10/27 and 11/1/2021. CENSUS: 142 SAMPLE SIZE: 81 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 were identified for F689, F700, F760, F880, F835 and F908: During a Standard Survey conducted 10/8/21 through 11/01/21, the survey team identified the following:	F 000		

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

Electronically Signed | 12/06/2021

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F 000	Continued From page 1 F689 s/s L The survey team identified that an IJ situation began on 07/18/21 when a resident sustained a fall due to a broken handrail that had been in disrepair since 7/18/2021 on the Pavilion unit. The immediacy was removed upon verification by the survey team on 11/1/2021. The NJ Department of Health sent a Notice of Determination of Immediate Jeopardy to the Facility Administrator on 10/08/2021, including the Immediate Jeopardy Template. The Facility failed to: -Provide a safe physical environment by not a.) ensuring that hallway handrails (used by residents as mobility enablers and assist with ambulation or standing) were securely mounted to the walls for 15 of 25 handrails and that hallway handrails were in good repair and free from sharp and jagged edges, missing pieces, and exposed nails for 26 of 50 handrails on the [redacted] unit ([redacted] Unit) and ensuring that electrical outlets were covered with outlet covers in 6 of 6 resident rooms (rooms [redacted], [redacted], and [redacted]) and that there was proper covering and protection on a bathroom light fixture so that live wires were not exposed in 1 of 36 rooms (room [redacted]) from vulnerable residents on a dementia unit, 1 of 5 unit reviewed ([redacted]). -Ensure a safe environment for residents throughout the facility when an active gas leak was identified in the facility laundry room (later verified by the gas company to by in the flex line of dryer #40 which was not out of service. -Securely safeguard hazardous chemicals, chef	F 000		

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knives, over-the-counter medications, and potentially dangerous equipment (self-closing door device) and devices (belts) from vulnerable and ambulatory residents by ensuring a functional locking mechanism was installed, maintained, or utilized on the respective doors to keep residents on 3 of 5 units ([redacted], and [redacted] Unit) safe and free of serious injury, harm, impairment, or death.
-Ensure that 2 supply closets were securely locked and free from the likelihood of resident access. The 2 supply closets were observed to be in unsafe, unsanitary conditions and contained items that would be detrimental to the health and safety of the residents for 2 of 25 residents (Resident [redacted] and [redacted], who were [redacted] impaired and ambulated independently on the [redacted] unit.

-The facility's failure to identify the environmental hazards posed a serious and immediate threat to the safety and wellbeing of all residents on all the units and resulted in an immediate jeopardy situation that began on 7/18/21 when Resident [redacted] on the [redacted] Unit had a fall caused by a broken handrail which was not corrected by the facility and the facility handrails continued to be in disrepair until 10/26/21 during the standard survey.

-The facility's failure to ensure that electrical outlets in 6 of 6 resident rooms (#[redacted], #[redacted] and #[redacted]) and exposed live wiring in 1 resident room (#[redacted]) posed a serious and immediate threat to vulnerable residents and resulted in an immediate jeopardy situation was identified on 10/08/2021 at 5:14 PM. The facility provided an acceptable IJ Removal Plan on 10/12/2021 at 4:00 PM. The IJ removal plan was

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verified on-site on 10/12/2021.

-The faulty ill-maintained conditions of the dryers (see F908) in combination with the active gas leak posed a serious and immediate threat to all residents that began on 10/19/21 at 9:10 AM and continued until 10/19/21 at 10:15 AM when the gas company responded and a violation from the gas company was subsequently issued.
-This presented an immediate jeopardy (IJ) situation for the identified residents for the likelihood that the residents would access the unsecured supply closets. The facility administrator was made aware of the IJ on 10/19/2021, a removal plan was submitted on 10/20/2021 and verified by the surveyors on 10/20/2021.

The non-compliance remained on 11/1/21 for no actual harm with the potential for more than minimal harm that is not immediate jeopardy based on the following; reference F689 s/s F.

F700 s/s K

The facility failed to ensure side rails were installed and maintained in a safe, secure manner and without gaps between the side rails and the mattress to prevent entrapment risks for 3 residents (Resident [redacted], and # [redacted]) on 2 of 5 units ([redacted] and [redacted] Unit). In addition, the facility failed to reduce additional entrapment risks when durable medical equipment (a [redacted] and a wheelchair) were locked and adjacent to the bed frames on the low ends of the bed. The surveyors observed one of the residents with his/her head in the gap between the mattress and the side rail, the side rail padding was covering his/her face and the resident was

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screaming. None of the residents were assessed for an entrapment risk with the use of the side rails.

This posed a serious and immediate risk for all residents who use side rails. which was was identified on 10/19/21 and again on 10/24/21 (for 2 additional residents). The department received an acceptable removal on 10/29/21 and was verified by the survey team on 10/29/21.

The non-compliance remained on 10/29/21 for no actual harm with the potential for more than minimal harm that is not immediate jeopardy based on the following; reference F700.

F760 s/s J

The facility failed to protect residents from the potential for significant medication error by not following the standards of practical administration of medication and also not following the facility policy for Medication Administration when 1 of 5 nurses (Agency LPN) on 1 of 4 units ([redacted]) observed during medication pass observation prepared to give [redacted] medications [redacted] mg and [redacted] mg, an anticoagulant [redacted], and a medication to [redacted] levels in the blood, [redacted] to the wrong resident. The Agency LPN did not follow the five rights of medication administration by identifying the correct resident with the correct medications. The 5 rights are the following: the right patient, the right drug, the right dose, the right route, and the right time. The surveyor intervened before the medications could be administered to Resident [redacted]. Interviews with the Agency LPN revealed it was her first day at the facility and was not trained/oriented or completed

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a med pass competency at the facility. This posed a serious and immediate threat for all the residents on [redacted]

The immediate jeopardy (IJ) began on 10/19/21 at 9:50 AM and continued until 10/20/21.

The Director of Nursing (DON) was notified of the IJ on 10/19/21 at 2:40 PM. The lack of training and orientation for an agency nurse that never worked at the facility previously and the failure of LPN#1 for not following the five (5) rights that should be used to reduce the risk of medication errors and harm (identifying a resident prior to administering medications) constituted to Immediate Jeopardy due to the potential for injury or death to the residents on [redacted] unit.

An acceptable removal plan was received on 10/20/2021 and verified by the survey team on 10/20/2021.

The non-compliance remained on 10/21/21 for no actual harm with the potential for for more than minimal harm that is not immediate jeopardy based on the following; reference F760.

F835 s/s L
reference F689, F700, F760, F880, F908

The facility Licensed Nursing Home Administrator (LNHA) failed to ensure: a.) the residents environment was safe and free from accidents/hazards by ensuring all handrails were properly secured throughout the facility after the LHNA was made aware that improperly secured handrails caused a fall on [redacted] and during survey on [redacted], surveyors observed 15 of 25 handrails were not secured to the walls and 26 of

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50 handrails were free from jagged edges, b.) exposed outlets and electrical wires were covered to prevent serious injury, c.) provide effective environmental, housekeeping, pest control measures to limit the spread of infections, d.) staff follows a system to inform the [redacted] of contagious infection diseases upon resident transfer, e. staff adhered to the appropriate transmission based precautions during resident care and environmental cleaning for the [redacted], f.) ensure a system to install and maintain bed rails in a safe and secure manner was followed, g.) a system was for identifying an active gas leak was in place in the facility laundry room, h.) the facility clothes dryers were maintained in a safe operating manner.

The failures of the LHNA to ensure the facility operated in manner that ensured residents were cared for in a manner and in an environment that enabled residents to maintain or attain their highest practicable physical, mental, and psychosocial well-being posed a serious and immediate threat to the health, safety and welfare of all residents who resided in the facility and resulted in an initial immediate jeopardy(s) (IJ) that were identified on 10/08/21 at 5:00 PM. An additional deficient practice that rose to the IJ level was identified during and on-site visit on 10/12/21 and the facility was notified on 10/14/21 at 1:30 PM. A removal plan was received by e-mail on 10/14/2021.

However, the LNHA administrator of record resigned on [redacted] and a new administrator of record was in place on [redacted].

The removal plan was verified by the survey team on 11/1/2021 during an onsite removal plan

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verification survey.

The non-compliance remained on 11/1/21 for no actual harm with the potential for more than minimal harm that is not immediate jeopardy based on the following; reference F835.

F880 s/s L

It was determined on 10/08/21, an IJ situation was identified for F880, which began on 10/08/21, and continued through 10/12/21. The facility was notified of the continued IJ situation after further off-site investigation on 10/14/21 at 1:30 PM.

In addition on 10/18/21, during survey, the survey team determined the IJ situation for F880 remained.

The facility submitted an acceptable removal plan via electronic mail (e-mail) on 10/22/21 at 5:38 PM.

The IJ removal plan was verified as implemented during an on site re-visit on 11/1/21.

The facility failed to ensure:

-effective housekeeping and environmental services were provided for 5 of 5 units
-a system for communication was followed to inform the [redacted] prior to transferring two residents who had a contagious infectious disease ([redacted]), for 2 of 2 residents (Resident [redacted] & Resident [redacted]) who were transferred from the facility [redacted] Unit to the [redacted]
-staff wore appropriate personal protective equipment upon entering residents rooms who

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were on transmission based precautions for 3 staff (Respiratory Therapist, Certified Nurse Aide & Housekeeping Staff), on 2 of 5 units ([redacted] & [redacted] Unit), d.) an effective pest control program was in place for 5 of 5 units
-the facility policy was followed to ensure the process for isolation was followed for 2 of 2 residents (Resident [redacted] and [redacted]) who had a suspected case of [redacted] (a contagious [redacted]), f. vital sign monitoring was completed for signs and symptoms of COVID-19 as indicated during a Covid-19 outbreak for 5 of 5 residents (Resident # [redacted], # [redacted], # [redacted] # [redacted], and # [redacted]) reviewed for Covid-19 monitoring, g. proper infection control measures were followed during a meal observation when staff used bare hands to cut up a food item prior to a resident's consumption for 1 of 5 nursing units ([redacted] Unit).

The facility's failure to identify the housekeeping and environmental hazards posed a serious and immediate threat to the safety and wellbeing of all residents who resided on the [redacted] Unit. A serious adverse outcome was likely to occur as the identified non-compliance occurred on a unit identified by the facility as having 58 residents diagnosed with dementia, and 33 out of the 58 residents that resided on the [redacted] Unit ambulated independently.

The non-compliance remained on 10/29/21 for no actual harm with the potential for more than minimal harm that is not immediate jeopardy based on the following; reference F880

F 908 s/s L

The facility failed to ensure that clothes dryers,

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located inside the laundry department, are maintained in safe operating conditions. On 10/19/21 at 11:45 the life safety code surveyor and Surveyor #5 toured the laundry area and observed 3 of 4 large commercial grade clothes dryers that were operational. The interior of the clothes dryer drums had large areas located in the dryer drums of embedded potentially combustible debris. The surveyor observed various color of brown and white potentially combustible debris that was embedded and blocking the air flow pockets of the drum. The Life Safety Code (LSC) Surveyor identified by smell a gas like odor, the surveyor instructed the MD to contact [the gas company-name redacted] immediately, and it was determined by the gas company representative that the dryer was positive for an active gas leak due to a gas valve that was in disrepair. At that time, the LSC surveyor interviewed the maintenance director regarding a procedure to maintain the integrity of the interior of the dryer drums and gas supply lines. The maintenance director stated there was no policy, procedure, or process in place to ensure the dryer drums were regularly maintained or regularly monitored for condition or to monitor the gas supply lines.

The facility's failure to maintain the commercial grade clothes dryers (dryers), located inside the laundry department, in safe a safe operating condition by ensuring the dryer drum air vents remained free of embedded potentially combustible debris that blocked the air flow for 3 of 4 operational dryers. This deficient practice posed a serious and immediate threat to the safety and wellbeing of all residents who resided in the facility.

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F 000	Continued From page 10 This resulted in an Immediate Jeopardy (IJ) situation that began on 10/19/21. The facility submitted an acceptable removal plan via electronic mail (e-mail) on 10/22/2021. The IJ removal plan was verified prior to receipt of the facility's written removal plan and verified by the survey team as implemented during the survey on 10/20/2021. The non-compliance remained on 10/22/21 for no actual harm with the potential for more than minimal harm that is not immediate jeopardy based on the following; reference F908.	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	F 550		12/28/21

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F 550	Continued From page 11 provision of services under the State plan for all 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 record review, it was determined that the facility failed to provide a dignified environment for 11 of 38 resident's, (Resident #[redacted], #[redacted], and #[redacted]) reviewed for a dignified existence. The deficient practice was evidenced by the following: 1. On 10/18/21 at 9:18 AM, Surveyor #1 observed Resident [redacted] on the [redacted] Unit with his/her breakfast tray set up on the bed and he/she and was eating his/her meal on the bed (using the bed as a table). Surveyor #1 interviewed the resident at this time, and he/she stated that he/she has been eating on the bed for a month because someone took his/her bedside	F 550	This response to findings outlined in the Statement of Deficiencies CMS 2567 is the facility□s credible allegation of compliance. Preparation and/or execution of this response does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The response is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility respectfully disagrees with these findings, notwithstanding the following actions have been taken: F550 Element One – Corrective Actions	

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F 550	Continued From page 12 table. The resident further stated that he/she asked the staff for a bedside table, but that they did not provide one to him/her. The resident stated that he/she got "used to eating like this." On 10/19/21 at 9:30 AM, Surveyor #1 interviewed the Certified Nursing Assistant (CNA) who stated that she was employed in the facility for [redacted] years. She stated that not all the residents have bedside tables and half of the bedside tables were broken. She stated that she had asked facility management for bedside tables for over a year, and they haven't provided the tables that the residents need. She stated, "We told the Administrator, and he does nothing about it." On 10/19/21 at 9:40 AM, Surveyor #1 interviewed another CNA who stated that Resident [redacted] has not had a bedside table and added that she knew that some of the other residents didn't have bedside tables requiring them to eat on the beds or with the tray on the seat of a chair. She stated that she notified maintenance and administration, but they have not provided the bedside tables that she requested. On 10/20/21 at 10:53 AM, Surveyor #1 interviewed Resident [redacted] who stated that he/she still did not have a bedside table and continued to eat his/her meals on the bed. Surveyor #1 observed that there was no bedside table in the resident's room. On 10/20/21 at 11:22 AM, Surveyor #1 interviewed the Licensed Practical Nurse (LPN) who stated that she knew that the resident did not have a bedside table and that there were some other residents that did not have them either. She added that the administration knew about the	F 550	• The bedside table for Resident [redacted] was replaced. Resident [redacted] was interviewed by social services to confirm their wish to eat in their room and to use a bedside table. The care plan was reviewed and updated to reflect the residents dining preferences. The exterminator conducted repeated visits to eradicate the flies • The bedside table for Resident [redacted] was replaced. The care plan of Resident [redacted] was reviewed and updated to reflect this residents dining needs to assure the resident was served and ate [redacted] meals in a dignified manner. The exterminator conducted repeated visits to eradicate the flies • The MDS assessments of [redacted] and [redacted] for Resident [redacted] were reviewed and modified to reflect the cognitive status of the resident. The nails of Resident [redacted] were immediately trimmed by nursing staff . Resident [redacted] was re-evaluated by therapy for proper positioning when OOB. The IDT reviewed and updated the care plan of Resident [redacted] to reflect positioning, grooming, and showering to assure the resident's care needs were met. The [redacted] company was contacted to assure the [redacted] aides reported to the facility nurse the care provided to Resident [redacted] prior to leaving the facility. The exterminator conducted repeated visits to eradicate the flies • The wheelchair of Resident [redacted] was repaired. The room and bathroom of Resident [redacted] was cleaned as was the bedside commode. Repairs were made	

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F 550	Continued From page 13 problem and did not provide the bedside tables as the staff requested. She stated that she would ask the Maintenance Director (MD) to get the resident a bedside table. She also confirmed that it was a dignity issue for the resident and that all residents should have the equipment that they needed to be able to eat their meals with dignity. On 10/21/21 at 11:08 AM, Surveyor #1 interviewed the MD who stated that residents should never be without a bedside table. He stated that bedside tables were on order and that some units did receive new bedside tables. He further added that he was not made aware that any bedside tables were missing on the [redacted] unit and that he would get the residents bedside tables if they were missing. The surveyor reviewed the medical record for Resident [redacted] which revealed that the Admission Record (AR) face sheet (an admission summary) indicated that Resident [redacted] was admitted to the facility with the diagnoses that included but were not limited to; [redacted]). The resident's Care Plan (CP) dated [redacted] indicated that Resident [redacted] had an ADL self-care performance deficit related to disease process and reflected a goal that Resident [redacted] would maintain a current level of function in Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene through the review date of [redacted]. The CP indicated the current interventions that were in place: -Encourage the resident to fully participate possible with each interaction.	F 550	in the bathroom of Resident [redacted] including the cracked walls and wood on the sink. The exterminator conducted repeated visits to eradicate the flies • The trash on the floor in Resident [redacted]'s room was cleaned, and the floor was mopped to remove the sticky surface. The toilet in the bathroom of Resident [redacted] was cleaned. A new mattress was provided to Resident [redacted] and the bedding was changed. Staff that provide care to Resident [redacted] on the night shift were re-educated about the need to change soiled linens prior to the end of their shift. The exterminator conducted repeated visits to eradicate the flies • The exterminator conducted repeated visits to eradicate the flies in the room of Resident [redacted] and the dining area where Resident [redacted] eats. • The dayroom on the [redacted] unit was immediately cleaned and any furniture ripped, in disrepair or visibly soiled was replaced or repaired as appropriate. • The toilet in the bathroom of Resident [redacted] was repaired. The exterminator conducted repeated visits to eradicate the flies. • The toilet in the bathroom of Resident [redacted] was repaired. The exterminator conducted repeated visits to eradicate the flies. F550 Element One – Corrective Actions • The toilet in the bathroom of Resident [redacted] was repaired. The exterminator conducted repeated visits to eradicate the flies.	

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F 550	Continued From page 14 -Bathing: the resident required assistance with bathing/showering as necessary. -Dressing: Requires staff participation to dress. 2. On 10/18/21 at 9:00 AM, Surveyor #1 observed Resident [redacted] eating breakfast off a folding chair. He/she was utilizing the folding chair as a table. The resident was unable to be interviewed at this time due to [redacted] Surveyor #1 observed that there was no bedside table in the resident's room. On 10/18/21 at 10:30 AM, Surveyor #1 interviewed the CNA who stated that he set Resident [redacted]'s breakfast up on a folding chair because the resident did not have a bedside table. The CNA then stated that he would try and find a bedside table for Resident [redacted] and that he should have notified the maintenance department so that Resident [redacted] could have had a bedside table to eat on instead of eating on a folding chair. The CNA also admitted it was a dignity issue and that residents should not be eating on folding chairs. On 10/21/21 at 11:32 AM, Surveyor #1 observed that Resident [redacted] still did not have a bedside table in his/her room. Surveyor #1 interviewed the CNA who stated that she told the Director of Nursing (DON) and MD the other day that the resident needed a bedside table, however the table was never provided. On 10/21/21 at 11:03 AM, Surveyor #1 interviewed the MD who stated that the resident not having bedside tables and resident's eating off of folding chairs and beds because they do not have a bedside table should "never happen-ever".	F 550	• The toilet in the shower room on the [redacted] unit was repaired. The exterminator conducted repeated visits to eradicate the flies. • The mattress in Resident [redacted]'s room was replaced. The common area floor where Resident [redacted] eats was cleaned as was the bathroom floor in Resident [redacted]'s room. The care plan for Resident [redacted] was reviewed and revised to address the negative behaviors of [redacted] and [redacted] on the floor. The exterminator conducted repeated visits to eradicate the flies. Staff were re-educated about the proper disposal of soiled diapers and the approaches to use with Resident [redacted] to avoid [redacted] on the floor and a toileting plan was implemented. • The common area floor where Resident [redacted] eats was cleaned as was the bathroom floor in Resident [redacted]'s room. The care plan for Resident [redacted] was reviewed and revised to address the negative behaviors of [redacted] and [redacted] on the floor. The exterminator conducted repeated visits to eradicate the flies. • Staff were re-educated about the proper disposal of soiled diapers and the approaches to use with Resident [redacted] to avoid [redacted] on the floor and a toileting plan was implemented. • Nursing staff received re-education regarding the proper process for disposal of soiled diapers and linens, cleaning of the floor when a resident [redacted] on the floor and contacting housekeeping to disinfect the floor, and toileting residents who tend to [redacted] on the floor.	

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F 550	Continued From page 15 He also revealed that it should never be like that ever and that he had requested all kinds of things and the old owners would not provide. On 10/21/21 at 11:36 AM, Surveyor #1 interviewed the MD who stated that he would obtain bedside tables for any resident on the [redacted] unit that needed them. Surveyor #1 gave the MD the room numbers for the residents that were missing bedside tables and he stated he would obtain them. The surveyor reviewed the medical record for Resident [redacted] which revealed in the AR that Resident [redacted] was admitted to the facility with the diagnoses that included but were not limited to; [redacted] The resident's CP dated [redacted] reflected that the resident had [redacted] issues associated with [redacted] and required limited to extensive assistance with ADL's. The CP dated [redacted] also indicated that Resident [redacted] had an [redacted] self-care performance deficit with interventions that included the following: -To encourage the resident to fully participate possible with each interaction. - To encourage the resident to use the call bell to call for assistance. - Staff were to monitor/document/report to Medical Doctor (MD) any changes or any potential for improvement, The CP dated [redacted] indicated that Resident [redacted] had [redacted] to [redacted] and [redacted] deficits related to the diagnose of [redacted] The interventions on the CP included the	F 550	• The exterminator has made repeated visits to the facility to eradicate the flies. Fly lights were also purchased and placed throughout the facility based on the recommendations of the exterminator. Element Two – Identification of at Risk Residents • All residents have the potential to be affected by these practices. • Audits were conducted to identify any areas in need of cleaning, any furniture in need of replacement or repair, and to identify sources of flies. • Audits of resident care needs were conducted to identify residents in need of bathing and grooming to assure their needs were met. • Furniture audits were conducted to identify which rooms required over bed tables or other furniture. • Therapy conducted audits of all resident wheelchairs and adaptive devices to ensure they were in proper and safe working condition. Element Three – Systemic Changes • Audits were conducted throughout the facility to identity areas in need of cleaning and or repair. A monthly carbolization schedule was developed by the housekeeping director in conjunction with the Administrator. • The management company contracted with [redacted] to provide housekeeping oversight supervision and train employees. The director of housekeeping was replaced. • The management company	

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F 550	Continued From page 16 following: -The resident will demonstrate improve and [redacted] skills. -Skilled Speech Therapy (ST) evaluation and treatment 3-5 week for [redacted] treatment and [redacted] insight, recall resident, caregiver, staff education and compensatory strategies. 3. On 10/19/2021, Surveyor #3 reviewed Resident [redacted]'s medical record. Resident [redacted] was admitted to the facility with diagnoses which included [redacted] The Quarterly MDS an assessment tool dated [redacted] developed by the facility to identify resident's needs and implement care interventions, revealed that Resident [redacted] was totally dependent on staff for all activities of daily living (ADL's). [redacted] referring to [redacted] was left blank on both a comprehensive Significant Change MDS dated [redacted] and the Quarterly of [redacted] On 10/19/21 at 9:30 AM, Surveyor #3 observed Resident [redacted] in bed screaming. Flies were observed in the room. Surveyor #3 further observed that the resident's [redacted] and [redacted] On 10/20/21 at 9:30 AM, Surveyor #3 toured the [redacted] Unit. Resident [redacted] was screaming. Surveyor #3 knocked on the door and went to the room. The resident had flies landing on all areas of his/her [redacted] Surveyor #3 left the room and asked the nurse to call the Director of Nursing (DON). Surveyor #3 accompanied the DON to the resident's room, and both observed the resident screaming, flaring his/her [redacted] on both	F 550	contracted with [redacted] to inspect and assist with repair of facility equipment as needed with maintenance issues. A new maintenance director was hired. • The procedure for completing work orders was reviewed and revised. Nursing and housekeeping staff received re-education about the process to notify maintenance and administration of any missing furniture to facilitate timely replacement. F 550 Element Three – Systemic Changes • Nursing staff received re-education regarding the provision of dignified care to the residents. • Therapy will conduct monthly audit of all wheelchairs and adaptive equipment issued to residents to be sure it is maintained in proper and safe working condition. • The facility infection control preventionist conducted re-education for both housekeeping and nursing staff regarding proper infection control techniques for cleaning and handling of soiled linens. Element Four – Quality Assurance • Root cause analysis was conducted and a QAPI performance improvement project team was formed to address resident dignity issues. Weekly, for three months, the nursing supervisor/designee will conduct rounds to ensure residents are provided with dignified care including bathing, grooming hygiene, and eating and shall report results of the audits to the administrator for three months. Quarterly	

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F 550	Continued From page 17 directions to swat away the flies. The DON stated that "I never see something like that." Surveyor #3 reviewed the shower log with the Unit Manager (UM). According to the shower log, Resident [redacted] was scheduled to be assisted with a shower on [redacted] by the [redacted] Aide. The process according to the UM, was the nurse would sign the shower log based on the schedule. The UM went on to add that the [redacted] Aide left before he reported to the unit and there was no documentation from [redacted] on what care was provided. Staff could not account if Resident received a shower on [redacted]. Later on that day the DON delegated two CNAs to shower the resident. On 10/21/2021 at 10:30 AM, the surveyor went to the room and observed multiple flies on the bed. An interview with the DON on 10/21/2021 at 11:30 AM, revealed that the pest control company was in the facility on both days, [redacted] and [redacted]. However, a vast amount of flies were still noted by the surveyor in the common areas and in resident's rooms. On 10/22/21 at 1:15 PM, Surveyor #3 interviewed the Infection Preventionist (IP) regarding the flies on the Unit during the breakfast meal. The IP told Surveyor #3 that the former Administrator was made aware of the flies. She went on to state that the facility needed to get an exterminator and nothing had been done about it. It is not acceptable to have staff swatting flies while assisting residents with their meals. Flies can lay eggs causing "maggots." On 10/26/21 at 1:02 PM, Surveyor #14 observed	F 550	the Director of Nursing will report aggregate findings and actions taken to the QAPI committee for review and further direction as appropriate. • Root cause analysis was conducted and a QAPI PIP team formed to address the issue of flies. Weekly, for three months, the housekeeping director/designee will conduct rounds and shall report results of his inspections to the administrator. Quarterly the Housekeeping Director will report inspection findings and actions taken to the QAPI committee for review and further direction until the problem is resolved. • Root cause analysis was conducted and a QAPI performance improvement project team was formed to address maintenance issues. The maintenance director/designee will conduct rounds, assess the condition of furniture, and identify any areas in need of repairs. The results of the rounds shall be reported to the administrator monthly for three months. Quarterly the Maintenance Director will report inspection findings and actions taken to the QAPI committee for review and further direction as appropriate. • Root cause analysis was conducted and a QAPI PIP team formed to address the issue of cleanliness of resident rooms, bathrooms, and common space areas. The housekeeping director/supervisor shall conduct daily and weekly rounds for three months and report corrective actions taken because of the rounds to the Administrator weekly. Housekeeping issues will be discussed at daily operation	

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F 550	Continued From page 18 Resident [redacted] with his/her eyes closed in a reclining [redacted] in the sunroom on the [redacted] Unit. The surveyor observed that the resident was scrunched up in the [redacted] with his/her [redacted] resting on a pillow. Surveyor #14 observed flies circulating around the resident's [redacted] One of the flies landed on the resident's closed eye and remained there for approximately 30 seconds. Surveyor #14 pulled the Recreation Aide on the unit aside and the Recreation Aide swatted the fly off the resident. At that time, the surveyor observed two more flies, flying around the resident's lunch tray. Surveyor #14 conducted an interview with the Recreation Aide at that time who stated that the flies on the unit were a new thing and maybe started a week ago. On 10/26/21 at 1:08 PM, Surveyor #14 interviewed Resident [redacted] s Licensed Practical Nurse (LPN) on the [redacted] unit who stated that he noticed the flies about a month ago. The LPN stated that the facility's former Administration who included the Administrator, Maintenance Director, Housekeeping Director, and Exterminator were fully aware of the concern regarding the flies but did nothing to resolve the issue. The LPN stated that the Exterminator was at the facility that morning, but he didn't think he did anything. The LPN further stated that the Exterminator told him that the flies were coming from the soiled linen room on the [redacted] unit. The LPN stated that he did not know how frequently the soiled linen room was cleaned. The LPN stated, "I'm not a huge fan of the flies landing on the residents and a lot of the residents." The LPN further stated that he did not think it was a dignified existence to have flies landing on residents who were physically incapable of swatting them away.	F 550	meeting and at weekly management meetings. The Administrator will review and act upon issues reported. Quarterly the Housekeeping Director will report housekeeping inspection findings and actions taken to the QAPI committee for review and further direction as appropriate. • Root cause analysis was conducted and a QAPI PIP team formed to address the issue of resident wheelchairs and adaptive equipment. Therapy will conduct monthly audits of all wheelchairs and adaptive equipment issued to residents on an ongoing basis to be sure it is maintained in proper and safe working condition. The results of the audits shall be reported to the administrator weekly for three months. Quarterly the Therapy Director will report audit findings in aggregate and actions taken to the QAPI committee for review and further direction as appropriate. Completion Date: 12/28/21	

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4. On 10/18/21 at 10:29 AM, during the initial tour, Surveyor #4 observed Resident [redacted] in bed resting. The resident's meal tray was still on the bedside table with an unopened container of milk and vanilla shake. The resident's [redacted] wheelchair had cracks in both arm rests. At that time, Surveyor #4 observed flies on the resident while he/she was lying in bed.

Surveyor #4 reviewed the medical record for Resident [redacted].

A review of the Admission Record face sheet (an admission summary) included that the resident was admitted with diagnoses which included: history [redacted]
A review of the most recent MDS, dated [redacted], reflected that the resident had a Brief Interview of Mental Status (BIMS) score of [redacted] which indicated the resident had a [redacted]. It further reflected that the resident required extensive assistance with most activities of daily living, including, transferring, dressing and toileting.

On 10/20/21 at 9:08 AM, Surveyor #4 entered Resident [redacted] room and observed the resident's bed covered with flies, and the bathroom had [redacted] on the floor and on the toilet seat. A staff member reported to surveyor #3 that Resident [redacted] was soiled with [redacted] Resident [redacted] was escorted to the shower by two (2) nursing aides.

On 10/20/21 at 10:17 AM, Surveyor #4 observed a housekeeper cleaning Resident [redacted]s room. The housekeeper stated she was sent from other facility to assist with cleaning and concluded by

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stating she did not understand much English.

On 10/21/21 at 11:06 AM, Surveyor #4 observed Resident [redacted] sitting in a [redacted] wheelchair at a table in the dayroom [redacted] participating in the activity. At that time, surveyor #4 observed two (2) flies on the resident's [redacted]

On 10/21/21 at 11:09 AM, Surveyor #4 went inside the room of Resident [redacted] and observed three (3) flies on his/her pillow and then flying all around [redacted] bed.

On 10/22/21 At 8:59 AM, Surveyor #4 observed several flies inside the room of Resident [redacted]. The floors were sticky, the bathroom had a strong smell of [redacted] on the toilet, wood exposed on the bathroom sink and cracks in the bathroom walls.

On 10/25/21 at 8:52 AM, Surveyor #4 observed inside the room of Resident [redacted], his/her bedside commode (portable toilet) which had [redacted] inside of it with flies in the room and on the bedside commode.

On 10/25/21 at 9:44 AM, Surveyor #4 interviewed the CNA. He stated the aides were responsible for cleaning the commode and then housekeeping will also come in to clean it. He further stated he did not get to Resident [redacted]s room yet because he had to stop and assist with breakfast. He concluded "it's just not enough staff."

On 10/26/21 at 11:47 AM, in the presence of Surveyors #3 and #4, the Infection Preventionist (IP) stated on all units the nursing staff have disinfectant wipes. She further stated the nursing

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staff are supposed to empty, rinse, and clean the commode and then the housekeeping staff will follow behind to sanitize it. The IP emphasized it was a joint effort, but the cleaning of the commode was the nursing staff and housekeeping staff disinfect and sanitize.

5. On 10/18/21 at 12:35 PM, Surveyor #4 entered in the room of Resident [redacted] and observed trash on the floor and the toilet dirty with [redacted].

On 10/18/21 at 1:52 PM, Surveyor #4 observed Resident [redacted] in the hallway sitting in his/her wheelchair. The resident did not acknowledge the surveyor at that time.

Surveyor #4 reviewed the medical record for Resident [redacted]

A review of the Admission Record face sheet revealed that the resident was admitted with diagnoses which included: [redacted]

A review of the quarterly MDS, dated [redacted] reflected that the resident had a BIMS score of [redacted] which indicated the resident had a [redacted]. It further reflected that the resident required extensive assistance with some activities of daily living, including, personal hygiene, dressing and toileting.

On 10/20/21 at 11:25 AM, Surveyor #4 observed

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Resident [redacted] lying in bed fully dressed and resting. Surveyor #4 attempted to interview the resident, but he/she only waved and told surveyor #4 "good morning."

On 10/21/21 at 11:13 AM, Surveyor #4 entered the room of Resident [redacted] and observed the floors still [redacted] and [redacted] stains on the toilet.

On 10/22/21 at 9:04 AM, Surveyor #4 observed Resident [redacted]s bathroom with two (2) flies on the toilet seat and the [redacted] stains still on the toilet seat from the day prior.

On 10/25/21 at approximately 9:34 AM, Surveyor #3 and #4 observed soiled sheets and flies in Resident [redacted] room.

On 10/25/21 at 9:36 AM, both surveyors in the presence of the CNA, observed Resident [redacted] room with the soiled sheets and flies. The CNA stated Resident [redacted] was able to get himself/herself out of bed. The CNA stated it was common for the 11 PM - 7 AM shift to not change the sheets. He further stated when they are working short staff and short with supplies it's hard to get to these rooms and change the resident's sheets. He concluded he "always" reports it but "we don't complain a lot because we are used to it." The CNA acknowledged he did not report the condition of the room to the nurse.

On 10/25/21 at 9:41 AM, the CNA in the presence of the LPN, entered Resident [redacted] room. In the presence of Surveyor #3 and #4, the LPN stated she was a full-time staff nurse and no one had reported the condition of the resident's room to her. The LPN further stated Resident [redacted] was common to refuse care. At that time, the CNA

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applied gloves and removed the soiled linens. Both surveyors observed the bed on the zipper side was ripped. The CNA turned over the mattress and the surveyors observed the blue side of the mattress stained and ripped with holes in it. Both the LPN and the CNA stated they continued to report these conditions.

6. On 10/22/21 at 9:08 AM, Surveyor #3 and #4 observed Resident [redacted] sitting in dayroom [redacted] eating breakfast. Both surveyors observed flies on the residents coffee cup, on the spoon that was inside of the oatmeal as well as on top of the oatmeal. In addition, there were flies on the resident's [redacted] and chair he/she was sitting in.

Surveyor #4 reviewed the medical record for Resident [redacted]

A review of the Admission Record face sheet included that the resident was admitted with diagnoses which included: [redacted]).

A review of the Admission MDS dated [redacted], reflected that the resident had a BIMS score of [redacted] which indicated the resident had a [redacted] cognition. It further reflected that the resident required supervision with one-person assistance with activities of daily living, such as eating.

On 10/22/21 at 10:51 AM, in the presence of the survey team the DON stated it was not acceptable for flies to be on the resident's food

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because "it is not hygienic." She acknowledged it posed an infection control issue but was unable to elaborate on it.

On 10/25/21 at 9:03 AM, Surveyor #3 and #4 observed Resident [redacted] siting at the table in dayroom [redacted] eating his/her breakfast. While the resident was eating there were flies on the utensils and flying around the resident.

7. On 10/18/2021, Surveyor #3 toured the [redacted] Unit and noted the following:

On 10/18/2021, the dayroom Surveyor #3 observed with stained flooring and [redacted] on the left side of the [redacted]. The residents appeared disheveled and unkempt. There was a strong [redacted] odor in resident rooms, [redacted] noted in [redacted], and furniture in disrepair, ripped and visibly soiled. There were residents sitting in the dayroom and water was observed puddled on the floor. There were some rooms observed to be covered with debris and flies were observed all over the residents rooms.

Surveyor #9 made the following observations regarding Resident [redacted]

On 10/21/21 at 8:50 AM, Surveyor #9 observed Resident [redacted] sitting up in his/her wheelchair eating breakfast. The resident stated that the toilet in the room was clogged. At that time, Surveyor #9 observed the toilet in the resident's room was clogged with a [redacted] and there were multiple flies flying around the toilet. Resident [redacted] further stated that every time the toilet is fixed, it breaks again. The resident also stated the toilet has been currently broken for the

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last one to two days and that the resident will just use the toilet even if it is clogged with [redacted]. Surveyor #9 further observed there were multiple flies flying around the resident while he/she was eating breakfast and a fly landed on his/her Styrofoam water cup. The resident stated that the flies have been in the room for about a month and that it was worse when the toilet is broken. The resident further stated that sometimes the flies landed on his/her food.

On 10/21/21 at 11:11 AM, Surveyor #9 observed Resident [redacted] lying in bed and a fly landed on the resident's [redacted]

Surveyor #9 made the following observations regarding Resident [redacted]:

On 10/21/21 at 8:55 AM, Surveyor #9 observed Resident [redacted] sitting up in bed. The resident stated every time the toilet is fixed, it works for a day or two before clogging again. The resident further stated the odor in the bathroom was "terrible." The surveyor then observed a fly land on the resident's [redacted] and the resident stated the flies have been "bad all summer."

On 10/22/21 at 9:08 AM, Surveyor #9 observed Resident [redacted] sitting up in his/her wheelchair next to the bed which had two flies on the pillows and one fly on the privacy curtain.

Surveyor #9 made the following observations regarding Resident [redacted]

On 10/21/21 at 9:00 AM, Surveyor #9 observed Resident [redacted] sitting on the side of bed. The resident stated he/she can't use the toilet in the room because it is broken and that he/she has to

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use the bathroom "across the hall" which was "very inconvenient." The resident further stated the flies are "a pain."

During an interview with Surveyor #9 on 10/21/21 at 9:05 AM, the CNA stated she reported the broken toilet to maintenance this morning and that they should be coming down shortly to fix it. The CNA further stated the toilet gets clogged "every so often." The CNA also stated that if the toilet is clogged, they take residents into an empty resident room to use the toilet. She further stated the shower room toilet was broken so residents can't use it. The CNA also acknowledged that the unit has had an issue with flies within the last few weeks and that pest control was on the unit a couple weeks ago.

Surveyor #3 observed, interviewed and reviewed the following for Resident [redacted]

On 10/25/21 at 11:37 AM, Surveyor #3 observed Resident [redacted] sitting in the dayroom [redacted] were observed on the resident's [redacted]. Surveyor #3 went to Resident [redacted] s room and observed multiple flies in the room and on the bed. The sheets were removed exposing a visibly soiled wet and stained mattress. Surveyor #3 accompanied the nurse to the room where the nurse observed and acknowledged the flies and the visibly soiled mattress.

An interview with the LPN assigned to the unit at that time, revealed that he didn't know who was responsible for cleaning and changing the mattresses or whom to contact regarding the mattress.

Resident [redacted] was admitted to the facility with

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F 550	Continued From page 27 diagnoses which included [redacted] and The Quarterly MDS, dated [redacted] revealed that Resident [redacted] scored [redacted] on the BIMS which indicated the resident was [redacted]. Resident [redacted] was rarely/never understood, and could respond adequately to simple direct communication only. A further review of the resident's MDS reflected that Resident [redacted] was totally dependent on staff for care. On 10/26/21 at 9:50 AM, Surveyor #3 toured the [redacted] Unit and observed Resident [redacted] eating the breakfast meal in the dayroom. Flies were observed on the table, on the plate and on the toast while Resident [redacted] was eating. Surveyor #3 called the nurse over to the table and he observed and acknowledged the same. The nurse swatted some of the flies away. The surveyor observed the common area, dayroom [redacted] where both residents (Resident [redacted] and the roommate [redacted]) would sit and eat. The surveyor observed the floor was wet and soiled. The nurse confirmed that both residents had a behavior of [redacted] on the floor. The floor was not cleaned after the roommate finished the breakfast meal, prior to Resident [redacted] sitting for the breakfast meal. The nurse confirmed that the roommate had just finished breakfast and was observed [redacted] on the floor. On 10/26/21 at 9:55 AM, Surveyor #3 entered room [redacted] and noted that Resident [redacted] bathroom was [redacted], a soiled diaper was	F 550		

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observed on the floor in the bathroom. Surveyor #3 conducted an interview with the CNA at that time who revealed that she provided incontinence care to the resident that morning.

An interview with the Infection Control Preventionist (IP) on 10/26/21 at approximately 11:40 AM regarding the flies noted in the common areas and resident's room revealed the following: the IP indicated that had been an issue since she started one month ago in another Unit and overheard the Unit manager reported it during morning meeting for the [redacted] unit. She stated clearly, " It is not acceptable to have staff swatting flies while assisting with meals.

An interview with the IP and the Housekeeping Director on 10/26/21 at approximately 11:45 AM, regarding residents [redacted] on the floor revealed the following: the IP told the surveyor that nursing staff were to first clean the floor then call housekeeping for disinfecting. Staff was not aware of the protocol.

On 10/26/21 at 12:09 PM, Surveyor #3 returned to the unit and noted that the bathroom was [redacted] with [redacted]. The soiled diaper was still on the floor. Surveyor #3 observed the Administrator was on the unit. Surveyor #3 accompanied the Administrator to Resident [redacted] room where he observed and acknowledged the wet floor and the soiled diaper in the room.

Review of the Pest Management log obtained from [redacted] revealed pest control was on the unit [redacted] and [redacted] with "No Reports" documented.

During an interview with Surveyor #9 on 10/21/21

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F 550	Continued From page 29 at 11:26 AM, the Maintenance Director stated the maintenance work orders are notified through the TELS computer application which goes straight to the maintenance staff's phone. He further stated that an outside contractor came the day prior to evaluate the toilet in room [redacted] and will be replacing it "soon." The facility policy titled, "Resident Rights" with a revised date of August 2009, indicated that employees shall treat all residents with kindness, respect and dignity. The policy indicated the following: -Residents are entitled to exercise their rights and privileges to the fullest extent possible. -The facility would make every effort to assist each resident in exercising his/her rights to assure that the resident was always treated with respect, kindness, and dignity. -Orientation and in-servicing training programs were conducted quarterly to assist the employees in understanding resident rights. A review of the facility's policy Resident Rights from Med-Pass revised 8/2009 included, "Employees shall treat all residents with kindness, respect and dignity ....." A review of the Housekeeping In-Service training dated [redacted], included, ..."clean and sanitize toilet (including raised toilet seats) using disinfectant cleaner. Use toilet brush for inside and cloth for the outside. A review of the Dignity In-Service - All Staff, dated [redacted], that was provided by the Licensed Nursing Home Administrator (LNHA) included, "Maintaining our resident's dignity is an important aspect of providing quality care ...."	F 550		

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F 550	Continued From page 30 A review of the Job description for the Director of Housekeeping, updated 5/2020 included, ..."Develop job descriptions sand orientation checklist for the housekeeping and laundry staff .....supervise purchasing, storage, and distribution of all housekeeping, cleaning and laundry supplies .... Maintain inventory of all facility linen in order to provide a continuous supply to the staff and residents (at a ration of 3:1), proper distribution of bed linen and towels on all wings to ensure continuous services to the residents, supervise the disposal of bio-hazardous waste in accordance with regulatory procedures. The undated and unsigned facility form titled, "Admission Agreement" indicated that the facility would provide the resident with services in accordance with State and Federal regulations. Such services included: room and board, general nursing care and nursing treatments such as administration of medication, preventative skin care, assistance with bathing toileting, feeding, dressing, mobility, housekeeping services, recreational activities and social programs and certain personal care services and as may be required for health, safety, and well-being of the resident among other services. NJAC 8:39-13.2(c),31.4(f), 31.5(a)31.8(c)(3)	F 550		
F 558 SS=F	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or	F 558		12/28/21

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F 558	Continued From page 31 other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review it was determined that the facility failed to ensure an adequate supply of linens (towels, bed linens, wash cloths, bed pads and gowns) were provided to accommodate the needs and maintain the dignity and well-being of all residents who resided in the facility for [redacted] Unit and [redacted] Unit) resident units. The deficient practice was evidenced by the following: 10/18/21 At 1:07 PM, Surveyor #5 toured [redacted] #1 and interviewed a Certified Nurse Aide (CNA) regarding the facility. The CNA stated the residents did not have soap, linens and we went through shifts without towels for the residents. 10/19/21 Surveyor #3 & #4: - 9:18 AM, Surveyor #3 & #4 toured the facility Laundry Department in the presence of the Housekeeping Director (HD). The laundry staff stated there was not enough supply of linens for the residents and stated the laundry detergent was received once per month. The laundry staff showed surveyor #4 a towel that was cut in half by the laundry staff for the purpose if increasing the amount of towels for the residents. At that time, Surveyor #3 & #4 interviewed the HD regarding the facility linens. The HD stated he	F 558	F 558 Element One – Corrective Actions • Linens, towels, gowns, bed pads, lift pads, and soap were immediately purchased and distributed to every unit in adequate amounts to ensure proper and timely resident care. • Par levels of linens, towels, gowns, bed pads, lift pads, and soap were established for each unit for each shift and laundry personnel educated about the correct number of linens to supply daily based on the par levels. • Diapers, pull ups, and disposable wipes were immediately ordered and received in sufficient amounts to meet the care needs of the resident. Element Two – Identification of at Risk Residents All residents have the potential to be affected by this practice. Element Three – Systemic Changes • Laundry was outsourced due to dryer issues and the contract vendor instructed to provide sufficient linens and towels to meet the facility required par levels with additional linen as a backup. • Nursing staff were informed about the par levels to ensure they have adequate supplies of linens towels, gowns, lift pads, and bed pads to provide care to residents and the process to follow in the event they need additional linens. • Par levels of diapers, pull ups and	

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F 558	Continued From page 32 started the position in [redacted], and has received "only one" shipment of linens since then. The HD stated there were three scheduled linen deliveries to the units daily, at 7AM, 3 PM, and 11 PM. Surveyors #3 and 4 observed the facility linen delivery shipment log which revealed the last linen delivery was documented as received on [redacted]. The document further revealed that the [redacted] shipment consisted of 20 towels, 20 bed pads, 20 gowns, 20 flat sheets, 20 fitted sheets, 20 pillowcase, 20 wash clothes, and 15 bags of blankets. The HD, in the presence of Surveyor #3 & #4, proceeded to count the current linen stock which confirmed, 16 pillowcases, 4 were counted as unopened and another 12 were in a packet that was ripped open. Both surveyors observed the linen storage shelves were empty and were labeled for wash clothes, bath towels and bed pads. The HD stated that he "constantly" told the facility Administrator (LHNA) that he needed a shipment of linen supplies and he still has yet to receive anything. At 9:37 AM, the HD confirmed and acknowledged the facility did not have enough linen supplies for the residents and stated there was no system in place to account for the linens and or verify what was delivered. The HD stated he did not have an accurate number of gowns and linens he currently had in stock in the facility. - 9:45 AM, Surveyor #4 interviewed a CNA on [redacted] regarding the availability of linen on [redacted]. The CNA stated some days there was not enough linen to provide care for all of the residents. She stated there was 25 residents on the unit and she had 11 on her assignment. she stated she only used one was cloth per resident. - 9:59 AM, Surveyors #3 and 4 interviewed the	F 558	disposable wipes were established by unit by shift and nursing staff re-educated to contact the nursing supervisor in the event additional supplies are needed. • The nursing supervisor has access to extra supplies and linens towels, gowns, lift pads, and bed pads if needed beyond the par levels sent daily to the units. Nursing staff were re-educated to contact the nursing supervisor in the event additional supplies are needed. • The facility policy for provision of linens, towels, gowns, lift pads, and bed pads to meet resident care needs was reviewed and revised to reflect the inclusion of par levels to ensure adequate supplies of linens, towels, gowns, lift pads, and bed pads and personal care items including diapers, pull ups, and wipes. Element Four – Quality Assurance • A QAPI root cause analysis was conducted to determine the correct number of linens, towels, gowns, bed pads and soap required by shift to care for residents. Based on the analysis weekly audits will be conducted for three months by the housekeeping director/designee to ensure enough linens, towels, gowns, lift pads, and bed pads are available on all shifts for the provision of resident care. Findings of the audits will be reported by the housekeeping director monthly to the Administrator and quarterly in aggregate to the QAPI committee for review and further action as appropriate. • A QAPI root cause analysis was conducted to determine the correct number of diapers by size, disposable	

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F 558	Continued From page 33 Unit Manager UM/LPN, on the [redacted] Unit inside the clean utility room laundry area. The UM/LPN stated the unit received very little linens. He stated he received mainly flat sheets but needed towels for the residents. The UM/LPN took surveyors #3 and 4 into the clean utility room and he counted two fitted sheets, seven pillowcases, no blankets, no gowns, no washcloths, and no bed pads. The UM/LPN stated there was not enough linen to care for the residents. At 10:06 AM, the surveyors interviewed a CNA, who stated stated he would have to cut towels in half to make enough and split between staff. He stated he never went to another unit to get supplies because they were short there too. Surveyor #2: - 9:28 AM, Surveyor #2 interviewed a CNA on the [redacted]. The CNA stated that the [redacted] was "short" on laundry such as pillowcases, towels, and gowns and that it was "most problematic." The CNA also added that she had 5 towels for every 10 residents when she really needed 2 to 3 towels for every resident. She further added that she did report this to management but felt as though she was "talking to a wall." - 9:43 AM, Surveyor #2 interviewed a CNA on the [redacted] Unit who has been employed 5 months on the [redacted] Unit. The CNA stated that sometimes the laundry was backed up from the night before. The CNA stated it gets backed up and I have not changed anybody yet today. Surveyor #1: - 9:21 AM, Surveyor #1 interviewed a Nursing	F 558	wipes, and pull ups required by shift to care for residents. Based on the analysis weekly audits will be conducted for three months by Central Supply to ensure enough diapers by size, disposable wipes and pull ups are available on all shifts for the provision of resident care. Findings of the audits will be reported by Central Supply monthly to the Administrator and quarterly in aggregate to the QAPI committee for review and further action as appropriate.	

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Assistant (NA) on [redacted] hallway who stated she had been employed at the facility for one month. She stated that she took the NA class online. She stated that she always had issues obtaining linens and supplies for the residents. The NA added that sometimes they had issues obtaining diapers, pull-ups of different sizes, and there were no disposable wipes. She added the washcloths were scarce and that the Certified Nursing Assistants (CNAs) have used sheets, pillowcases, or other linen to wash the residents. She stated that she usually worked the 7-3 shift and had 8-10 residents a day to care for. The NA #1 accompanied the surveyor to the unit linen supply room and there were 10 sheets, 3 blankets, no washcloths and a minimum number of diapers were observed in the supply closet of the[redacted] hallway.

- 9:30 AM, Surveyor #1 interviewed a CNA employed in the facility for 17 years and worked on the [redacted] Unit. She revealed that the staff did not receive linen until 8:30 AM, and sometimes not until 10:30 AM. She also stated that they must call laundry every day to find out when the linen would be delivered. "If a resident is incontinent and we don't have linen we have to use anything that's available. Sometimes we have to cut up bath blankets or cases [pillow] to be able to wash and clean the residents." She stated that she was assigned 15 residents today and confirmed by Surveyor #1.

- 9:40 AM, Surveyor #1 continued to interview the CNA who then accompanied the surveyor to the linen supply room on the [redacted] hallway[redacted]. Surveyor #1 observed that there were no washcloths, only two towels, some sheets and approximately 5 blankets and a few diapers in the

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linen closet. At that time, the CNA stated that the staff must cut up blankets and sheets to be used as washcloths to wash the residents. She stated that there were a lot of incontinent residents on that unit that required frequent changing, but they never had enough linen or incontinent briefs. The CNA accompanied the surveyor to the supply closet and there was no soap, deodorant, or toothbrushes. "This happens every day" and she stated that the linen should be stocked before they start the day however the laundry department would tell us that they were "short handed" the night before and they didn't have any linen for us to use in the morning and stated, "this happens constantly."

- 9:55 AM, Surveyor #1 toured the [redacted] Unit interviewed the Registered Nurse (RN) who worked on the [redacted] Unit for [redacted] years part time and stated she has never seen the facility so dirty. She stated that there was a lack of paper towels, and supplies (linen, gowns, washcloths, soap). She added that the unit had enough dressing supplies and respiratory supplies and stated it was the basic care need supplies that were lacking. She stated that there was only housekeeping on the day shift, and not on 3-11 PM or 11-7 PM shifts. She further stated that the facility had only one floor tech for the entire building. The RN stated "we put in work orders in the computer and they don't respond to the work orders. We must call the front desk and then they don't show up either." She also revealed that the facility did not have enough [redacted] pads. She stated, "they go to get laundered and don't come back." The RN stated that if we don't have enough [redacted] pads, then we can't get the residents out of bed. She stated that there was a census of 10 residents however the

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residents on the [redacted]r unit all required complete care with activities of daily living (dressing, bathing, feeding and all areas of personal hygiene).

- 10:11 AM, Surveyor #1 interviewed a CNA who stated she was employed since [redacted] and worked on the [redacted] unit. She stated that she was the primary care CNA on the [redacted] unit and she was the only CNA on the [redacted] Unit for three hours that morning and had 25 residents. She stated that someday's they had more linen than other days and "if we don't have enough linen, I would go to other units to see if they had any spare linen, and then I would go down to the laundry room. Sometimes they told me in the laundry room to take the linen from the 3-11 linen carts, and then the 3-11 shift would be short linen." She stated that she addressed it with the HD and that he would try to address the issue.

10/20/21

Surveyor #3 & #4:

- 8:50 AM Surveyor #3 & #4 interviewed the HD regarding the availability of linens in the facility. The HD stated he received a shipment of linens from another facility, and an overnight shipment was placed. He further stated some linens were given and he was not sure of the exact amount. The HD escorted the surveyors to the linen storage room and proceeded to count the linens. There were nine 9 pillowcases, 20 flat sheets, no towels, and no fitted sheets. The HD brought both surveyors into the main laundry area and located on a table were 25 additional pillowcases. At that time, the HD counted the amount of linen on a

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cart that was to be sent to a unit. There was 35 pillowcases, 11 flat sheets and 3 fitted sheets on the cart. He further stated the facility census was 142 and did not offer a par for each unit, and if there was sufficient linens on the cart.

- 8:59 AM, Surveyor #4 interviewed a CNA on [redacted] The CNA stated the census was 25 on [redacted] and she had not received the linen cart yet. She stated a housekeeper came and removed the empty the linen cart at 7:30 AM and still had not returned. She further stated she has not been able to perform morning care, or get the residents out of bed because there was no linen on the unit. The CNA stated there were no towels or bed sheets either, to provide care for her assigned residents. The CNA stated there was always a shortage of linens and she worked at the facility 3 days per week. She further stated she would have to cut bath towels to provide care to the residents and there were not enough supplies to provide resident care.

- 9:13 AM, in the presence of Surveyor#4, a Housekeeper brought the linen cart to [redacted] The CNA #2 proceeded to count the linens for Surveyor #4. The linen cart contained: 10 bed pads, 6 blankets, 11 towels, 35 pillowcases (she stated that was the most she ever seen), eight (8) fitted sheets, 15 flat sheets and no resident gowns.

Surveyor #1:

- 8:50 AM, Surveyor #1 toured the [redacted] Unit, and the surveyor interviewed the Registered Nurse who stated that there was no linen on 11-7 shift. She stated that when she got report from the 11-7 nurse, the nurse told her that there was

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no linen delivered, and the nurse also reported to her that she went to the Laundry Department and no-one was working and there was no access to linen.

- 9:15 AM, the a CNA accompanied Surveyor #1 to the linen closets located on the [redacted] and [redacted] halls of [redacted] Surveyor #1 observed: 3 flat sheets, 2 towels and 2 blankets, 10 gowns on the [redacted] hall, and on [redacted] hall there were no towels or wash cloths, 5 gowns, 7 pillowcases and 3 sheets. The CNA stated that there was "hardly any linen" to change the beds or to wash the residents which was verified by Surveyor #1.

-9:25 AM, Surveyor #1 interviewed the CNA, and in the presence of the Surveyor, the CNA called to the laundry department for linen. The CNA had the laundry attendant on speaker phone and the surveyor could hear the conversation between the CNA and the laundry attendant (LA) staff. The LA told the CNA that there was no linen because "the state" shut the dryers down. The CNA then reiterated that there was no linen to wash the residents or to change the beds and the LD loudly exclaimed to the CNA "There is NO LINEN", "There is nothing I can do!" The surveyor then interviewed the LA who also confirmed that there was no linen to provide to [redacted] so that the staff could provide care to the residents.

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Surveyor #2:

- 9:04 AM, Surveyor #2 interviewed Resident [redacted] in the presence of the CNA on the [redacted] Unit. Resident [redacted] stated that [redacted] had requested

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clean clothes for over two weeks and [redacted] had not been provided them. The CNA stated she had waited for lines to be provided to complete her morning care and no pillow cases were provided.

The survey team requested a facility policy for linen regarding process and distribution.

On 10/26/21, the LHNA provided the survey team with a policy dated 07/19/21, titled [management company name] Healthcare Management, Linen-Handling of...

The policy did not reveal a process for providing a PAR linen level to ensure the units and residents were provided with the appropriate amount of linens. The policy did not reveal a process for ripping various linen items to use as wash cloths and other needed linen items when an adequate supply of linens was not provided by the facility.

The undated and unsigned facility "Admission Agreement" indicated that the facility will provide the resident with services in accordance with State and Federal regulations. Such services included: room and board, general nursing care and nursing treatments such as administration of medication, preventative skin care, assistance with bathing toileting, feeding, dressing, mobility, housekeeping services, recreational activities and social programs and certain personal care services and as may be required for health, safety, and well-being of the resident among other services.

N.J.A.C 8:39-21.3(a)(b), 21.4

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F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §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	F 584		12/28/21

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F 584	Continued From page 41 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Complaint# NJ149075, NJ149176 Based on observation, interview, and review of other facility documentation it was determined that the facility failed to a.) maintain the resident's environment, equipment and living areas in a safe, sanitary, and homelike manner. This was cited at an E level. This deficient practice was cited at a lower level at the last annual survey of 3/12/21. A plan of correction submitted by the facility at the time failed to maintain cleanliness in the facility. This deficient practice was identified for 3 of 5 units [redacted] and [redacted] Units) and was evidenced by the following: Surveyor #1 conducted a tour of the [redacted] Unit on 10/8/21 at 9:15 AM. Surveyor #1 interviewed a staff member who was sitting at the nursing station who identified herself as the LPN/UM. The LPN/UM stated that the [redacted] Unit was comprised of all [redacted] residents and some residents that had [redacted]. She stated that the census was 58 residents and that 33 of the residents ambulated independently. The LPN/UM identified the two hallways as [redacted] hallway and [redacted] hallway During the tour Surveyor #1 identified the following: 1.) Hallway floors in front of the nurse's station	F 584	F584 Element One □ Corrective Actions Court One " The handrail by the staffing office was repaired. " The handrails in the staffing hallway were repaired " The handrail near the nursing station near the double fire doors was repaired " The broken air conditioning units in the small sitting room in front of the nursing station were repaired. " The dining room wallpaper was repaired. " The ceiling tiles in the dining room were replaced and the cobwebs cleaned " The air conditioning unit in the TV room was repaired " The edges of the handrail between the janitors closet and the soiled utility room was repaired. " The call bell system in resident rooms [redacted], and [redacted] were repaired and tap bells were provided until repairs were completed. " The toilet in Room [redacted] was repaired. " The fish tank was removed. " Tap bells were provided to all residents that had call bell issues. " The toilet in room [redacted] of Resident [redacted] was repaired. The exterminator has treated the room to eliminate the flies. " The toilet in Resident [redacted] □s room	

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F 584	Continued From page 42 on the [redacted] and [redacted] hallways were sticky, dirty with brown dried substance that the staff (Housekeeping and Certified Nursing Assistant) identified as [redacted]. It appears that someone walked in the [redacted] and tracked it through the unit. There were pieces of trash, orange needle covers, tissues and cups on the floors throughout the halls. 2.) The resident bathroom that was located on the [redacted] hallway had dried feces on the toilet and cups and trash were on the floor. 3.) Room #[redacted] floor was wet with black substance and debris and tissues were on the floor. The resident was confused and laying in bed and was not able to be interviewed. 4.) Room [redacted] there were black skid marks and scuffs over the entire floor and under the beds. There were [redacted] all over the floors and walls and some trash located on the floors. The mattress on the bed was faded, ripped with foam coming out the side. The trim on the wall behind the bed was broken and coming off the walls. [redacted] were observed smeared on the walls. 5.) Room [redacted] and [redacted], the air conditioning unit covers were missing, and the inside of the air conditioning units were exposed and were full of dust and debris. 6.) Room [redacted] there was a large brown spill with dried drips running down the wall and the floor was covered in brown dried debris, food particles and red stains. 7.) Room [redacted] there were deep gouges in the	F 584	was repaired. The exterminator has treated the room to eliminate the flies. " The toilet in Resident [redacted]s room was repaired. The exterminator has treated the room to eliminate the flies. [redacted] " The [redacted] and [redacted] hallways floors in front of the nursing station and down the hallways were washed, waxed and all trash removed. " The resident bathroom in the [redacted] hallway was cleaned and trash removed from the floor. " The floor in room [redacted] was leaned and all debris discarded. " The skid marks on the floor in room [redacted] were cleaned and the walls were wiped clean. Trash on the floor was discarded. The mattress in room [redacted] was replaced. The trim on the wall behind the bed was repaired. " The air conditioner unit covers in rooms [redacted] and [redacted] were immediately replaced. " The wall and floor in Room [redacted] were immediately cleaned and all debris discarded. " The gouges in the walls in Room [redacted] & Room [redacted] were repaired. The floor in Room [redacted] was cleaned. " The gouges in the walls and the torn wallpaper in Room [redacted] were repaired. " The side rail in room [redacted] bed was repaired and the resident evaluated for the need for a side rail. " The floor and walls in Room [redacted] were immediately cleaned. " An audit of the furniture in resident rooms on each unit was completed to	

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F 584	Continued From page 43 walls and floors were dirty. 8.) Room [redacted] the walls had deep gouges. Some gouges were observed to be spackled but unpainted. 8.) Room [redacted] the walls had deep gouges and the wallpaper was torn in multiple areas. 9.) Room [redacted], the siderail at the top of the resident's bed on the left side near the top of the bed was loose and twisted. 10.) Room [redacted] the floor was dirty, discolored with scuff marks, [redacted] on the floor in multiple areas and there were [redacted] smears observed on the wall near the door. 11.) The furniture in residents' rooms such as beds, cabinets were worn, broken, chipped, and rust on the bedframes. 12.) The wallpaper located in front of the nurse's station and throughout the [redacted] and [redacted] hallways were torn and peeling off the walls. 13.) The resident's wheelchair in room [redacted] was dirty, dusty with a torn seat cushion and torn arm rest with foam coming out from the tears. 14.) Rooms [redacted] and [redacted] had broken blinds and bed sheets were being utilized as curtains. 15.) The privacy curtains in most rooms were stained, dirty and unclean. 16.) Room [redacted] had [redacted] in and around the toilet from 10/8/21 until 10/12/21. 17.) In rooms [redacted] and [redacted] the window blinds were broken and bed sheets were being utilized	F 584	immediately replace and/or repair any beds, cabinets, or bedframes that were worn, broken, chipped, or rusted. " The wallpaper in front of the nurse□s station and throughout [redacted] and [redacted] hallways that was torn, or peeling was repaired. " The wheelchair of the Resident in Room [redacted] was repaired and the cushion replaced. " The broken window blinds in Rooms [redacted] and [redacted] were replaced and the bedsheets removed. " The privacy curtains throughout the facility were cleaned and/or replaced. F584 Element One □ Corrective Actions " The toilet in Room [redacted] was immediately cleaned. " The housekeeper interviewed on [redacted] received re-education regarding their role and responsibilities for cleaning resident rooms and bathrooms and common space areas. " An audit of housekeeping equipment was completed, and all required equipment and supplies were ordered to effectively clean and carbolize resident rooms, bathrooms, and common space areas. " The resident room floors and hallways on [redacted] were all terminally cleaned and carbolized and a monthly schedule set up for stripping and waxing of all floors. " Nursing staff received re-education related to use of the TELS app for requesting work related to identified maintenance issues. Paper work orders are also available to staff to complete.	

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F 584	Continued From page 44 as curtains. On 10/8/21 at 9:30 AM, Surveyor #1 interviewed a Certified Nursing Assistant (CNA) who acknowledged the uncleanliness and unsanitary condition of the [redacted] hallways floors and resident bathroom and stated that it was the housekeeper's responsibility to clean those areas. She identified that the [redacted] dried substance that was located on the floor of the hallway was [redacted] She stated that it was there that morning and she reported it. During this interview the housekeeper for [redacted] hallways approached Surveyor #1 who conducted an interview with her at that time. The [redacted] hallway housekeeper confirmed that the hallway floors were dirty with food, debris, and [redacted] of [redacted]. She also accompanied Surveyor #1 to the resident's bathroom on the [redacted] hallways and confirmed that the toilet had [redacted] all over the seat and trash on the floor. She explained that she came in late and did not have a chance to clean the unit. She added that she used a string mop to clean the floors but that it was the floor technician's responsibility to deep clean the floor with an electric floor scrubber, but they did not have a floor scrubber at this time. She also added that any staff member could have wiped up the [redacted] that was located throughout the halls. (during the interview, Surveyor #1 observed multiple staff members walking throughout the halls and past the [redacted] that was located on the hallway floors). The housekeeper did not have an explanation about the cleanliness of the unit. On 10/8/21 at 10:15 AM, Surveyor #1 conducted a tour of the [redacted] and [redacted] hallways of the [redacted] Unit	F 584	The process for requesting work was reviewed and staff re-educated about how to request repairs or other maintenance services. " The administrator of record during the surveyor has been replaced effective 10/22/21. " [redacted] was hired to provide housekeeping oversight and supervision and assist with staff education and systems corrections. " [redacted] the aluminum cover on the double doors leading to resident rooms was repaired. " Blinds were purchased and installed in Room [redacted]. " All handrails on Hallway [redacted] and [redacted] were inspected and repaired. New end caps were ordered and are being replaced as received. " The air conditioning units in Rooms [redacted] and [redacted] were cleaned and the covers were replaced. " The electrical outlets in Rooms [redacted] and [redacted] were immediately covered. " The clogged toilet in Room [redacted] was repaired. " The mattress in Room [redacted] was replaced. " The wall and floor in Room [redacted] was cleaned " The floor in room [redacted] was cleaned " Ads have been running for housekeeping staff. In the interim additional contracted housekeeping staff were hired to clean all resident units. " Soiled linen bags were purchased and placed on all units for use by aides. " Additional housekeepers were hired	

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F 584	Continued From page 45 with the housekeeper from the [redacted] hallway and the Housekeeping Director (HD). At the time of tour, the HD could not locate the housekeeper from the [redacted] hallway. During the tour, the HD confirmed that the hallways and the resident room floors were "very, very" dirty and unsanitary. He stated that he relayed his concerns to "corporate office" that he needed the proper supplies and assistance to sanitize and scrub the floors in the halls and the resident's rooms. He stated that he only had string mops instead of microfiber mops. He said that the microfiber mops were effective at preventing cross contamination. He also added that resident rooms were supposed to be carbolized (deep cleaned), but that it has not been done for months. He said that when a resident's room was carbolized that all the furniture from the resident's room was removed, bedside curtains were cleaned and that floors were stripped and rewaxed. He revealed that this had not been done in months because he didn't have the staff to do the job and he didn't have a floor scrubber to be able to clean the floor properly. He added that the floor scrubber broke a few months ago and that he has been asking the cooperate office for a new one but has not received yet. On 10/8/21 at 10:25 AM, the Director of Nursing (DON), the Infection Preventionist (IP), the LPN/UM and the Maintenance Director (MD) accompanied Surveyor #1 to tour [redacted] unit, A and [redacted] hallways. All disciplines agreed that that they were very concerned about the cleanliness of the hallway's floors and floors in the resident's rooms. All disciplines also agreed and confirmed that the cleanliness of the floors and walls in the hallways and in resident rooms were unacceptable. The MD confirmed that the facility	F 584	for 3-11 and 11-7 shift to perform all required cleaning of resident rooms and common space areas. " Housekeeping supplies were ordered to ensure sufficient cleaning and disinfecting products are available in the facility to thoroughly clean and maintain a sanitary environment. " Laundry detergent was ordered, and par levels discussed and implemented with the vendor. Laundry is currently outsourced until the facility laundry is back in service. " Linens and towels were ordered and received and placed in use. Laundry is currently outsourced with linens and towels supplied by the vendor until the facility laundry is back in service. until the facility laundry is back in service. " An inventory of all linens was completed, and par levels were developed for all linens and towels by unit by shift. An offsite laundry service is providing all needed linens until the facility laundry is back in service. " The toilet in Room [redacted] was replaced. " The housekeeping director reviewed the laundry delivery schedule with the facility administrator and revised the schedule and linen amounts and re-educated laundry staff regarding all changes. F584 Element Two □ Identification of at Risk Residents " All residents have the potential to be affected by these practices. " Audits were conducted on all units to	

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F 584	Continued From page 46 has not had a floor scrubber, but that it was ordered. The IP stated that it was an infection control issue because of the excessive amount of fecal matter present and urine on the floor within the resident's environment posed an infection control issue. On 10/8/21 at 11:30 AM, Surveyor #1 interviewed CNA who stated that maintenance issues were reported through a computer system and the maintenance department were supposed to check the system and fix the concerns. She stated that she was unsure on how to enter the concerns in the computer system, but that she would report it to the nurse so the nurse could notify maintenance. She added that the environmental conditions on the [redacted] were "horrible" and that even when issues were reported nobody does anything about it. On 10/8/21 at 11:35 AM, Surveyor #1 interviewed the Licensed Practical Nurse (LPN) who had been employed in the facility for [redacted] years and who worked on the [redacted] Unit. The LPN stated that she reported concerns to the maintenance staff directly about the broken handrails however they don' fix them. The LPN also revealed that the resident rooms have not been carbolized for months. On 10/8/21 at 2:30 PM, Surveyor #1 interviewed the Licensed Nursing Home Administrator (LNHA). The LNHA stated that he and the Regional Directors of Operations conducted an "environmental round" together on 10/4/21. The LNHA stated that a few "dirty" rooms were identified but admitted that they did not go into all the resident rooms.	F 584	identify all areas in need of cleaning, all blinds in need of replacement, all air conditioners in need of repair, all bathrooms in need of cleaning and toilets in need of repair, all broken equipment in need or repair or replacement and all supplies needed. " Call bell audits were conducted to identify any with functional issues and provide tap bells if needed. " Blinds throughout the facility were checked to identify any in need of repair or replacement. " Side rail audits were conducted to identify any in need of repair or replacement. " Bedding was checked to identify any beds or mattresses in need of repair or replacement. " Electrical outlets and lighting fixtures were inspected to identify in need of repair or replacement. Element Three □ Systemic Changes " A room carbolization and cleaning schedule was established for each unit and staff re-educated to ensure compliance. " Par levels of supplies, all types of linens, and equipment were established, and any needed items were purchased and placed in use or are being provided by the outsourced laundry service. " Floor stripping and waxing schedules were implemented, and staff re-educated to ensure compliance. " Daily housekeeping rounds are conducted to ensure the facility is maintained in a clean and safe condition.	

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F 584	Continued From page 47 The LNHA provided Surveyor #1 with an email dated 10/5/21 at 11:13 AM from the Regional Director of Operations (RDO) and titled, "Housekeeping Rounds". The email contained the following information: 1.) Room [redacted] needs better floor cleaning. 2.) Room [redacted] needs cleaning. 3.) Room [redacted] needs to be carbolized ASAP (as soon as possible) 4.) Room [redacted] needs to be carbolized ASAP 5.) Room [redacted] total carb needs to be done ASAP 6.) Vent hallway needs to be stripped. 7.) Room [redacted] total carb needed ASAP. 8.) Room [redacted] total carb needed ASAP. 9.) Room [redacted] total carb needed ASAP. The email indicated that the work needed to be done by the end of the week, however this was not done and this was confirmed by the LNHA. The LNHA admitted that the environmental and housekeeping concerns identified by himself and the RDO were not rectified because the facility did not have the proper floor scrubber. The LNHA then provided Surveyor #1 with a receipt dated [redacted] for a floor scrubber. The LNHA could not provide Surveyor #1 with any documentation as to when the residents rooms on the [redacted] Unit were last carbolized. On 10/12/21 at 9:30 AM, Surveyor #1 interviewed the LNHA who stated that he did not have the staffing to carbolize resident rooms and stated that he was not a, "Slum Lord". He then stated that it would be important to assure that resident rooms were carbolized and deep cleaned to prevent the spread of "germs" and admitted that the rooms were dirty but did not give a detailed	F 584	" Administration conducts walking rounds a minimum of weekly with the housekeeping director/designee to inspect all facility areas including resident rooms, bathrooms, and common space areas to ensure all areas are clean and safe for use by Residents. " Cleaning and housekeeping policies were reviewed and updated as necessary, and staff received re-education as appropriate. " A new housekeeping director was hired and was trained by [redacted] who is contracted to provide oversight supervision and staff education. Element Four □ Quality Assurance " Root cause analysis was conducted and a QAPI performance improvement project team was formed to address maintenance issues. The maintenance director/designee will conduct rounds weekly and inspect the condition of furniture, handrails, blinds, call bells, and electrical outlets to identify and correct any areas in need of repairs. The results of the rounds shall be reported to the administrator weekly for three months. Quarterly the Maintenance Director will report inspection findings and actions taken to the QAPI committee for review and further direction as appropriate. " Root cause analysis was conducted and a QAPI PIP team formed to address the issue of cleanliness of resident rooms, bathrooms, and common space areas. The housekeeping director/supervisor shall conduct daily and weekly rounds for three months and report corrective actions	

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F 584	Continued From page 48 explanation as to why. He did indicate that he felt that "someone" was doing it on purpose because he did make sure that things were fixed and cleaned but had no evidence to this claim. Surveyor #1 interviewed the RDO on 10/12/21 at 9:42 AM who stated that when "environmental rounds" were conducted on 10/4/21 he provided the LNHA with a list of concerns. He could not answer as to why the environmental concerns were not fixed but felt that it was "sabotage" or "vandalism" but had no evidence to this statement. He then stated that the rooms should have been carbolized and cleaned as per the carbonization schedule and that a lack of staff was a "huge" factor as to why the environment was not clean or sanitary. He then added that it was not an excuse and that a lot of work needed to be completed in the facility. Surveyor #1 conducted a tour of [redacted] Unit on 10/18/21 at 12:31 and observed the following: 1.) The "staffing office" hallway had broken handrail. The surveyor touched the handrail, and a piece of the handrail broke off. 2.) The surveyor observed that there were multiple loose handrails in the "staffing hallway". 3.) On [redacted] the surveyor observed a loose handrail near the nurse's station near the double fire doors. 4.) Both air conditioning units were broken in the small sitting room in front of the nurse's station. 5.) The push bar on fire doors had pieces missing which exposed sharp edges on both doors. 6.) The wallpaper in the dining room was peeling off the walls, cobwebs were observed in the corners of walls and water stains were observed on the ceiling tiles.	F 584	taken because of the rounds to the Administrator weekly. Housekeeping F584 Element Three □ Systemic Change " issues will be discussed at daily operation meeting and at weekly management meetings. The Administrator will review and act upon issues reported. Quarterly the Housekeeping Director Element Four □ Quality Assurance " will report housekeeping inspection findings and actions taken to the QAPI committee for review and further direction as appropriate. " Root cause analysis was conducted and a QAPI performance improvement project team was formed to address the safety and condition of mattresses, bed frames, and side rails. A QAPI team was formed to conduct rounds and inspect the condition of beds, mattresses, and side rails to identify and correct any in need of repair or replacement. The results of the rounds shall be reported by the QAPI team leader to the administrator weekly for three months. Quarterly the Administrator will report inspection findings and actions taken to the QAPI committee for review and further direction as appropriate. " A QAPI root cause analysis was conducted to determine the correct number of linens, towels, gowns, bed pads and soap required by shift to care for residents. Based on the analysis weekly audits will be conducted for three months	

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F 584	Continued From page 49 7.) The air conditioning unit in the TV room was broken on the wall. 8.) Broken handrail with sharp edges located between the janitor's closet and soiled utility room. 9.) The call bell system was not functioning in resident rooms and bathrooms in rooms [redacted], [redacted], and [redacted] 10.) The toilet in room [redacted] was not flushing correctly. The resident in that room stated that he/she was manually pouring water down the toilet so that it would flush. 11.) The fish tank in the "staffing" hallway was without a proper filtration system. The water was stagnant and dirty with algae. There was a live fish in the tank. On 10/18/21 at 01:57 PM, Surveyor #1 interviewed the MD in the presence of the life safety surveyor who stated that the call bell system on [redacted] unit has been broken for a month due to faulty wiring in the walls. He stated that administration knew that the call light system was not working, and that the unit was not ready for residents to live there. He also stated that the Administrator was supposed to provide the residents with tap bells but does not know why he didn't provide them to the residents. On 10/08/2021 at 10:30 AM, Surveyor #3 conducted the tour after the breakfast meals and observed the following: 1.) Hall [redacted] on the [redacted] Unit ([redacted]) the double door leading to the resident rooms, the	F 584	by the housekeeping director/designee to ensure enough linens, towels, gowns, lift pads, and bed pads are available on all shifts for the provision of resident care. Findings of the audits will be reported by the housekeeping director monthly to the Administrator and quarterly in aggregate to the QAPI committee for review and further action as appropriate.. Completion Date: 12/28/21	

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Aluminum cover was missing exposing a jagged sharp edges creating a potential for injury.

2.) Observation on 10/08/2021 at 10:45 AM, Hall A revealed flooring with [redacted] stains, stained wallpaper, and furniture in disrepair.

3.) Observations on 10/08/2021 at 11: 00 AM, revealed missing blinds in room [redacted].

4.) Observations on 10/08/2021 at 11:15 AM, revealed hands rails not mounting properly on the wall. 15 of the 25 handrails on Hall [redacted] were not properly mounted to the wall. 12 of the 25 handrails were broken exposing jagged edges.

5.) Observations on 10/08/2021 at 11:30 AM, of room [redacted] and #[redacted] revealed 2 broken air conditioning. The air conditioning covers were missing, large amount of dust and debris were noted inside the air conditioning units.

6.) Observations on 10/08/2021 at 11:35 AM, of Resident rooms #[redacted] and #[redacted] revealed 2 uncovered electrical outlets.

7.) Observations on 10/08/2021 at 11:40 AM, of Resident room #[redacted] revealed a clogged toilet covered with feces. The toilet was observed in the same condition on 10/12/2021 at 08:30 AM.

8.) Observation on 10/08/2021 at 11:45 AM, revealed a discolored, torn mattress in room # [redacted].

9.) Observation on 10/08/2021 at 11:50 AM, of Resident room [redacted] revealed a [redacted] substance splattered on the wall and [redacted] substance on the floor.

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10.) Observations on 10/08/2021 at 11:55 AM, of Resident room # [redacted] a [redacted] substance on the floor.

Surveyor #3 conducted an interview with a CNA assigned to the [redacted] on 10/08/2021 at 12:05 PM who stated, "Life is nasty here. Since I start working here, no trash bag to place the dirty linen. You cannot get clean linen every day. We do not have gown or wash cloth. We had [redacted] on the floor since [redacted]. We had asked housekeeping to clean the floor, we were told , I am not assigned to this hall. We are working short of staff every day."

Surveyor #3 conducted an interview with the LPN/UM assigned to the [redacted] Unit on 10/08/2021 at 12:15 PM. The LPN/UM stated that the [redacted] had been on the floor on [redacted] Unit since [redacted]. The LPN/UM stated that the housekeeping staff were informed but she did not reach out to the Housekeeping Director (HD) for follow up.

On 10/08/2021 at 12:30 PM, Surveyor #3 observed a housekeeping staff in the soiled utility room. An interview with the staff revealed that housekeeping staff were scheduled to work the day shift only. There was no staff assigned on the 3:00 PM-11:00 PM shift. The housekeeping staff went on to state that the facility did not have the staff to perform the required cleaning. We do not have the supplies".

Surveyor #3 interviewed the HD on 10/08/2021 at 1:15 PM. The HD stated that he scheduled eight staff for work that day, but only 4 staff reported to work. The HD further stated that housekeeping

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staff were expected to clean resident rooms and common areas daily and follow a cleaning schedule. However, he indicated that staff failed to report to work almost every day. He acknowledged that the floor had not been scrubbed because the facility did not have the equipment needed to clean the floor. Upon further inquiry, the HD revealed that he did not have the staff to complete the work.

During a follow up interview on 10/08/2021 at 2:30 PM, the HD stated that he was aware of the condition of the [redacted] Unit and he kept requesting supplies from the Administrator and was left empty handed. He went on to say, "It is a travesty, imagine having a family member living in that condition. Behaviors or not the condition of the room, fully all operational things, the simple décor, cracking walls, over all the customer service. The facility needed to be staffed better. These are nursing issues, cannot speak for them".

Additionally the HD stated, "I do not have the equipment needed, such as an auto scrubber. I had asked the corporate administrator and the Administrator for an auto scrubber it falls on deaf ears. I have been told numerous times, 'We are working on it.' It had been seven weeks."

Surveyor #9 made the following observations in Room [redacted] on [redacted]

On 10/21/21 at 8:50 AM, Surveyor #9 observed Resident [redacted] sitting up in his/her wheelchair eating breakfast. The resident complained that the toilet in the room was clogged. At that time,

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the surveyor observed the toilet in the resident's room was clogged with a [redacted] and there were multiple flies flying around the toilet. Resident [redacted] further stated that every time the toilet is fixed, it breaks again. The resident also stated the toilet has been currently broken for the last one to two days and that the resident will just use the toilet even if it is clogged with [redacted] The surveyor further observed there were multiple flies flying around the resident while he/she was eating breakfast and a fly landed on his/her Styrofoam water cup. The resident stated that the flies have been in the room for about a month and that it is worse when the toilet is broken. The resident further stated that sometimes the flies land on his food.

On 10/21/21 at 8:55 AM, Surveyor #9 observed Resident [redacted] sitting up in bed. The resident stated every time the toilet is fixed, it works for a day or two before clogging again. The resident further stated the odor in the bathroom is "terrible." The surveyor then observed a fly land on the resident's forehead and the resident stated the flies have been "bad all summer."

On 10/21/21 at 9:00 AM, Surveyor #9 observed Resident [redacted] sitting on the side of bed. The resident stated he/she can't use the toilet in the room because it is broken and that he/she has to use the bathroom "across the hall" which is "very inconvenient." The resident further stated the flies are "a pain."

On 10/21/21 at 11:11 AM, Surveyor #9 observed Resident [redacted] lying in bed and a fly landed on the resident's [redacted].

On 10/22/21 at 9:08 AM, Surveyor #9 observed

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Resident [redacted] sitting up in his/her wheelchair next to the bed which had two flies on the pillows and one fly on the privacy curtain.

During an interview with Surveyor #9 on 10/21/21 at 9:05 AM, the Certified Nursing Assistant (CNA) stated she reported the broken toilet to maintenance this morning and that they should be coming down shortly to fix it. The CNA further stated the toilet gets clogged "every so often." The CNA also stated that if the toilet is clogged, they take residents into an empty resident room to use the toilet. She further stated the shower room toilet is broken so residents can't use it. The CNA also acknowledged that the unit has had an issue with flies within the last few weeks and that pest control was on the unit a couple weeks ago.

Review of the Pest Management log obtained from [redacted] revealed pest control was on the unit [redacted] and [redacted] with "No Reports" documented.

During an interview with Surveyor #9 on 10/21/21 at 11:26 AM, the Maintenance Director stated the maintenance work orders are notified through the TELS app which goes straight to the maintenance staff's phone. He further stated that [redacted] came the day prior to evaluate the toilet in room [redacted] and will be replacing it "soon."

Melody

On 10/19/21 at 9:18 AM, the laundry staff stated there was not enough supply; laundry detergent comes once a month; and there was barely enough towels and linens for the residents. Surveyor #4 observed a towel that was cut in half.

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F 584	Continued From page 55 On 10/19/21 at 9:22 AM, the HD stated since [redacted] he had only received one shipment of laundry detergent. On 10/19/21 at 9:25 AM, the HD stated there are three deliveries 7 AM, 3 PM, and 11 PM. Surveyors #3 and #4 observed the last delivery log which revealed on [redacted] there were 20 towels, 20 bed pads, 20 gowns, 20 flat sheets, 20 fitted sheets, 20 pillowcases, 20 wash clothes, and 15 bags of blankets delivered. At 9:32 AM, the HD, in the presence of the surveyors, counted the inventory in the storage room. The inventory count revealed 16 pillowcases and shelves were observed to be empty but labeled for wash clothes, bath towels, and bed pads. The HD stated he constantly told the LNHA he needed a shipment of supplies and still had not received any. The HD acknowledged there were not enough supplies for the current residents. The HD stated there was not a system in place to account for the linens or to verify what was delivered. The HD acknowledged he did not have an accurate number of gowns and linens he had in the facility. On 10/19/21 at 9:45 AM, an agency CNA, working on [redacted], stated there was always a shortage of linens. The CNA stated some days there were not enough to care for all the residents. The CNA further stated that she had 11 residents on her assignment today and only had enough to use one wash cloth per resident. On 10/19/21 at 9:59 AM, the LPN/UM on the [redacted] unit stated the unit received very little linens. He stated they receive mainly flat sheets but needed towels. The LPN/UM took the	F 584		

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surveyors into the unit clean utility room and the surveyors observed two fitted sheets, seven pillowcases, no blankets, no gowns, no washcloths, and no bed pads. The LPN/UM further stated there was not enough linen to care for the residents.

On 10/19/21 at 10:06 AM, the CNA on the Pavilion unit stated he would have to cut towels in half to make enough and split them between the staff. He stated he never went to another unit for supplies because the other units are short as well.

On 10/20/21 at 8:50 AM, the HD stated he received a shipment of linens and placed an overnight shipment. The HD stated some linens were given but he was not sure of the exact amount. In the presence of the surveyors, the HD counted the linens in the storage room. The count revealed nine pillowcases, 20 flat sheets, no towels, and no fitted sheets. In the main laundry area and in the presence of the surveyors, the HD counted 60 more pillowcases, 11 flat sheets and 3 fitted sheets. The HD stated the facility census was 142 residents.

On 10/20/21 at 8:59 AM, a second agency CNA, working on [redacted] stated she had not received the linen cart yet and that she was unable to perform morning care or get the residents out of bed yet because there was no linen on the unit.

On 10/20/21 at 9:07 AM, a third agency CNA, working on [redacted] stated she was not able to get the residents on her assignment out of bed or perform morning care yet because there were no linens on the unit. The CNA stated there were no towels or bed sheets.

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On 10/20/21 at 9:10 AM, the second agency CNA, working on [redacted] stated there was always a shortage of linens and that she worked 3 days a week. The CNA further stated she would have to cut bath towels in order to provide care to the residents.

On 10/20/21 at 9:13 AM, a housekeeper delivered a linen cart to [redacted] The second agency CNA counted the linens in the presence of surveyor #4. The linen count revealed 10 bed pads, six blankets, 11 towels, 35 pillow cases, eight fitted sheets, 15 flat sheets and no gowns.

The job description titled, "Facility Administrator" with a date of May 2020 indicated that the primary purpose of the position is to direct the day-to-day functions in the facility in accordance with current federal, state, local standards, guidelines, and regulations that govern long-term care facilities to assure that the highest degree of quality of care can be provided to residents at all times. The duties and responsibilities include the following:
-Review the policies and procedures that govern the operations of the facility.
-Review job descriptions and performances evaluations of each staff position.
-Create and maintain an atmosphere of warmth, personal interest, positive emphasis, as well as a calm environment throughout the facility.
-Make routine inspections of the facility to assure that established policies and procedures are being implemented and followed.
-Consult with department directors the operation of their departments and assist in eliminating/correcting problem areas, and/or improvement of services.

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-Assure that the building and grounds are in good repair.
-Assist the Maintenance Director in developing and implementing waste disposal policy and procedures.
-Assure that the facility is maintained in a clean and safe manner for resident comfort and convenience.
-Assure that all residents receive care in a manner and in an environment that maintains or enhances their quality of life without abridging the safety and right of other residents.

The job description titled, "Maintenance Director" and dated May 2020 indicated that the primary purpose of this position is to maintain the orderly functioning of all equipment in the facility including the kitchen, laundry, heating, air conditioning and elevators as well as purchasing the necessary supplies for repair, maintenance, and emergencies within the budgetary guidelines. The main duties include the following:
-Assure the proper maintenance and running of all electricity and plumbing in the entire building.
-Assure the proper maintenance and running condition of all equipment in the building.
-Perform all repairs that do not fall under the purview of housekeeping.
-Supervise repairs and routine maintenance of the building and all departmental equipment.

The undated "Maintenance and Repair" policy provided to Surveyor #1 on 10/12/21 at 3:46 PM indicated the following:
-existing structures should be replaced or repaired as needed.

The job description titled, "Director of Housekeeping" with a of May 2020 indicated that

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the Director of Housekeeping was responsible for planning, organizing, staffing, directing, coordinating, reporting, budgeting and physical management of the housekeeping departments employees and equipment in a way that maximum cleanliness and order throughout the building and laundry services for both resident clothing and facility linen are maintained. The HD must
- Be physically and mentally capable of performing job duties.
-Must have compassion, tolerance and understanding for the elderly.
-Update and correct personnel policies pertaining to the housekeeping and laundry staffs and submit to the Administrator for approval.
To staff and residents (at a ratio of 3:1).
-Supervise the laundry staff to ensure proper handling of isolation linen and clothing, laundering, and drying all delivered linen and clothing, proper distribution of clean clothing to residents, and proper distribution of bed linen and towels on all wings to ensure continuous service to residents.
-Implement any plan of corrections as required by state and federal surveys in the housekeeping department.
-Provide monthly, quarterly, and annual reports including recommendations for changes in center practice for the Quality Assurance and Performance Improvement Committee.

The facility policy titled, "Cleaning Methods-Housekeeping", updated on 05/17/21 indicated that the facility will develop a cleaning schedule utilizing the same procedure for rooms on isolation precautions. Clean the room thoroughly once the resident had been discharged. Terminal cleaning of the walls,

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blinds, curtains are not recommended unless they are visibly soiled. High touch cleaning surfaces will be cleaned and disinfected on a more frequent schedule compared to minimal touch housekeeping surfaces. High touch surfaces include, but are not limited to:
-bed rails
-call bells
-doorknobs
-faucet handles
-light switches
-surfaces in and around toilets in resident rooms
Cleaning of resident rooms will be performed daily to include:
-high dusting
-spot-cleaning the walls
-windows
-doors
-light fixtures
-ledges
-tables
-chairs
-beds
-call bells
-floors
-vacuuming carpets

The policy also indicated that curtains were to be cleaned on a routine basis and when visible soiled, bathrooms daily and that equipment was to be maintained in good repair.

The facility undated and unsigned "Admission Agreement" indicated that the facility would provide the resident with services in accordance with State and Federal regulations. Such services included: room and board, general nursing care and nursing treatments such as administration of medication, preventative skin

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care, assistance with bathing toileting, feeding, dressing, mobility, housekeeping services, recreational activities and social programs and certain personal care services and as may be required for health, safety, and well-being of the resident among other services.

The facility undated form titled, "Housekeeping Carbed Room Schedule" indicated that terminal cleaning of room would be done on a revolving schedule and the following cleaning would take place:
-Remove waste
-High dust
-Clean and disinfect all flat surfaces
-dust mop
-Disinfect the bathroom
-Stock supplies
-Wet mop the floor

The facility policy dated March 2016 and titled, "Bathroom Cleaning" indicated that housekeeping was to be provided with a complete outline of the equipment and supplies necessary to perform daily routine cleaning of the bathrooms. The policy specified that daily cleaning would be done to ensure optimum levels of cleanliness and sanitation, prohibit the spread of infection and bacteria and maintain the outward appearance of the facility.

NJAC 8:39-4.1 (a), 11, 12, 21.3 (a) (b), 27.2 (j), 31.2 (a-e), 31.3, 31.4 (a-f),

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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 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 interviews, review of the medical records, and review of other pertinent facility documentation, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH) a facility reportable event (FRE) for a resident that sustained a serious injury of an unknown origin. This deficient practice was	F 609	F609 Element One – Corrective Actions • Resident [redacted] no longer resides at the facility. • The investigation documents regarding the incident involving Resident [redacted] that were found by the Administrator	12/28/21

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F 609	Continued From page 63 identified for 1 of 38 residents reviewed (Resident [redacted], and was evidenced by the following: During the tour of the ventilator unit on 10/21/21 at 10:47 AM, Surveyor #2 observed Resident [redacted] lying in bed with his/her eyes opened and the resident was [redacted]. The surveyor observed that there were pillows placed beneath the resident's [redacted] (on both sides). According to the Admission Record (AR), Resident [redacted] was admitted to the facility in [redacted] with diagnosis which included but were not limited to: [redacted] Further review of the AR revealed that on [redacted], the resident's diagnosis information was updated to include an [redacted] that occurred during the resident's stay at the facility. Review of Resident [redacted] Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted], revealed that resident was readmitted to the facility from an acute hospital on [redacted]. Further review of the MDS revealed that the resident had a [redacted] required total dependence of two persons for bed mobility and transfers and had a functional impairment of the [redacted]) on both sides.	F 609	at the time of the survey were provided to the survey team noting the event should have been reported due to the nature of the injury. Based on staff interviews during the survey the location of the incident was not able to be clearly identified. • An AAS 45 reportable event form was completed and NJDOH notified of the investigation of the incident involving Resident #127. Element Two – Identification of at Risk Residents All residents who sustain injuries of unknown origin may be affected by this practice. Element Three – Systemic Changes • Staff received re-education regarding investigating and reporting of injuries of unknown origin to the NJDOH as required. • The DON and Administrator of record at the time of the occurrence were no longer employed at the facility at the time of the survey. • All incidents are discussed during morning operations meetings to ensure proper investigations are completed timely to rule out and prevent abuse or neglect and reported as required within regulatory timeframes and in compliance with facility policies. • The DON/designee/Administrator are notified immediately of any injuries of unknown origin and notifies NJDOH as required. The DON completes the AAS45 reportable event form and reviews all	

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F 609	Continued From page 64 Review of Resident [redacted]'s individualized, comprehensive Care Plan (CP) included an entry dated [redacted] which indicated that the resident had a [redacted] and [redacted] and [redacted]. Review of an entry dated [redacted], illustrated that the resident was totally dependent on staff for all ADL's (activities of daily living) and transfers via the [redacted] with a two-person physical staff assistance. Further review of the CP revealed an entry dated [redacted], which detailed that the resident had a [redacted] and was ordered a [redacted] to the affected area. Review of the Progress Notes revealed an entry dated [redacted] at 4:27 AM, written by the Registered Nurse (RN) who documented that the CNA (Certified Nursing Assistant) noted a [redacted] to Resident #[redacted] while doing care. The nurse documented that he/she was notified, and a complete assessment was done. The RN documented that there was no history of trauma and noted a [redacted] of the skin on the resident's [redacted]. Further review of the Progress Notes revealed a Post-Incident Follow-up note dated the next day on [redacted] at 10:10 PM, in which the RN documented that [redacted] were still present with swelling and the Nurse Supervisor was made aware. The RN documented that the physician was called and ordered a [redacted] of the [redacted] The Progress Notes further revealed that the the Unit Manager (UM) documented on [redacted] at 6:23 PM, that the [redacted] was	F 609	incident investigation documents to determine the cause of incidents and actions that need to be taken to prevent further incidents. Element Four – Quality Assurance Incidents are reviewed daily Monday through Friday at morning operations meetings. The DON/designee reviews incident investigations to rule out abuse and/or neglect and to ensure timely notification of NJDOH as required. Trend analysis of incidents is being conducted weekly for the next month then monthly going forward by the DON/designee. Findings are discussed with the Administrator and reported quarterly in aggregate to the QAPI committee for action as appropriate.	

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F 609	Continued From page 65 completed and showed a [redacted]. She documented that the Physician's Assistant (PA) and resident's responsible party (RP) were notified of the resident's condition and transfer, and he/she was sent to the ED (Emergency Department) for evaluation of [redacted]. Further, the PA documented on [redacted] at 12:32 PM that the resident was readmitted to the facility on [redacted] after admission to acute care hospital on [redacted] after an [redacted] of the [redacted] was ordered on [redacted] and the resident was found to have a large amount of [redacted] in the [redacted] and the [redacted] revealed an [redacted] The PA documented that the resident was treated for a [redacted]. The PA also documented that there was no clear mechanism of injury; and suspected that this may have occurred related to transfers in the [redacted] as there was no documented fall or injury within the resident record. The PA also documented that [redacted] ([redacted]) was noted on [redacted]). The PA documented that a left [redacted] was placed by [redacted] and a follow-up appointment was scheduled in one week. Further review of the Progress Notes revealed that on [redacted] at 2:01 PM, the PA documented that she awaited a full report from the ER and Administration as to the details of the even that caused the resident's [redacted] On 10/25/21 at 12:19 PM, the surveyor attempted to phone the PA who was not available for interview. On 10/22/21 at approximately 9:00 AM, the	F 609		

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surveyor requested all investigations and facility reported events that pertained to Resident [redacted] from the last quarter of [redacted] from the Licensed Nursing Home Administrator (LNHA).

On 10/25/21 at 8:45 AM, the LNHA furnished the surveyor with seven investigations dated [redacted] through [redacted]. He stated that he was not able to locate any documented evidence that the facility reported any incidents related to the resident to the NJDOH. The surveyor reviewed the information that was provided which failed to contain documented evidence that the facility reported the event to the NJDOH regarding the resident's [redacted] and [redacted] which was identified as an injury of an unknown origin.

On 10/25/21 at 11:06 AM, the surveyor interviewed the MDS Coordinator who stated that she believed that she learned that Resident [redacted] had sustained a [redacted] and learned of it in the morning Clinical Report Meeting. She stated that she spoke with the former Unit Manager (UM) who informed her that her resident had [redacted] sustained a [redacted]. She further stated that she knew that there was an investigation done and it should have been in the nursing office.

On 10/25/21 at 4:04 PM, the surveyor interviewed the former UM via telephone. She stated that an investigation into Resident [redacted] was conducted by either the former Director of Nursing (DON) or former LNHA. She stated that it was established that the resident's injury likely occurred at the [redacted] Unit due to improper [redacted] transfer when the residents [redacted] was not properly secured in the [redacted] prior to transfer. She stated

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that she was unsure how it was determined that the injury occurred in the [redacted] Unit versus the facility's [redacted] Unit where the resident resided. She stated that it was her understanding that the injury should have been reported to the NJDOH.

On 10/26/21 at 11:39 AM, the surveyor interviewed the Interim DON who stated that the nurse who noted a [redacted] on the Resident [redacted] should have called the physician for an [redacted] right away stat since the resident was not able to say what happened. She further added that, "We are here to help the residents and not to hide things."

She stated that the process for an injury of an unknown origin would include an investigation to determine if the injury was from an incident involving possible abuse. She confirmed that the facility protocol was to notify the NJDOH within two hours when a resident had a serious injury of unknown origin. She stated that a written investigation would follow and should have included a summary of the event, resident behaviors, the resident's care plan, medications, and a look-back which would have included staff interviews when a difference was noted in the resident's condition. She stated that a left humerus fracture was a major injury and the facility should have reported it to the NJDOH. She stated that she was "flabbergasted" that the injury of unknown origin was not reported. She further stated that both the former DON and LNHA were responsible.

The surveyor attempted to phone the RN for an interview on 10/26/21 at 12:23 PM but the RN was unavailable for the interview.

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On 10/26/21 at 3:02 PM, the LNHA provided the surveyor with an Incident Investigation that pertained to Resident [redacted] that was dated [redacted]. He stated that it was located within the former DON's office and he was unable to explain why he was unable to locate it previously. He stated "one hundred percent" of all injuries of an unknown origin or abuse should be reported to the NJDOH immediately or within two hours of notification. He stated that the facility would first report to the NJDOH and then investigate the incident. He was unable to provide documented evidence that it was reported to the NJDOH.

The surveyor reviewed the facility policy, "Abuse Policy & Procedure" dated 08/2014, "Accident and Incident Reports" dated 01/05, and "Abuse Investigating and Reporting" (undated policy) which revealed the following:

The facility requires that any allegations of abuse be addressed immediately in accordance with all Federal and State regulations. All allegations will be evaluated in a prompt and thorough manner.

Definitions of Abuse and Neglect:
The supervisor/Nurse Manager/Director of Nursing/designee will interview all staff who have provided care in the case of a physical injury, such as a fracture. Staff members will be asked to provide a written statement before leaving their shift.
The Director of Nursing/designee will gather supporting documentation to include the medication and treatment records, 24 hour report, History and Physical, progress notes, nurses' notes, doctors' orders, X-rays, labs, etc.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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Any injuries or bruises will be measured and documented.
The Administrator or designee will be apprised of all relevant information. The Director of Nursing /designee will then place a call to the office of the Ombudsman and the DOHSS regarding all allegations. The Medical Director will be notified of all allegations of abuse.

The Administrator/designee will be provided with the results of all the investigation within five business days.

Policy: It is the policy of this facility to document all accidents and incidents occurring to residents, employees and visitors.

Procedure: Definition of Accident/Incident is any unusual occurrence, e.g., fall or abuse. Nursing observations such as skin tear or hematoma are not unusual occurrences ...hematomas need to be documented in the interdisciplinary notes and appropriate action taken for treatment or findings.

Procedure: All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown origin ...will be reported to the facility administrator, or his/her designee to the following persons or agencies:
The state licensing certification agency responsible for serving or licensing the facility. The resident representative of record. Law enforcement officials. The residence attendant physician. The facility medical director.

Verbal or written notices to agencies may be submitted via special carrier, fax, email or by telephone. Notices will include, as appropriate: The name of the resident, The number of the

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	315280	A. BUILDING _____ B. WING _____	C 11/01/2021

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F 609	Continued From page 70 room in which the resident resides, The type of abuse that was committed for example verbal, physical, neglect, etc., The date and time the alleged incident occurred, The name or names of all persons involved in the alleged incident, What immediate action was taken by the facility. The administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five working days of the occurrence of the incidents. NJAC 8:39-43.5(a)2	F 609		
F 610 SS=D	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 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 reviews and review of pertinent documentation obtained	F 610	F610 Element One – Corrective Actions	12/28/21

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F 610	Continued From page 71 from the facility, it was determined that the facility failed to: a) thoroughly investigate an allegation of a staff-to-resident abuse in a timely manner, and b) thoroughly investigate an injury of unknown origin. This deficient practice was identified for 2 of 28 sampled residents, (Resident [redacted] and [redacted]) and was evidenced by the following: 1. During the Recertification Survey, on 10/22/2021 at 8:33 AM, the Licensed Nursing Home Administrator (LNHA) reported to the survey team that an allegation of staff-to-resident abuse occurred on [redacted] in the evening and he was not made aware until that morning. The resident involved was Resident [redacted]. The LNHA further stated that the Nursing Supervisor/Registered Nurse (RN), sent the employee home but did not report the incident immediately. He also stated that he would collect statements and report his findings to the survey team. On 10/22/2021 at 9:30 AM, the surveyor reviewed Resident [redacted]'s clinical record and according to the Admission Record (AR), Resident [redacted] was admitted to the facility with diagnoses which included but were not limited to; [redacted] The Quarterly Minimum Data Set (MDS), a resident assessment tool used to facilitate the management of care dated [redacted] reflected that Resident [redacted] scored [redacted] on the Brief Interview for Mental Status (BIMS) which indicated the resident had a [redacted] The MDS also revealed that the resident was [redacted] and could	F 610	• The incident that occurred with Resident [redacted] was re-investigated by the DON and Administrator and witness and staff statements obtained. • A late entry notation was made in Resident [redacted]s medical record by the nurse that included an assessment of the skin made at the time of the incident. • The staff involved in the incident received re-education regarding timely completion of investigation documents including written witness statements, resident assessment, and progress notes that reflects results of resident assessment, notification of responsible party and physician, and actions taken to protect the resident. • The incident that occurred with Resident [redacted] was re-investigated by the DON and Administrator and witness and staff statements obtained. The investigation documents were revised to reflect the statement of LPN who showered Resident [redacted]. Staff that provided care to Resident [redacted] on [redacted] received counseling and re-education regarding assessing residents and documenting findings when incidents occur, and completing statements as required by facility policy and regulatory requirements. • The LPN who showered the resident without assistance was counseled and re-education about following the care plan when transferring residents. • The MDS assessment of [redacted] and [redacted] for Resident [redacted] were corrected and resubmitted to accurately reflect their [redacted] status. Late entry notations	

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F 610	Continued From page 72 only [redacted] On 10/22/2021 at 8:50 AM, the surveyor along with the survey-Team Coordinator (TC) went to the unit and observed Resident [redacted] sitting quietly in the dayroom. A skin assessment was conducted by the nurse in the presence of the surveyor at 9:08 AM which revealed no redness noted on Resident [redacted] There was no entry made regarding the incident in the resident's clinical record. A review of the documents provided by the facility on 10/22/2021 revealed the following: A medical transport staff documented the following: "I was standing at door looking through window. I saw two patients standing in front of the desk bickering. The staff in pink grabbed a pt [patient] by the shirt and dragged the resident by shirt to wheelchair. [The resident] came back to desk and again she grabbed a fist full of shirt and dragged [resident] back down the hallway." A review of an undated statement from the Certified Nursing Assistant (CNA) involved with the alleged abuse revealed the following: " Resident [redacted] was bothering another resident, the other resident was getting [redacted], ...the nurse was sitting behind the desk and can vouch that the statement that was written was inaccurate. I was telling Resident [redacted] to leave the other resident alone from behind the desk. [Resident [redacted]] tried to follow the other resident again as the other resident was walking away. I grabbed [his/her] shirt sleeve and escorted [him/her] through the double door, [he/she] then	F 610	were made in Resident [redacted]'s medical record by the nurse. The care plan was reviewed and revised as appropriate. • The staff involved in the incident received re-education regarding timely completion of investigation documents including written witness statements, resident assessment, and progress notes that reflects results of resident assessment, notification of responsible party and physician, and actions taken to protect the resident. Identification of at Risk Residents All Residents have the potential to be affected by these practices. Element Three – Systemic Changes Staff received re-education related to the facility policies and regulations for conducting timely investigations to rule out abuse or neglect, obtaining witness statements, and documenting the results of resident assessment and actions taken because of an incident in the medical record including notification of the responsible party and physician, and revision as appropriate of the resident care plan. Element Four – Quality Assurance Incidents are reviewed daily Monday through Friday at morning operations meetings. The DON/designee reviews incident investigations to rule out abuse and/or neglect and to ensure timely notification of NJDOH as required. Trend analysis of incidents is being conducted weekly for the next month then monthly	

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F 610	Continued From page 73 came back and I did the same thing again only this time, I walked [him/her] all way to the other side." On 10/22/2021 at 9:30 AM, the surveyor reviewed the electronic progress notes. There was no entry made regarding the incident in the clinical record. There was no documentation that the family and the physician were contacted. On 10/25/2021 at 1:30 PM, a telephone interview with the supervisor who was on duty that day revealed that she was made aware of the alleged staff-to-resident abuse and requested a statement from the witness. She indicated that she assessed the resident but did not follow-up with any documentation. The facility protocol was for the Nursing Supervisor (NS) on duty to notify the administrator immediately. She was to collect statements from all witnesses and initiate the investigation. The NS did not report the alleged violation until the next day. The NS did not attempt to interview or assess any other residents on the involved CNA's assignment. The NS indicated that she was aware of the protocol to follow but did not follow the facility's policy. The NS further stated that she was in-serviced on abuse but could not recall the date. She also indicated that she was aware of the timeframe required to inform the LNHA of any allegation of abuse. The following entries were entered in the electronic clinical record on the following date and times regarding Resident [redacted]. A review of the Nurse's Note written on	F 610	going forward by the DON/designee. Findings are discussed with the Administrator and reported quarterly in aggregate to the QAPI committee for action as appropriate.	

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[redacted] at 15:53 [3:53 PM], indicated that Resident [redacted]'s [redacted] was made aware of the alleged incident of abuse from a staff member and that Resident [redacted] was noted to have no new injury. The note also indicated that the resident had no complaints of pain and the Medical Doctor (MD) was made aware. No new orders at this time.

A review of a [redacted] note dated [redacted] at 22:58 [10:58 PM], indicated that the resident had a [redacted] on the [redacted] and that it was acquired [i.e. hospital, in-house]. (The note did not specify where the [redacted] was acquired).

An interview on 10/27/21 at 10:10 AM, with the CNA involved with the alleged abuse revealed that she was inside the nursing station; Resident [redacted] was bothering another unsampled resident (Resident [redacted]). Resident [redacted] was getting upset and was crying. Resident [redacted] came and reported the incident and Resident [redacted] followed Resident [redacted] to the nursing station. She stated that while she was still inside the nursing station with the nurse, she grabbed the resident by the tip of the shirt near the [redacted] and escorted Resident [redacted] through the double door.

According to the CNA, the second time she did not have the time to re-enter the nursing station. The CNA told the surveyor she was at the gate when she observed Resident #[redacted] returning and was walking toward Resident [redacted]. She told the surveyor that she placed her arms under Resident [redacted] and escorted him/her to the double door to the other side. She further stated that she had been working through an agency for the facility and had never been involved in any incident.

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F 610	Continued From page 75 On 10/28/2029 at 12:30 PM, the LNHA e-mailed some documents regarding the allegation investigation, which were reviewed by the survey team. There was no statement from the nurse who witnessed the incident. According to the interview with the CNA involved in the incident, the nurse was sitting at the nursing station and observed the encounter with Resident [redacted]. There was no statement from that nurse. There were no entries in the clinical record regarding the incident. The CNA file provided by the facility signed on 1[redacted], indicated that the involved CNA received an annual in-service orientation on Elder Justice Act. There was no late entry in the clinical record regarding the Nursing Supervisor assessment. The family and the physician were notified the next day around 3:53 PM. 1.) A review of the facility's abuse policy dated 01/05 and last updated 08/2014, documented the following: Policy: this facility will not tolerate any form of resident abuse or neglect. This facility requires that any allegations of abuse be addressed immediately in accordance with all Federal and State regulations. All allegations will be evaluated in a prompt and thorough manner. Measures to reduce the likelihood of abusive behavior will be mandated from the pre-employment period throughout the employee's length of service. Abuse and neglect in-servicing will be done at least annually. The following were noted under Procedure. The RN Supervisor will contact the Director of	F 610		

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Nursing (DON) immediately upon suspicion or confirmation of abuse. If the DON is unable to be contacted, the Administrator will be contacted.
Staff members will be asked to provide a written statement before leaving their shift.
Confused residents will be interviewed with a witness present.
The DON/designee will gather supporting documentation to include the medications, and treatments 24 hours report, history and physical progress notes, nurse's notes, doctor's orders, X-rays, labs.
Any injuries or bruises will be measured and documented.
Employee statement form will be filled out completely. The employee must sign the statement notes.

An incident form will include the following information:
Name of involved resident
Date and time the incident occurred.
The circumstances surrounding the incident.
Where the incident took place.
The name (s) of those participating in the act.
Physician and family notification.
Treatment rendered.
The " Resident Interview Form" attached to the Abuse policy was not filled out and submitted with the investigation as directed in the policy. The facility's investigation included no statement from the nurse that was present at the nursing station.
On [redacted] the nurse indicated that a bruise was present on Resident [redacted], the [redacted] was not measured, an incident report was not completed.

2. On 10/19/2021 the surveyor reviewed

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Resident [redacted] clinical record. Resident [redacted] was admitted to the facility with diagnoses which included [redacted]. The quarterly MDS, revealed that Resident [redacted] was totally dependent on staff for all activities of daily living (ADL's), [redacted] referred to as cognitive status was left blank on both significant change MDS dated [redacted] and the quarterly of [redacted]. Resident [redacted] had a [redacted] According to the MDS dated [redacted] Resident [redacted] required a 2-person physical assist for surface-to-surface transfers.

On 10/22/2021 at 9:15 AM, the surveyor went to the unit and could not locate Resident [redacted]. The door was closed. The surveyor approached the Licensed Practical Nurse (LPN) and inquired about Resident [redacted]. The LPN told the surveyor that he gave a shower to Resident [redacted] this morning and the CNA dressed Resident [redacted]. The LPN informed the surveyor that Resident [redacted] was in dayroom [redacted]

On 10/22/2021 at 9:24 AM, the surveyor observed Resident [redacted] in dayroom [redacted] being assisted by a second LPN with the breakfast meal. Resident [redacted] had a short sleeve shirt on. The surveyor observed a [redacted] area which was raised on Resident [redacted]. The second LPN indicated that she was not aware of the [redacted] A CNA who was working on the unit approached the resident, looked at the [redacted] area and told the surveyor that he did not know anything about it. An interview with the first LPN revealed that he was not aware of there being a [redacted]. The surveyor accompanied the first LPN to the dayroom and

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observed the LPN observed and acknowledged the same large [redacted] and [redacted] area on the resident's [redacted]

On 10/22/2021 at 9:25 AM, an interview with the CNA assigned to Resident [redacted] revealed that she was not aware of the [redacted] The CNA further stated that when she reported to the unit this morning [referring to [redacted] Resident [redacted] was already dressed and sitting in the dayroom.

On 10/22/2021 at 9:30 AM, an interview with the Unit Manager (UM) revealed that he was not made aware of a [redacted]. The surveyor accompanied the UM who approached the resident and observed the area and acknowledged that it appeared to be a [redacted].

The surveyor reviewed the active Treatment Administration Record (TAR) for [redacted] which reflected that the skin assessment was signed by the first LPN this morning. There were no entries regarding the [redacted]. The surveyor asked the first LPN about the skin assessment. The first LPN indicated that he did not have the time to fully assess the resident. The surveyor again asked the first LPN about the shower that morning. The first LPN told the surveyor that the CNA dressed up Resident [redacted] after the shower.

That same day at 10:15 AM, the surveyor again interviewed the first LPN who assisted Resident [redacted] with the shower. The LPN told the surveyor he showered Resident [redacted] early before 7:00 AM and stated that he did not assess Resident #[redacted] for any skin abnormality. He went on to state that he did not have the time to fully assess Resident [redacted] The surveyor inquired about the transfer mode during the shower. The LPN indicated that

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F 610	Continued From page 79 he transferred the resident without assistance. On 10/22/2021 at 10:17 AM, the surveyor escorted another surveyor who observed and confirmed evidence of the [redacted] of the arm appearing to be a [redacted] Resident [redacted] could not explain what had happened and the Unit Manager indicated that he was not made aware of the [redacted] The surveyor reviewed the progress notes (PN) at 2:59 PM, there was no documentation regarding the [redacted]. The above concerns were discussed with the LNHA and the Director of Nursing (DON) that same day and the facility indicated that an investigation would follow. No further information or investigation was provided by the facility on exit day. On 10/28/2021 at 12:30 PM, the LNHA e-mailed the investigation to the TC. The surveyor reviewed the forwarded document and could not find any statement from the first LPN who showered and dressed Resident [redacted] that morning. During the second interview on 10/22/2021 at 10:15 AM, the first LPN told the surveyor that he transferred Resident [redacted] to the recliner chair without assistance. He showered the resident and transferred Resident [redacted] back to bed. He then dressed the resident and transferred the resident back to the recliner chair without assistance. None of this information was entered in the investigation. According to the MDS dated [redacted] Resident [redacted] was a two-person physical assist for surface-to-surface transfers.	F 610		

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F 610	Continued From page 80 The following entry on the clinical record dated [redacted] at 10:35 AM, indicated the following: "Note Text: Resident reported to have [redacted] on [redacted]. Supervisor notified. Resident assessed, VSS [vital signs stable]. No s/s [signs and symptoms] of pain or discomfort. [redacted] color [redacted]. MD notified, ordered [redacted]. Voicemail left for family." The surveyor reviewed the facility's policy titled, " Changes in a Resident's Condition or Status", dated 01/05 which indicated the following: Policy: Changes in a Resident's Condition or Status It is the facility policy except in medical emergencies, to notify the resident, his/her attending physician and representative (sponsor) of changes in the resident's condition and/ or status. Under procedure #5 All changes in the resident's medical condition will be recorded in the resident's medical record in accordance with the facility's charting and documentation policies and procedures".	F 610		
F 623 SS=F	NJAC. 8:39-4 (a) 12 Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's	F 623		12/28/21

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representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 11/01/2021

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) COMPLETION DATE
F 623	Continued From page 82 must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	F 623		

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F 623	Continued From page 83 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to: a.) notify the representative of the New Jersey State Long-Term Care Ombudsman about a resident's transfer to the hospital, and b.) have a facility Policy and Procedure in place for the notification of the New Jersey State Long-Term Care Ombudsman. This deficient practice was identified for 4 of 4 residents reviewed for notifications during hospitalization (Resident [redacted], [redacted], [redacted], and [redacted]). This deficient practice was evidenced by the following: A review of the progress note dated [redacted] at 4:31 PM, revealed that Resident [redacted] was sent to the Emergency Room and admitted to the hospital with a diagnosis of [redacted]). The progress notes revealed that the resident was re-admitted to the facility four days later on [redacted] during the evening shift. Further review of a progress note dated [redacted] at 1:23 AM reflected that Resident [redacted] was sent to the Emergency Room again and admitted with a diagnosis of	F 623	F623 Element One – Corrective Actions • The Office of the NJ State Long-Term Care Ombudsman was provided with notification in writing of the transfer of Resident #[redacted] on [redacted] to the hospital due to [redacted], the admission to the hospital for [redacted] on [redacted] as required by regulations. • The Office of the NJ Ombudsman was provided with notification in writing of the transfer of Resident # [redacted] on [redacted] to the hospital due to [redacted] status, the admission to the hospital for [redacted] on [redacted] as required by regulations. • The Office of the NJ State Long-Term Care Ombudsman was provided with notification in writing of the transfer of Resident [redacted] on [redacted] to the hospital then transferred to another facility after discharge from the hospital as required by regulations. • The Office of the NJ State Long-Term Care Ombudsman was provided with notification in writing of the transfer of	

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F 623	Continued From page 84 [redacted]). An additional progress note dated [redacted] written during the evening 3 PM-11 PM shift, revealed that the resident was re-admitted to the facility on that date. There was no documentation in the medical record that the New Jersey State Long-Term Care Ombudsman representative was notified in writing regarding the unplanned hospitalizations. A review of the progress note dated [redacted] at 11:41 PM revealed Resident [redacted] was sent to the hospital and admitted with a diagnosis of [redacted]. The progress notes revealed that the resident was re-admitted to the facility three days later on [redacted] during the evening shift. Further review of a progress note dated [redacted] at 9:11 AM, reflected that Resident [redacted] was sent to the hospital again and admitted with a diagnosis of [redacted]. An additional progress note dated [redacted] on the 3 PM-11 PM shift revealed the resident was re-admitted to the facility on that date. There was no documentation in the medical record that the New Jersey State Long-Term Care Ombudsman representative was notified in writing regarding the unplanned hospitalizations. A review of the progress note dated [redacted] at 3:00 PM revealed Resident [redacted] was sent to the hospital and would then be sent to another facility when discharged from the acute hospital. Further review of the progress notes reflected Resident [redacted] did not return to the facility. There was no documentation in the medical record the New Jersey State Long-Term Care Ombudsman representative was notified in writing regarding the hospitalization.	F 623	Resident [redacted] on [redacted] to the hospital with a diagnosis of [redacted] as required by regulations. • The Social Worker, Admissions Director and LNHA received re-education regarding the regulation to notify the Office of the NJ State Long-Term Care Ombudsman of all transfers and discharges from the facility per regulatory requirements. Element Two – Identification of at Risk Residents All Residents have the potential to be affected by this practice. Element Three – Systemic Changes • A Notification of the Office of the NJ State Long-Term Care Ombudsman policy was written and implemented that addresses all the regulatory requirements for providing copies of the notice of resident transfer and/or discharge and the reason for the move to the Office of the Ombudsman. Staff were educated about the policy. • The Admissions department will notify the Office of the NJ State Long-Term Care Ombudsman of all transfers and/or discharges in compliance with regulatory requirements as outlined in the policy and maintain a log of all notifications. Element Four – Quality Assurance Weekly for the next four weeks then monthly for the next three months Admissions will provide the Administrator with a copy of the Office of the NJ State Long-Term Care Ombudsman notification	

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F 623	Continued From page 85 A review of the progress note dated [redacted] at 6:27 PM revealed Resident [redacted] was sent to the hospital and admitted with a diagnosis of a [redacted]). The progress notes revealed that the resident was readmitted to the facility on [redacted] during the evening shift. There was no documentation in the medical record that the New Jersey State Long-Term Care Ombudsman representative was notified in writing regarding the unplanned hospitalization. On 10/21/21 at 12:05 PM, Surveyor #4 interviewed the Social Worker (SW) who stated she was never trained on the process of notifications to the ombudsman's office and was never told she was supposed to notify the New Jersey State Long-Term Care Ombudsman's office. During an interview in the presence of the surveyor team on 10/22/21 at 1:38 PM, the administrator (LNHA) stated that the facility did not notify the Ombudsman's office because they did not know they had to do it. He further stated, "Is it a regulation?" Adding that he was "not aware of that." During an interview with Surveyor #7 on 10/22/21 at 2:08 PM, the Admissions Director (AD) stated that she did not send notification of the discharges to the New Jersey State Long-Term Care Ombudsman's office. The AD further stated, "I have worked in nursing homes for the past [redacted] years and I have never heard of notifying the ombudsman office of transfers or discharges." During a follow-up interview in the presence of	F 623	log of all transfers and/or discharges of residents. Admissions will provide statistics in aggregate at the quarterly QAPI committee meeting for action and further guidance as appropriate.	

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F 623	Continued From page 86 the survey team on 10/22/21 at 2:54 PM, the LNHA stated that the facility did not have a policy for notification of the New Jersey State Long-Term Care Ombudsman's office for discharges. No additional documentation was provided to the survey team during the survey to refute the surveyor's findings. NJAC 8:39-4.1(a)(32)	F 623		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions.	F 636		12/28/21

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F 636	Continued From page 87 (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to complete the Comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the	F 636	F636 Element One – Corrective Actions • The annual MDS assessment for Resident [redacted] was completed and	

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F 636	Continued From page 88 management of care, in a timely manner for 3 of 36 residents (Residents [redacted] and [redacted]) reviewed for completion of MDS assessments. This deficient practice was evidenced by the following: According to the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2019, Version 1.17.1, indicated that Comprehensive Assessments (Annual) should be completed no later than 14 calendar days after the Assessment Reference Date (ARD) of the MDS. On 10/21/21, the surveyor attempted to review the MDS assessments for Resident [redacted] and [redacted], which revealed the following: A review of the MDS section of the Electronic Medical Record (EMR) for Resident [redacted] revealed that the Annual MDS on [redacted] was still "in progress." The EMR did not reflect that the facility completed the annual MDS assessment for the resident. According to the ARD, the MDS completion date should have been [redacted]. The resident's last comprehensive Annual MDS assessment was [redacted] A review of the MDS section of the EMR for Resident [redacted] revealed that the Annual MDS on [redacted] was "in progress." The EMR did not reflect that the facility completed the annual MDS assessment for the resident. According to the ARD, the MDS completion date should have been [redacted]. The resident's last comprehensive Annual MDS assessment was [redacted]. A review of the MDS section of the EMR for	F 636	submitted on [redacted] The IDT team reviewed the care plan on [redacted]. • The annual MDS assessment for Resident [redacted] was completed and submitted on [redacted] The IDT team met and reviewed the care plan on [redacted] • The annual MDS assessment for Resident [redacted] was completed and submitted on [redacted] The IDT team met and reviewed the care plan on [redacted]. • The new MDS Coordinator was provided with required education and a computer to complete MDS assessments. Element Two – Identification of at Risk Residents All Residents have the potential to be affected by this practice. Element Three – Systemic Changes • The [redacted] was contracted with the conduct an audit of all MDS assessments to identify those that were late and required completion and submission and will conduct monthly audits on an ongoing basis. • Additional MDS staff were brought in by the management company to complete all late assessments while the facility hired and trained an additional MDS coordinator. • Nursing staff received re-education regarding the requirement to complete and submit MDS assessments timely in compliance with regulations. Element Four – Quality Assurance Weekly for the next four weeks then monthly for the next three months the	

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F 636	Continued From page 89 Resident [redacted] revealed that the Annual MDS on [redacted] was "in progress." The EMR did not reflect that the facility completed the annual MDS assessment for the resident. According to the ARD, the MDS completion date should have been [redacted]. The resident's last comprehensive Annual MDS assessment was [redacted] During an interview with Surveyor #8 on 10/21/21 at 11:59 AM, the MDS Coordinator stated there are "quite a few" MDS assessments that were overdue because both MDS coordinators worked part time and were not able to complete them all in a timely manner. The MDS Coordinator stated, "The facility just hired a full-time MDS coordinator two weeks ago, who was waiting for a computer, so she can be more productive. The facility had two part-time MDS Coordinators working on the overdue MDS list until the full time MDS Coordinator can get up to speed." All overdue residents: Resident [redacted], Resident [redacted], and Resident [redacted] on the resident assessment list were "in progress" but not completed. The part time MDS Coordinator stated the facility was aware of the number of overdue residents' MDS assessments and the MDS Coordinators are trying to "catch up." The part time MDS Coordinator and the full time MDS Coordinator would do all the "overs." The part time MDS Coordinator stated, "The facility had no unit managers so the MDS assessments had been difficult to do." On 10/25/21 at 12:40 PM, Surveyor #8 interviewed the Director of Nursing (DON) about when the MDS assessments are supposed to be completed. The DON stated that the quarterly assessments should be done every three months so the facility would know what kind of skilled	F 636	MDS Coordinator will provide the DON/designee with a copy of the MDS assessment report generated by the electronic Health Record to substantiate timely completion and submission of MDS assessments in compliance with regulations. The DON/designee will provide MDS completion statistics in aggregate at the quarterly QAPI committee meeting for action and further guidance as appropriate.	

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F 636	Continued From page 90 care the residents would need. The DON stated there were "problems" with the MDS assessments; "they are quite behind." The DON stated, "We only had a part-time person working on them, but we just hired a full-time person. I just know they are catching up, I'm not aware how many are overdue. Hopefully, anytime something comes up, we're care planning them for emerging problems." A review of the facility's MDS policy, "MDS Implementation and Review" dated 1/05, reflected the following: "It is the policy of this facility to implement the Minimum Data Set (MDS) on each resident within a designated period of time. (New admissions within 14 days). To update the minimum data set every 90 days or whenever a significant change is evident., 3. Quarterly updates are to be done on residents according to current federal guidelines, and 4. Annual MDS's will completed within 7 days prior to and by the anniversary date (365th day) of the most recent full assessment." N.J.A.C. 8:39-11.1	F 636		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to accurately complete the Minimum Data Set assessment for 1 of 7 residents reviewed for accidents/falls	F 641	F641 Element One – Corrective Actions • The MDS assessment of [redacted] was corrected and resubmitted to reflect the	12/28/21

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F 641	Continued From page 91 (Resident [redacted]). This deficient practice was evidenced by the following: According to the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2019, included instructions to accurately assess falls within the Minimum Data Set (MDS) Assessments. The manual included when recording data to Section J, staff are to: "Review all available sources for any fall since the last assessment," and, "review nursing home incident reports and medical record (physician, nursing, therapy, and nursing assistant notes) for falls and level of injury." The manual further included to "Determine the number of falls that occurred since admission/entry or reentry or prior assessment and code the level of fall-related injury for each." Throughout the day on 10/25/21, the surveyor reviewed the medical record for Resident [redacted] which revealed the following: A review of the Admission Record face sheet (an admission summary) revealed that Resident [redacted] was admitted to the facility with diagnoses that included but were not limited to: [redacted] A review of the resident's Quarterly Minimum Data Set (MDS), and assessment tool used to facilitate the management of care, dated [redacted], included in [redacted] Health Conditions that the resident had one fall with injury since the last	F 641	falls experienced by Resident [redacted] on [redacted] and [redacted]. The MDS nurse who failed to properly code the MDS was counseled and re-educated. Element Two – Identification of at Risk Residents All residents have the potential to be affected by this practice. Element Three – Systemic Changes • The Charts Group was contracted with the conduct an audit of MDS assessments to identify those that were inaccurate and required modification and resubmission. The Charts group will conduct monthly audits on an ongoing basis. • Additional MDS staff were brought in by the management company to assist with MDS assessment corrections identified by the Charts Group audit. • The facility hired and trained an additional MDS coordinator who reviews MDS assessments to ensure they are accurately coded. • Nursing staff received re-education regarding the requirement to review the record during the look back period when completing MDS assessments to assure they are accurately coded. Element Four – Quality Assurance Weekly for the next four weeks then monthly for the next three months the MDS Coordinator will provide the DON/designee with an audit of 25% of MDS assessments to substantiate accurate coding in compliance with MDS	

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F 641	Continued From page 92 MDS assessment, and no other falls. (Prior to the resident's quarterly MDS dated [redacted] there was a Quarterly MDS dated [redacted] according to the MDS assessment list for 2021 pertaining to Resident [redacted]. A review of the resident's individualized, comprehensive Care Plan (CP), revised on [redacted] included that the resident was a risk for [redacted] problems, poor safety awareness, and [redacted] use. The CP also included that the resident had falls on [redacted] and [redacted] A review of a Progress Note dated [redacted] at 3:44 AM, reflected that the resident had a fall in the facility and the note included that the resident was found sitting on the floor next to the bed in the resident's room. A review of a Progress Note dated [redacted] at 11:37 PM, reflected that the resident had a second fall and included the Nurse Practitioner was notified of the resident's fall. During an interview with Surveyor #9 on 10/25/21 at 12:06 PM, the MDS Coordinator stated the information used for the MDS assessments was obtained from the resident's medical record, resident interviews, and staff interviews. The MDS Coordinator further stated that Section J was completed by the MDS nurses and that the department responsible for the section should ensure that it is coded accurately. The MDS Coordinator then reviewed Resident [redacted]s medical record and acknowledged there was documentation related to two falls on [redacted] and [redacted]. The MDS Coordinator further stated that the MDS nurse who completed the [redacted]	F 641	instructions. The DON/designee will provide MDS coding statistics in aggregate at the quarterly QAPI committee meeting for action and further guidance as appropriate.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 93 Quarterly MDS for Resident [redacted] should have coded in [redacted] that there were two falls, a fall with no injury and a fall with injury, since the last MDS assessment on [redacted] During an interview with Surveyor #9 on 10/25/21 at 12:41 PM, when asked if the MDS nurses should complete the MDS assessments accurately, the Director of Nursing stated, "I would hope that they would." No additional documentation was provided to refute the surveyor's findings prior to surveyor inquiry. The facility did not provide any additional information. NJAC 8:39-11.1	F 641		
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 §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	F 656		12/28/21

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	315280	A. BUILDING _____ B. WING _____	C 11/01/2021

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F 656	Continued From page 94 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, and record review, it was determined that the facility failed to implement Care Plan interventions to address residents with known maladaptive behaviors such as [redacted] on the floor in their bathroom and common areas of the facility. This deficient practice was identified for 2 of 38 residents reviewed for care planning (Residents [redacted], and [redacted]), and was evidenced by the following: During the tour of the [redacted] Unit on 10/18/2021, Surveyor #3 observed that the dayroom had stained flooring, [redacted] on the floor in the sunroom, [redacted] in dayroom, and [redacted] on the	F 656	F 656 Element One – Corrective Actions • Resident [redacted] was reassessed by the interdisciplinary team to determine probable causes for the behaviors of [redacted] on the floor. The care plan was reviewed, and additional specific interventions added to address the negative behaviors of [redacted] and [redacted] on the floor. • Resident [redacted] was reassessed by the interdisciplinary team to determine probable causes for the behaviors of [redacted] on the floor. The care plan was revised to include the	

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F 656	Continued From page 95 furniture. The above concerns were addressed with the nursing staff which revealed that both residents, Resident [redacted] and [redacted] shared a room and had behaviors of [redacted] and [redacted] on the floor. 1. According to the Admission Face Sheet, Resident [redacted] was admitted to the facility with diagnoses which included [redacted] and [redacted]. The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted] revealed that Resident [redacted] scored [redacted] out of [redacted] on the Brief Interview for Mental Status (BIMS) which indicated the resident had [redacted]. A further review of the MDS revealed Resident [redacted] was rarely or never understood, and could responds adequately to [redacted] communication only. Further review of the clinical record revealed that Resident [redacted] was totally dependent on staff for care. On 10/26/2021 at 10:11 AM, two surveyors observed Resident [redacted] on the floor at the entrance of the nursing station. Housekeeping was called to mop the floor, Resident [redacted] was escorted to the room for care after the episode. An interview with the nurse confirmed that Resident [redacted] had a behavior of [redacted] and [redacted] on the floor. Resident #95's Comprehensive Care Plan	F 656	problem of [redacted] on the floor and interventions were implemented to address these negative behaviors. Element Two – Identification of at Risk Residents All residents have the potential to be affected by this practice. Element Three – Systemic Changes • The report titled "Care Plan Reviews Due" in Point Click Care, the facility electronic medical record, was run to identify residents whose care plans required review. • Staff received re-education related to behavior management techniques to consider for residents who display negative behaviors. • The psychologist and/or psychiatrist treating Residents who display negative behaviors will assist nursing staff with identification of interventions that may be affective in curbing negative behaviors. Element Four – Quality Assurance Weekly for the next four weeks then monthly for the next three months the IDT will provide the DON/designee with an audit of 25% of behavioral care plans to substantiate negative behaviors are being addressed. The DON/designee will provide the behavioral care plan statistics in aggregate at the quarterly QAPI committee meeting for action and further guidance as appropriate.	

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initiated on [redacted] was reviewed. There was no identified focus/ goals or interventions related to the maladaptive behavior of [redacted] and [redacted] on the floor in the room and common areas of the facility. The behavior was not addressed in the care plan. There was no directive in place for the staff to manage the behavior.

2. Resident [redacted] shared the room with Resident [redacted] Resident [redacted] displayed behaviors of [redacted] on the floor. Resident [redacted] had a care plan that addressed the behavior as follows:

Care Plan focus area noted the following: Resident [redacted] had a behavior problem of [redacted] & [redacted] on the floor; yelling/cursing disrupting others related to [redacted], [redacted] & decreased [redacted]

The goal was: Resident [redacted] will have fewer episodes of Specify: [redacted] on the floor initiated since [redacted].

Interventions for the resident's Care Plan included:

- Resident [redacted] will have fewer episodes of Specify: [redacted] on the floor. - Anticipate and meet needs.
- Document behaviors, and resident response to interventions.
- Housekeeping to clean bathroom twice a day.
- If reasonable, discuss behavior. Explain/reinforce why behavior inappropriate and/or unacceptable.
-Praise any indication of progress/improvement in behavior.

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F 656	Continued From page 97 The Care Plan was not revised to implement specific intervention on how the behavior would be addressed. Surveyor #3 observed Resident [redacted] on the floor during meals, staff confirmed the behavior. According the Infection Preventionist the nursing staff were to initiate cleaning and call housekeeping for disinfecting the area. The care plan did not include how Resident [redacted] would be educated or redirected to curtail the behavior. There were no meaningful interventions in place for the staff to manage the behavior. The facility policy dated 01/05 and titled, "Care Plans-Comprehensive" reflected that the policy of this facility is to develop a individual and comprehensive care plan for each resident which includes measurable objectives and timetables to meet the resident's medical, nursing and psychological needs. The policy specifically indicated that in the [redacted] Unit that the team would meet and review the resident's plan of care on admission and weekly and that Care Plans were also reviewed and updated as changes in the resident's condition dictates The undated and unsigned facility "Admission Agreement" (AA) indicated that the facility would provide the resident with services in accordance with State and Federal regulations. Such services included: room and board, general nursing care and nursing treatments such as administration of medication, preventative skin care, assistance with bathing toileting, feeding, dressing, mobility, housekeeping services, recreational activities and social programs and certain personal care services and as may be required for health, safety, and well-being of the resident among	F 656		

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F 656	Continued From page 98 other services. The AA also indicated that the resident and the resident designees are encouraged to participate in the development of the resident's Care Plan. The Resident's care plan was to be developed upon admission and updated throughout the resident's stay based on the resident's medical condition and personal needs and lays out specific care and assistance to be provided to the resident by the facility's staff members. The AA specified that as the resident's wishes or needs change, the resident's care plan would be updated. NJAC 8:39-11.2e2.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the nursing staff failed to a.) document the administration of medications on the Medication Administration Record (MAR), and b.) ensure the reconciliation, accountability, and notification of the physician for the use of a floor mat. This deficient practice was identified for 3 of 5 residents, (Resident [redacted], #[redacted] and [redacted]) reviewed for documentation and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse	F 658	F658 Element One □ Corrective Actions Resident [redacted] " The LPN and RN who failed to correctly document the administration of medications on the medication administration record at the time of administration for Resident [redacted] were counseled and re-educated. Resident [redacted] The physician wrote an order for the use of floor mats at bedside when in bed on [redacted]. Staff that provide care for	12/28/21

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F 658	Continued From page 99 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 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 Resident Face Sheet, Resident [redacted] was admitted to the facility with medical diagnoses that included, [redacted] Review of the resident's Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] revealed that Resident [redacted] was identified with [redacted] with behaviors that occurred daily, needed limited	F 658	Resident [redacted] received re-education about obtaining orders prior to the use of bed mats when in bed for Residents that need them. The care plan was reviewed and includes an intervention for the use of the bed mat for Resident [redacted] when in bed. Element Two □ Identification of at Risk Residents All residents may be affected by these practices. Element Three □ Systemic Changes " Nursing staff received re-education to assure the MAR/TAR is signed for the administration of medications at the time of administration and to obtain a physician order as required for bed mats prior to their use. " A new consultant pharmacist was engaged and is auditing all charts making notations of missing signatures on the MARs or TARs as part of the monthly audits. " The policy for administration of medications was reviewed to ensure the procedure includes the requirement to sign for all medications and treatments at the time of administration. A copy of this policy is at every nursing station as a reminder. " The policy to obtain physician orders prior to the use of adaptive devices as required such as floor mats at bedside was reviewed and staff re-educated as noted above. Element Four □ Quality Assurance " Monthly for the next three months the	

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F 658	Continued From page 100 assistance from staff for Activities of Daily Living (ADLs) and identified with no impairment of upper or lower extremities. On 10/21/2021 at 10:41 AM, the Surveyor #8 reviewed Resident [redacted]s MAR for the month of [redacted]. During the review of the MAR, Surveyor #8 observed 15 signature areas on the MAR that were not completed by the Registered Nurses (RN) and Licensed Practical Nurses (LPNs) across all shifts. Resident #[redacted] medications included: [redacted] milligrams (mg) [redacted] tablet by mouth every 6 hours for [redacted] to be given at 12AM, 6AM, 12PM and 6PM. The dates and times of missing signatures were as follows: 12AM on 10/18/21; 6AM 10/18/21; 12PM on 10/6/21, 10/7/21, 10/8/21, 10/12/21, 10/13/21, 10/18/21, 10/19/21, 10/20/21; 6PM 10/1/21, 10/2/21, 10/16/21, 10/17/21, 10/20/21. [redacted] mg [redacted] tab by mouth at bedtime for bipolar disorder to be given at 9PM. The dates of missing signatures on those dates were 10/7/21 and 10/16/21. [redacted] tablet [redacted] mg [redacted] tab by mouth at bedtime (9PM). The dates for the missing signatures were 10/1/21, 10/4/21, 10/7/21, 10/19/21. [redacted] tab [redacted] mg [redacted] tablet by mouth once daily (9AM) - missing signature date 10/3/21. [redacted] mg tablet [redacted] tablet by mouth every morning and bedtime (9AM & 9PM) - missing signatures 9PM 10/1/21, 10/2/21, 10/7/21. No other documentation was observed noting why the medications were not given or signed by	F 658	DON/UM/designee will audit 10 random charts to ensure the MARs and TARs are properly completed and there are no missing signatures for ordered medications. The DON will provide the audit statistics in aggregate at the quarterly QAPI committee meeting for action and further guidance as appropriate. " Monthly for the next three months the DON/UM/designee will audit the charts of residents who sustain a fall to ensure there are physician orders for bed mats or other adaptive devices prior to their use. The DON will provide the audit statistics in aggregate at the quarterly QAPI committee meeting for action and further guidance as appropriate..	

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the nursing staff.

On 10/21/2021 at 10:58 AM, the surveyor interviewed the LPN on [redacted] who worked the day shift. The MAR was not signed for eight days of the [redacted] MAR during the day shift. The LPN stated signing the MAR indicated that a medication was given. The LPN also stated, "My job is to give the medications and sign for it. There is no reason the MAR didn't get signed, but I know I gave it to him every day. I just forgot to sign the MAR."

On 10/25/21 at 11:03 AM, the surveyor interviewed the Infection Preventionist (IP) regarding medication administration. The IP stated that she expected documentation on the MARs immediately after the resident was administered the medications. The IP stated, "If the MAR is not signed, it means you didn't give the medications. If not signed for multiple times, there needs to be a one-on-one meeting with the staff member, because it meant it was probably a routine occurrence." The surveyor informed the IP, the LPN informed Surveyor #8 she was too busy to sign the MAR after giving the medications. The IP stated, "How are you too busy to sign the MAR? It's a part of your job." The IP further stated, "Yes, she was supposed to sign the MAR. Everyone should sign the MAR immediately after giving medication, on all shifts."

On 10/26/21 at 11:17 AM, the surveyor interviewed the Interim Director of Nursing (DON) regarding medication administration. The DON stated she would expect the LPN to read the order, identify the resident, right dose, right route, then stand next to resident to make sure they take the meds and were not choking. The DON

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further stated if there were [redacted] medications given, the LPN must check to make sure the [redacted] medication was effective. After the medications were given, the LPN should sign for the medications after administration. The DON stated "If there are missing signatures, I would assume that the med [medication] wasn't given. If it isn't signed, it isn't done. If a medication error occurred, the staff would have to call the physician to let him know." The DON stated her expectation was the LPN would give the medication to the resident and sign the MAR immediately after administering the medications to the resident.

On 10/27/21 at 1:30 PM, the surveyor conducted a follow up interview with the IP regarding the LPN on the night shift who didn't sign the [redacted] 2021 MAR for Resident [redacted]. The IP stated she would be getting a statement from the LPN about why the MAR wasn't signed. The IP did not provide the surveyor with any statements from the staff regarding failure to sign the MAR.

A review of the facility policy titled, "Medication Administration - Policy and General Guidelines", dated 5/02. Under the heading "Documentation: Charting the Administration of a Medication - a. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of the medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications. Charting of medication administration shall be kept current

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and shall be completed immediately following the administration of the drug; and d. The resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration. Initials on each MAR are verified with a full signature in the space provided."

On 10/18/21 at 10:04 AM, during the initial tour, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) on the [redacted]n unit who stated she had started on [redacted]. The UM/LPN stated Resident [redacted] had a fall recently with no major injuries.

The surveyor reviewed the medical record for Resident [redacted]

A review of the Admission Record face sheet revealed the resident was admitted with diagnoses which included: [redacted].

A review of the annual MDS, dated 10/4/2021, reflected that the resident had a Brief Interview of Mental Status (BIMS) score of [redacted] which indicated the resident had [redacted]. It further reflected that the resident required extensive assistance with most activities of daily living, including transferring, dressing and toileting. In addition, in [redacted] Health conditions that the resident had two (2) or more falls since admission.

A review of the resident's individualized care plan revised [redacted], included that the resident had falls on [redacted]

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and [redacted] with an intervention which included the use of floor mats to bedside initiated on [redacted].

A review of the current physician's Order Summary Report (OSR) dated [redacted], reflected there was not a physician's order (PO) for the floor mats.

On 10/18/2021 at 10:29 AM, the surveyor observed Resident [redacted] lying in bed resting. The left side of the resident's bed was against the wall with the half side rail up on the right side. There were no floor mats (made from high-impact foam to help prevent injury from potential falls) observed in the resident's room while Resident [redacted] was lying in bed.

On 10/22/2021 at 10:58 AM, the surveyor observed Resident [redacted] in bed and no fall mats on the side of the bed.

At approximately 11:00 AM, the surveyor interviewed the UM/LPN who stated Resident [redacted] had fall mats in the room.

At approximately 11:05 AM, the surveyor interviewed the LPN, who stated Resident [redacted] never had fall mats and had not fallen recently.

At approximately 11:10 AM, the surveyor interviewed the CNA, who stated Resident [redacted] never needed fall mats.

On 10/26/21 at 12:35 PM, the surveyor observed Resident [redacted]'s bed against the wall and no floor mats in the room. Resident [redacted] was observed seated in the dayroom [redacted] in a [redacted] wheelchair. At that time, surveyor #14 interviewed

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F 658	Continued From page 105 a second CNA #2. The CNA #2 stated that she got the resident up out the bed that morning and did not see any floor mats in the resident's room. On 10/27/21 at 10:58 AM, the surveyor interviewed the UM/LPN. The UM/LPN acknowledged if there was a floor mat intervention on the care plan then the resident should have the floor mats. He stated Resident [redacted] was a high fall risk so he/she should have the floor mats while in bed. He further stated he was not familiar with any interventions put in place prior to him starting at the facility but knows since he started, Resident [redacted]s falls have been from the wheelchair and not out of the bed. The UM/LPN stated he was not sure if there was an order for the floor mats but if so, it would be on the Treatment Administration Record (TAR). The UM/LPN and surveyor #4 reviewed the TAR and the UM/LPN acknowledged there was no evidence for the reconciliation, accountability, or notification to the physician for the floor mats. On 10.27.21 at 9:53 AM, the Survey Team Coordinator (TC) requested the facility policy for the policy for "Charting and Documentation" policy. The facility did not provide the policy. NJAC 8:39-11.2(b), 29.2(d)	F 658		
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	F 684		12/28/21

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F 684	Continued From page 106 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 observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to: a.) notify appropriate personnel within the facility of a potential [redacted] b.) appropriately implement physician orders for the treatment of a suspected [redacted] diagnosis; c.) notify a resident's physician of a change in condition; and, d.) document in the resident's medical record the change in condition. This deficient practice was identified for 3 of 38 residents, (Resident [redacted] and [redacted] reviewed for quality of care and was evidenced by the following: 1. According to the Admission Record (AR), Resident [redacted] was admitted to the facility with medical diagnoses that included but was not limited to; [redacted] Review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] revealed Resident [redacted] was identified with a [redacted] and needed limited assistance from staff for activities of daily living (ADLs). The quarterly MDS further	F 684	F684 Element One – Corrective Actions • Resident [redacted] was treated with the [redacted] as ordered on [redacted] – [redacted]. The staff who failed to notify the facility IC Preventionist and follow treatment procedures for a resident with suspected scabies received counseling and re-education by the facility IC Preventionist including notification of the IC Preventionist and DON/Supervisor of a contagious infection, implementing physician treatment orders, following proper treatment procedures, and documenting actions taken in the medical record. • Resident [redacted] was treated with the [redacted] as ordered on [redacted] with good response per the physician. The staff that failed to properly document notification to the physician about the delay in receipt of the [redacted] cream and failed to follow proper procedures for a resident with suspected [redacted] received counseling and re-education by the facility IC preventionist regarding notification of the ICP and DON of a contagious infection, implementing physician treatment orders, following proper treatment procedures, and documenting actions taken in the medical record. The [redacted] appointment scheduled was canceled due to insurance	

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F 684	Continued From page 107 reflected that the resident was identified with an [redacted] impairment. On 10/22/2021 at 9:30 AM, Surveyor #8 reviewed Resident [redacted]'s progress notes which revealed a Physician's Order (PO) by the Nurse Practitioner (NP) dated [redacted], for [redacted] cream (is a medication and an [redacted]) to be applied at night and washed off eight hours later. The diagnosis for the medicated cream was [redacted]. No isolation precautions were ordered by the NP at that time. During an interview with the Infection Preventionist (IP) on 10/22/2021 at 1:53 PM, the IP stated she received a text message from the (Director of Nursing) DON on 10/22/2021 at 9:52 AM, about a resident in the facility with possible scabies. The IP showed Surveyor #8 the text message from the DON on her cell phone. The IP stated that she first became informed of the scabies diagnosis for Resident [redacted] when she received the text message from the DON. On 10/22/2021 at 2:35 PM, Surveyor #8 conducted a telephone interview with the NP about Resident [redacted] diagnosis. The NP stated no test were performed for [redacted], but it looked like a [redacted] and the diagnosis was her "best guess" based on her assessment of the resident. The NP stated the resident would have to be sent to [redacted] for [redacted] for a "definitive" diagnosis, which could take months. The NP ordered the [redacted] topical [redacted] to be applied to all body parts, use down to [redacted] as a one time dose, [redacted] hours at [redacted]. The NP stated that she discussed the treatment and order with the day shift LPN the day she	F 684	issues. Resident [redacted] was discharged to the hospital on [redacted] prior to rescheduling the [redacted] visit. • A late entry note by the LPN was entered into PCC the EHR on [redacted] at 13:01 noting that on [redacted] at 12:53 the nurse was told by the activity aide of the c/o of [redacted] by Resident [redacted] who then refused assessment indicting [redacted] had no [redacted]. No redness noted by nurse. There is follow up skilled note on [redacted] by another LPN who assessed no [redacted] or [redacted] and resident refused meds – MD aware. There is a subsequent note on [redacted] about c/o of [redacted] and offer of [redacted] refused and MD made aware. Element Two – Identification of at Risk Residents All Residents have the potential to be affected by this practice. Element Three – Systemic Changes • Nursing staff received re-education regarding notification of the physician and significant other when a resident experiences any change in condition. • Nursing staff received re-education on regarding immediate notification of the IC preventionist and the DON/Supervisor of any resident with a rash with a treatment order for suspected [redacted] or other highly contagious infection and the facility policies and protocols to be followed when treating for possible [redacted]. • The facility policies and protocols for scabies were reviewed by the Medical Director & DON and dated and signed by	

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F 684	Continued From page 108 prescribed the order. On 10/22/2021 at 2:50 PM, Surveyor #8 interviewed the LPN who stated the NP told her that the [redacted] on the resident looked like [redacted] so the NP ordered the medicated [redacted] cream to treat the resident. The LPN further stated that she faxed the physician order (PO) to the pharmacy, documented the PO in the treatment book, flagged it and passed it on to the next shift before she left work that day. The LPN also stated the resident was treated with [redacted] cream last evening at 9 PM. When the surveyor observed the Treatment Administration Record (TAR), the evening LPN didn't sign for the application of the [redacted] cream on the TAR. The day shift LPN stated that evening shift LPN said she did do the treatment but didn't sign the TAR. The LPN further stated," I did not know it was a reportable condition. I was supposed to let the IP know, but she could see the notes in my report. I should've let the IP know when the NP told me it was [redacted] On 10/25/2021 at 12:34 PM, Surveyor #8 interviewed the DON on what to do if a resident had a suspected [redacted] diagnosis. The DON stated, " I would be expected to be notified, and for the resident to be treated by the physician." The DON further stated, "I don't know anything that happened with the resident's treatment." On 10/26/2021 at 2:40 PM, Surveyor #8 received a signed TAR for Resident [redacted] treatment dated [redacted] which indicated the treatment was completed the previous evening.	F 684	the Administrator. A copy was placed in a folder on each unit for easy reference by the nursing staff. Element Four – Quality Assurance Monthly for the next three months the IC Preventionist will audit 10 random charts of Residents with reports of skin issues, to ensure [redacted] appointments are scheduled as need, documentation that the physician and IC preventionist were notified timely, and assure ordered treatments are provided per facility policies or protocols as appropriate. Findings from these audits will be reported to the DON who will provide audit statistics in aggregate at the quarterly QAPI committee meeting for action and further guidance as appropriate.	

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F 684	Continued From page 109 On 10/27/2021 9:57 AM, Surveyor #8 interviewed the day shift LPN who stated Resident [redacted] did not receive the [redacted] cream treatment for the [redacted] on [redacted] or [redacted] because it wasn't signed for on the TAR. Surveyor #8 reiterated that the LPN (from the previous day shift) said that the LPN that worked the evening shift on [redacted], performed the treatment for the resident. The LPN stated that she had spoke to the LPN who worked that evening shift on [redacted], who informed her the treatment was never done until [redacted] On 10/28/21 at 3:36 PM, Surveyor #8 received an email from the IP with LPN's statement regarding Resident [redacted] treatment. The LPN documented in the statement, "I was given report by the 7-3 nurse that the resident was seen by the NP that shift and diagnosed with [redacted]. I asked if the resident was treated and the 7-3 nurse stated, 'No the medication was ordered but isn't in yet.' I did not administer cream to the resident on [redacted] because it wasn't delivered and there wasn't any available in the building on my 3-11 shift." According to the facility policy, "PROCEDURE TO BE FOLLOWED WITH SUSPECTED[redacted] the facility had not followed any of the procedure from sections 1-6 for Resident [redacted] 2. During the tour of [redacted] Unit (identified as [redacted] unit) on 10/18/2021 at 09:30 AM, Surveyor #3 observed Resident [redacted] sitting in a recliner chair in the dayroom. The resident was screaming and continuously [redacted] his/her [redacted] On 10/19/2021, the surveyor toured the unit again and observed Resident [redacted] in bed	F 684		

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F 684	Continued From page 110 [redacted] and [redacted] all over. On 10/20/2021 at 08:45 AM, Surveyor #3 went to the [redacted] Unit. The door was closed. From the double door leading to the resident room, the surveyor could heard the resident screaming. The surveyor knocked at the door and entered the room. Resident [redacted] was covered with flies. The surveyor went to the nursing station and asked the nurse to call the Director of Nursing (DON). The surveyor accompanied the DON to the room and we both observed the flies on the resident's bed and on the resident's [redacted]. The DON stated, " I've never seen something like that." That same day, the DON delegated 2 aides from a sister facility to shower Resident [redacted] Surveyor #3 reviewed Resident [redacted]'s clinical record on 10/20/2021, which reflected that Resident [redacted] had diagnoses which included [redacted]. The Quarterly Minimum Data Set dated [redacted] (MDS), an assessment tool developed by the facility to identify resident's needs and implement care interventions, revealed that Resident [redacted] was totally dependent on staff for all activities of daily living (ADL's). Under "Section [redacted] which addressed activity of daily living indicated that Resident [redacted] required extensive assistance of staff for bed mobility and transfer. On 10/20/2021 at 09:45 AM, Surveyor #3 reviewed the shower log with the Unit Manager and according to the log Resident [redacted] was to be showered on [redacted] by the hospice aide. The Unit Manager (UM) indicated that the nurse would sign the shower log based on the schedule.	F 684		

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There was no system in place to account for the care provided by the [redacted] aide. The UM told the surveyor that the [redacted] aide left before he reported on the unit. There was no documentation from [redacted] about what care that was provided. That same day, the DON delegated 2 aides from a sister facility to shower Resident [redacted]

On 10/20/2021 at 10:15 AM, the surveyor interviewed the CNA's who reported that Resident [redacted] was cooperative with the shower and had a [redacted]. The aides also reported that Resident [redacted] were [redacted] and they applied a barrier cream.

On 10/20/2021 at 10:30 AM , the surveyor interviewed the UM regarding Resident [redacted] rash. The UM informed the surveyor that Resident [redacted] had a treatment ordered for the [redacted]. The surveyor then inquired if Resident [redacted] had been seen or evaluated by a [redacted] for the [redacted]. The UM indicated that the [redacted] had not been in the facility since the pandemic.

The surveyor further reviewed the clinical record and noted that Resident [redacted] was treated with [redacted] cream in [redacted] for a [redacted] and again, in [redacted]. According to the physician order the cream was to be applied after care. The surveyor reviewed the clinical record with the UM and could not find any [redacted] consult.

On 10/20/2021 at 12:30 PM, during a second interview with the UM, he stated that the physician was notified of the [redacted] again today. The physician wrote an order for Resident [redacted] to be treated with [redacted] cream followed with a

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F 684	Continued From page 112 [redacted] consult. The following entries were entered in the medical record, "Note Text: pt [referring to patient] seen By MD this shift for f/u [follow up] on [redacted] with [redacted] mainly on [redacted] infection-will treat with [redacted] treatment and repeat after 2 weeks,if no improvement. cont [redacted] cream bid [twice a day] for 14 days. will f/u. [redacted] eval." On 10/25/2021 at 12:46 PM, Surveyor #3 interviewed the physician regarding the treatment ordered for Resident [redacted]. The physician informed the surveyor that the facility was aware of the protocol to follow. She did not elaborate further. On 10/26/2021 at 9:57 AM, during a telephone interview with the UM, he confirmed that Resident [redacted] was being treated for a presumptive case of [redacted]. The treatment was applied on [redacted] on the 03:00 -11:00 PM shift. Resident [redacted] was showered on the morning of [redacted] The surveyor reviewed the Treatment Administration Record (TAR) and confirmed that the treatment was applied. The surveyor asked the UM if he was aware of the protocol to follow. The UM told the surveyor the treatment was applied and Resident [redacted] was showered the next day. He stated clearly that he was not aware of any protocol to follow. No directive was provided to the staff who applied the treatment. On 10/26/2021 at 11:45 AM, during an interview	F 684		

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F 684	Continued From page 113 with the IP, she indicated that she was not aware of any presumptive case of [redacted] on the [redacted] Unit. She went on to state she had the policy and the protocol to follow. On 10/26/2021 at 02:07 PM the IP provided an undated policy titled, "[redacted] Policy." The following were noted: Prophylactic [redacted] Treatment X 1 [redacted] Lotion [redacted] apply on entire [redacted] for 10 min. only then rinse off) including [redacted] at HS (night) after a shower. Shower prior to tx[treatment] is to remove body lotion applied. Shower 8 hours after. Wear gloves and gowns during close contact with resident, clothing or bed linens, and during treatment period. All personal clothing's linens and privacy curtains will be laundered by outsource only during the treatment period. Non washable items can be sealed in plastic bags for a period of 7-14 days to [redacted] the [redacted] Prophylactic treatment to a suspicious resident will include his/her roommate (s) and environmental cleaning of treated residents. Social worker will be assisted by unit nurses in notifying the resident's families/ responsible party to explain the treatment and environmental cleaning, including the laundry of personal clothing.	F 684		

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Infection Control Nurse will inform ancillary departments on start date and end date of quarantine.

This above protocol was not followed as the staff were not aware on how to proceed with the treatment. The IP was made aware only after the treatment had been applied.

3. On 10/20/2021 at 9:58 AM, Surveyor #5 observed Resident [redacted] was visibly [redacted], and the resident stated both of his/her [redacted].

On 10/20/2021 at 10:37 AM, Surveyor #4 observed Resident [redacted] in the activities room with Activities Aide (AA) #1. The resident was touching his/her [redacted] and their [redacted] were visibly [redacted]. Resident [redacted] then told AA #1 that his/her [redacted] were burning. AA #2 asked the resident if he/she notified the nurse and the resident stated, "no." AA #2 left to find the nurse but came back stating she could not find the nurse. Resident [redacted] then told Surveyor #4 that his/her [redacted] started to [redacted] that morning.

During an interview with Surveyor #9 on [redacted]0/21/21 at 12:46 PM, AA #1 stated Resident [redacted] complained of his/her [redacted] hurting the day prior and that AA #2 notified the nurse that same day.

On 10/22/21 at 8:58 AM, Surveyor #9 observed Resident [redacted] sitting up on the side of the bed eating breakfast. The resident stated that both of his/her [redacted] and was unsure if the physician assessed him/her.

During an interview with Surveyor #9 on 10/22/21 at 10:50 AM, AA #2 stated that two days prior,

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Resident [redacted] entered the activities room and complained that his/her [redacted]. AA #2 further stated that after receiving the complaint, she notified the nurse.

During an interview with Surveyor #9 on 10/22/21 at 12:05 PM, the Licensed Practical Nurse (LPN) stated that if a resident had a change in condition, she would assess the resident, notify the physician, and document the change in condition. The LPN further stated that on 10/20/2021, the AA notified her that the resident's [redacted] so she attempted to assess the resident, but the resident refused. The LPN also stated that she did not document the encounter in the resident's medical record because she was pulled to work another floor and that the physician was probably not notified. The LPN further stated that the resident's complaint should have been documented in the medical record.

During an interview with Surveyor #9 on 10/22/21 at 12:26 PM, the Infection Preventionist (IP) stated that if a resident had a change in condition, the nurse should assess the resident and notify the physician for any new orders. The IP further stated that the nurse should document the resident's change in condition and the physician's response.

During an interview with Surveyor #9 on 10/22/21 at 1:21 PM, the interim Director of Nursing (DON) stated that if a resident had a change in condition, the nurse should notify the physician and document the encounter. The DON further stated that "if it is not documented, it is not done."

During a follow-up interview with Surveyor #9 on 10/26/21 at 11:27 AM, the DON stated that if a

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F 684	Continued From page 116 resident with a change in condition refused an assessment by the nurse, the nurse should still notify the physician. The DON further stated that the nurse should document all resident refusals. Review of the facility's Changes in a Resident's Condition or Status policy, dated 1/2005, included, "it is the policy of this facility, except in medical emergencies, to notify the resident, his/her attending physician and representative (sponsor) or changes in the resident's condition and or/status" and, "All changes in the resident's medical condition will be recorded in the resident's medical record." NJAC 8:39-27.1 (a)	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced	F 688		12/28/21

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F 688	Continued From page 117 by: Based on observation, interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure that residents with decreased range of motion and mobility received prescribed treatments to prevent contractures. This deficient practice was identified for 1 of 2 residents, (Resident [redacted]) reviewed for decreased Range of Motion and Mobility and was evidenced by the following: During the tour of the [redacted] Unit on 10/21/2021 at 9:49 AM, Surveyor #2 observed Resident [redacted] lying in bed asleep. Surveyor #2 observed that the resident's [redacted] were clenched [redacted]). Surveyor #2 did not observe [redacted] or [redacted] in the resident's room. Surveyor #2 interviewed the Registered Nurse (RN) who was present outside of the resident's room at that time. She stated that the resident was in a [redacted] state, wore [redacted] for a couple of hours per day and required [redacted] ([redacted] assistance to transfer out of the bed. According to the Admission Record Resident [redacted] was admitted to the facility in [redacted] of [redacted] with diagnoses which included but were not limited to: [redacted]). Review of Resident [redacted]'s annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted], revealed that the resident was [redacted] impaired, was totally dependent for	F 688	F688 Element One – Corrective Actions • The palm guard for the left hand and the hand roll for the right hand were placed on Resident [redacted] Nursing staff who failed to put the required hand roll and palm guard on Resident [redacted] were counseled and received re-education about using ordered [redacted], and [redacted] as ordered by the physician to prevent contractures. Instructions for the use of the palm guard was added to the CNA POC in the EHR. On 12/2/21 the use of the handroll was discontinued. Element Two – Identification of at Risk Residents All residents that are at risk for contractures have the potential to be affected by this practice. Element Three – Systemic Changes • Nursing staff received re-education about the use of [redacted], [redacted], and other devices as ordered by the physician to ensure residents with decreased range of motion and mobility receive prescribed treatments to prevent contractures. • Therapy evaluates the use of adaptive devices to prevent [redacted] quarterly or more often as needed and provides staff education whenever a new device is ordered. Element Four – Quality Assurance The Unit Manager/charge nurse conducts daily rounds to monitor residents with	

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F 688	Continued From page 118 activities of daily living with assistance of one staff member and was totally dependent for bed mobility and transfers with two staff member assistance. Further review of the MDS indicated that the resident had functional limitation in range of motion in [redacted]). Review of Resident [redacted] s Care Plan revealed an entry dated [redacted], indicated that the resident had increased tightness [redacted] in the [redacted] and tended to keep [redacted] and [redacted] and was at high risk for [redacted] and was recommended to have [redacted] (a permanent tightening of the [redacted], [redacted]) management (revised on [redacted]). The related interventions included the use of a [redacted] to the [redacted] at all times except for hygiene and exercise with skin checks and a [redacted] for six hours in the AM as tolerated with skin checks. Review of the [redacted] Physician's Order Form revealed that on [redacted], an order was placed for a [redacted] to [redacted] at all times except for hygiene and EXS [sic.]. On [redacted] an order was placed for a [redacted] to the [redacted] for six hours at [sic.] in the morning as tolerated. On 10/22/2021 at 9:48 AM, Surveyor #2 observed Resident [redacted] lying in bed asleep. Surveyor #2 observed that the resident did not have a [redacted] on the [redacted] or a [redacted] on the [redacted]	F 688	orders for [redacted] and other devices to ensure they are used as ordered to prevent [redacted]. Weekly for three weeks then monthly for the next three months the Nursing Supervisor/designee will conduct random rounds to check Residents with orders for [redacted] and other devices to ensure they are used as ordered to prevent [redacted]. Findings of these audits will be reported to the DON who will provide audit statistics in aggregate at the quarterly QAPI committee meeting for action and further guidance as appropriate.	

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F 688	Continued From page 119 At 9:52 AM, Surveyor #2 interviewed the Certified Nursing Assistant (CNA) who stated that Resident [redacted] care entailed mouth care, full body wash, lotion, and a clean gown. She stated that the resident was required to wear [redacted] around the clock, and they were only removed during care. She stated that the resident had not had them on since [redacted], when they were sent to the laundry to be washed. She further stated that the resident had a new [redacted] in the drawer and she did not put it on the resident because the resident was supposed to have two of them on, not one as the resident should have worn them [redacted] She stated that the purpose of the [redacted] was to prevent [redacted] and to prevent the resident's [redacted] from cutting into his/her [redacted]. She further stated that she was not required to document [redacted] use, it was just part of the resident's daily ritual. At 9:56 AM, Surveyor #2 interviewed the RN who stated that Therapy told nursing that Resident [redacted] should have [redacted] on. She stated that she last saw the resident wearing them on [redacted]. She stated that [redacted] Use was not ordered on the Medication Administration Record (MAR) or Treatment Administration Record (TAR) and was not required to be signed out as administered. Surveyor #2 requested to view the resident's MARS/TARS which the RN provided. Surveyor #2 reviewed the TAR in the presence of the RN and noted the following orders: [redacted] to [redacted] at all times except for hygiene and EXS start [redacted] and [redacted] to the [redacted] for [redacted] at [sic] AM as tolerated start on [redacted]. Surveyor #2 noted that the [redacted] was signed out on the 7-3 shift and 3-11	F 688		

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F 688	Continued From page 120	F 688		

shift through [redacted] and the 11-7 shift was left blank on [redacted] The [redacted] was signed out to be placed on the resident at 8 AM and removed at 2 PM through [redacted]. When interviewed, the RN stated that the signatures (initials) that were documented on the TAR were not hers. Surveyor #2 reviewed the back of the TAR in the space provided for both initials and signature identification which was blank. The RN showed the surveyor a copy of the resident's MAR and stated, "See, this is my signature." The RN was unable to state why the TAR entries were signed out on [redacted] by someone other than herself. She further stated that she needed to make sure that the resident's [redacted] were on going forward.

At 1:18 PM, Surveyor #2 interviewed the Occupational Therapist (OT) who stated that she worked at the facility since [redacted] and was not familiar with Resident [redacted] She reviewed the resident's therapy notes in the presence of the surveyor and stated that the resident was seen by OT from [redacted] through [redacted] for [redacted] related to [redacted] and recommendations were made for the resident to wear [redacted]. She stated that the resident was discharged from therapy on [redacted] with recommendations for a [redacted] in the [redacted] for [redacted] hours except for with care and a [redacted] was to be worn on the left around the clock except for during hygiene. She stated that if a [redacted] were not available staff were permitted to use [redacted] instead. She stated that the [redacted] was made of [redacted] and was secured to the [redacted] with [redacted] and was utilized when a [redacted] was present. She further stated that a

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F 688	Continued From page 121 [redacted] and a [redacted] may be used interchangeably, and staff should have been in-serviced on usage. On 10/22/2021 at 1:27 PM, Surveyor #2 interviewed the Director of Rehabilitation who stated that staff were able to call down to the Therapy Department to request replacement [redacted] and [redacted] if the residents were lost or missing. She stated that Resident [redacted] was evaluated by therapy quarterly, annually and as needed if a concern was identified by nursing. She provided Surveyor #2 with a copy of a staff in-service that was conducted with the former [redacted] RN Unit Manager and a facility RN on [redacted]. On 10/25/2021 at 9:35 AM, Surveyor #2 observed Resident [redacted] lying in bed and the resident had a [redacted] on the [redacted] and a [redacted] on the [redacted]. The surveyor reviewed the Rehabilitation policy, "Splinting Number: 5:08" (undated) which revealed the following: ...Nursing, patient or care giver to alert rehab department if there is a need to readjust wear schedule or if splint needed ... NJAC 8:39-27.2(m)	F 688		
F 689 SS=L	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	F 689		12/28/21

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F 689	Continued From page 122 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint # NJ 149075 Part A. Based on observation, interview, record review, and review of other pertinent facility documentation, 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 a.) ensure all hallway handrails (used by residents as mobility enablers and assist with ambulation or standing) were securely mounted to the walls for 15 of 25 handrails on the [redacted] Unit, and ensure hallway handrails were in good repair and free from sharp, jagged edges with exposed nails and missing pieces for 26 of 50 handrails on the [redacted] Unit, exposed nails on a piece of wood located within a handrail located on the [redacted] Unit, and improperly secured and loose handrails identified on 3 of 5 resident units ([redacted] Unit, #[redacted] Unit and [redacted]), b.) ensure that electrical outlets were covered with outlet covers in 6 of 6 resident rooms (rooms [redacted], [redacted], and [redacted], and an appropriate cover protected a bathroom light fixture to prevent exposed live wires (identified in 1 of 36 resident rooms, room #[redacted] on, 1 of 5 units ([redacted] Unit). The facility's failure to provide securely mounted handrails in good repair, free of jagged edges, missing pieces, and free of exposed nails on	F 689	F689 Element One – Corrective Actions Part A – IJ Removal Actions • Handrails on [redacted] identified by surveyors including 15 of 25 hallway handrails were securely fixed to the wall. • Handrails on [redacted] identified by surveyors including 26 of 50 hallway handrails exposed nails, and missing pieces were repaired. • Handrails on [redacted] unit, [redacted] unit and the [redacted] identified by surveyors that were improperly secured or had wood within the handrail were repaired. • Handrails by the Medical supply room by resident room [redacted] was secured to the wall. • The loose corner handrail by Resident Rooms [redacted] was secured to the wall. • The top protective cap of the handrails by Resident rooms [redacted] was repaired. • The handrail by room [redacted] on [redacted] was repaired. • The handrail by the staffing office, by the fire door at the nurses station, and in between the janitors closet were repaired • The push panic bar on the fire doors were repaired. • Covers were placed on electrical	

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F 689	Continued From page 123 wood located inside a handrail, posed a serious and immediate threat to the safety and wellbeing of all residents who resided in the facility. A serious adverse outcome was likely to occur/occurred as the identified non-compliance resulted in an Immediate Jeopardy (IJ) situation that was identified on 10/08/21 at 5:00 PM. It was also identified that the IJ situation began on 07/18/21, when a resident sustained a fall due to a broken handrail on the [redacted] unit, which remained in disrepair. The facility submitted an acceptable removal plan via electronic mail (e-mail) on 10/22/21 at 5:38 PM. The removal plan was verified by the survey team during a removal plan revisit on 11/1/2021. See Example 1. Part B Based on observation, interview, record review, and review of other pertinent facility documentation, 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 c.) ensure that 2 supply closets containing hazardous materials were securely locked and free from the likelihood of resident access. The two supply closets were observed to be in unsafe, unsanitary conditions and contained items that would be detrimental to the health and safety of the residents for 2 of 25 residents (Resident [redacted] and [redacted]), who were [redacted] and ambulated independently on the [redacted] unit, and d.) consistently implement fall interventions per a	F 689	outlets in resident Rooms [redacted] and [redacted] • Light fixture covers were replaced in resident bathroom [redacted] on [redacted] • The unit manager LPN received education regarding how to use the computer TELS system to report maintenance issues. Part B - IJ Removal Actions • Supply closets with hazardous materials were securely locked on [redacted] to protect residents in Rooms [redacted] & [redacted] and any other resident who may be [redacted] impaired. • The supply closet on [redacted] was cleaned and all trash properly discarded, supplies properly stored, air conditioning unit repaired, sharp metal objects discarded, and all other items properly stored. • The [redacted] disinfectant cleaner was properly stored and all trash and debris on the floor discarded • The door to the housekeeping closet on the [redacted] unit by Room [redacted] had a self-closure mechanism and new lock installed on the door and the room was cleaned and content properly stored. • The door to the soiled utility room on the [redacted] unit had a self-closure mechanism and new lock installed on the door and the room was cleaned and content properly stored. • The bathroom door on the [redacted] unit had a self-closure mechanism and new lock installed on the door and a sign noting staff bathroom only placed on the door.	

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F 689	Continued From page 124 resident's care plan, complete an incident report and documentation per facility policy for a resident with a history of [redacted] and who sustained a fall (Resident [redacted]). The facility administrator was made aware of the immediate jeopardy (IJ) related to the unsecured supply closets on 10/19/2021, a removal plan was submitted on 10/20/2021 and verified by the surveyors on 10/20/2021. See Example 1. Part C Based on observation, interview, record review, and review of other pertinent facility documentation, 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 e.) ensure a safe environment for residents throughout the facility when an active gas leak was identified in the facility laundry room. The faulty ill-maintained conditions of the dryers in combination with the active gas leak posed a serious and immediate threat to all residents who resided in the facility. This resulted in an Immediate Jeopardy (IJ) situation that began on 10/19/21 at 9:10 AM and continued until 10/19/21 at 10:15 AM, when the gas company responded and subsequently issued a violation. See Example 1. PART D	F 689	• Fall interventions were reviewed and staff re-educated to minimize the risk of falls for Resident [redacted]. • Staff were re-educated about proper completion of incident reports and documentation per facility policy when a resident sustains a fall (Resident [redacted]) Part C - IJ Removal Actions • The gas company was immediately called to the facility and shut the gas to the valve in the laundry room to a dryer which was not in service at the time of the leak. All other valves were checked by [redacted] who verified there were no other gas leaks. • All dryers were taken out of service and the laundry shut down with all linens and personal clothing outsourced until the new dryers were received and installed. F689 Element One – Corrective Actions • Laundry staff received re-education about properly cleaning debris and lint between each dryer load to ensure safe and proper functioning. Currently all laundry is outsourced to a vendor pending reopening of the facility laundry. Part D - IJ Removal Actions • In the med room on [redacted] the two knives were immediately removed and returned to the kitchen and the belts were discarded . • The hole in the med room door on [redacted] was immediately repaired and a self-closure mechanism and new lock placed on the door. • The door to the soiled utility room on the [redacted] unit had a self-closure mechanism and new lock installed on the	

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F 689	Continued From page 125 Based on observation, interview, record review, and review of other pertinent facility documentation, 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 f.) securely safeguard hazardous materials, chef knives, over-the-counter medications, and potentially dangerous equipment (self-closing door device) and devices (belts) from vulnerable and ambulatory residents by ensuring a functional locking mechanism was installed, maintained, or utilized on the respective doors to keep residents safe and free of serious injury, harm, impairment, or death, on 3 of 5 units ([redacted] and [redacted] Unit). The facility's failure to identify the environmental hazards posed a serious and immediate threat to the safety and wellbeing of all residents residing on the identified units. A serious adverse outcome was likely to occur as the identified non-compliance was occurring on a unit identified as having residents diagnosed with [redacted] or [redacted] diagnoses, who were also able to ambulate independently around the unit. This resulted in an IJ situation that began on 10/24/21 when the Two (2) knives were observed in the unsecured drawer in the unlocked Medication Room. The IJ continued facility alleged complete implementation of the elements of their removal plan accepted on 10/29/21 and verified by the survey team. The facility administration was notified of the Immediate Jeopardy situation on 10/24/21 at 4:00 PM. The facility failed to securely safeguard hazardous chemicals, chef knives,	F 689	door and the metal was discarded and content properly stored. Part A – Continuation • The care plan and Aide Kardex for Resident [redacted] was reviewed and revised to reflect updated interventions to minimize the risk of falls. Staff that provide care for Resident [redacted] received re-education regarding the care pan and Kardex changes. • Staff received re-education about the procedure to document in the medical record assessment findings after a resident experiences a fall or other incidents, notification of the physician and responsible party and documentation of same in the medical record and how to complete an investigation including obtaining written statements and completing investigation documents. Element Two – Identification of at Risk Residents Part A All residents have the potential to be affected by these practices Part B All residents have the potential to be affected by these practices Part C All residents have the potential to be affected by these practices Part D All residents have the potential to be affected by these practices Element Three – Systemic Changes Part A - IJ Removal Actions • Facility-wide audits were conducted to	

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F 689	Continued From page 126 over-the-counter medications, and potentially dangerous equipment (self-closing door device) and devices (belts) from vulnerable and ambulatory residents by ensuring a functional locking mechanism was installed, maintained, . After consultation with the office, it was determined that an Immediate Jeopardy (IJ) situation was identified on 10/24/2021 at 4:00 PM. An acceptable removal plan was received on 10/27/21 (for hazardous knives) and the removal plan was verified onsite on 10/29 /21. See Example 1. The evidence is as follows: Part A 1. On 10/08/21 at 9:15 AM, Surveyor #1 conducted a tour of the [redacted] Unit. Surveyor #1 interviewed a staff member who was sitting at the nursing station who identified herself as the Licensed Practical Nurse Unit Manager (LPN/UM). The LPN/UM stated that the [redacted] Unit was comprised of residents who had [redacted] (a cognitive impairment) and some of the residents had behavioral disturbances that were related to the [redacted]. The LPN/UM stated that the current resident census was 58, and 33 of the 58 residents ambulated independently on the unit. Surveyor #1 observed the following: a. Resident room: [redacted], and [redacted] had uncovered exposed electrical outlets that were accessible to residents. b. Resident room [redacted] had an uncovered	F 689	identify all handrails on all resident units that needed repair or replacement parts. Parts were ordered and in the interim repairs were made to prevent resident injury. • Staff received re-education about reporting any loose handrails or unsafe handrails to their supervisor and creating a work order for maintenance for immediate repair. Part B - IJ Removal Actions • Facility-wide audits were conducted to identify all closet doors hazardous materials stored inside had new locks and self-closure devices installed on all units including [redacted], and [redacted] • Staff received re-education about properly closing and locking all closet and utility storage doors where hazardous items are stored to prevent resident access. • Facility-wide audits were conducted to identify all missing outlet covers on all units including [redacted], and [redacted] and missing covers were replaced. F689 Element Three – Systemic Changes • Facility-wide audits were conducted to identify all missing bathroom light fixture covers on all units including [redacted], and [redacted] and repairs were completed. • Maintenance rounds are conducted daily and checking outlet covers and light fixtures was added to the checklist. Part C - IJ Removal Actions	

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F 689	Continued From page 127 bathroom electrical light fixture with exposed electrical wires which were at the ground level and accessible to vulnerable residents. c. The hallway [redacted] and hallway [redacted] on the [redacted] unit had 15 of 25 handrails that were observed as being loose and were not securely mounted to the walls and some of the handrails were observed as hanging off of the wall; and 26 out of 50 hallway handrails were broken with sharp, jagged edges, and missing pieces with exposed nails. At that time, the surveyors observed multiple residents ambulating through the halls and using the handrails as enablers for ambulation. On 10/08/21 at 9:30 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated that she was assigned to provide care to the residents in rooms [redacted] through [redacted]. She stated that if she noticed any maintenance issues that she would report concerns to the nurse so that the nurse could notify the maintenance staff. She added that she was unaware that electrical outlets in rooms [redacted] and [redacted] needed to be covered and stated that she did not report it because she was not aware. She stated that the uncovered light fixture in room [redacted] had been that way (did not specify length of time) and that she did not report it because she did not know that it should have been covered. On 10/08/21 at 10:25 AM, Surveyor #1 interviewed that Maintenance Director (MD) who stated that he was unaware that there were uncovered electrical outlets in rooms [redacted] and [redacted] He further stated that he was unaware that there was an uncovered light fixture with exposed electrical wires in room [redacted] He stated that those concerns would be a	F 689	• [redacted] checked the entire facility where gas entered the facility and confirmed there were no other gas leaks. • All dryers in the laundry were taken out of service and new dryers ordered. Laundry was outsourced until replacement dryers are installed and functional. • A schedule for cleaning the dryers was established by the vendor contracted to assist the housekeeping director. Part D - IJ Removal Actions • Facility-wide audits were conducted to identify any closets, utility rooms, med rooms, and staff bathrooms in need of new locks and self-closure devices on all units. Part A – Continuation • Staff received re-education related to: o notification of the physician and responsible party with changes in condition and documentation in the medical record o Assessment of residents and documentation of findings in the medical record after incidents including falls and update the resident care plan o The process to investigate incidents, complete an incident report and obtain witness statements in accordance with facility policy Element Four – Quality Assurance Part A - IJ Removal Actions Root cause analysis was conducted, and a QAPI performance improvement project was implemented to assure all handrails are securely attached to the wall and in good repair with no sharp edges. The maintenance director/designee will	

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F 689	Continued From page 128 hazard because of the confused residents that resided on the [redacted] Unit. At that time, the MD, Director of Nursing (DON), Infection Preventionist (IP) and LPN/UM accompanied the surveyor on a tour of the [redacted] Unit and confirmed the surveyors observations regarding the handrails on the [redacted] and [redacted] hallways that were not securely mounted to the walls, were loose and broken. The MD stated to Surveyor #1, at that time, that he was not aware that "so many" handrails in the halls were broken and had jagged, sharp edges. He admitted that the handrails were in disrepair and that they needed to be addressed right away to prevent someone from getting injured. He also revealed that the building was in "bad shape" when the new owner took over, but that was no excuse. The DON, IP and LPN/UM were all in agreement that the aforementioned areas of concern were a hazard to the residents safety on the [redacted] unit. On 10/08/21 at 11:30 AM, the Surveyor #1 interviewed a CNA who stated that maintenance issues were reported through a computer system and the maintenance department was supposed to check the system and fix the concerns. She stated that she was unsure on how to enter the concerns in the computer system, but that she would report it to the nurse so the nurse could notify the maintenance department. She stated that the environmental conditions on [redacted] were "horrible" and that even when issues were reported nobody did anything about it. The CNA did not elaborate about what the "horrible" conditions were and at that time, made a hand gesture and pointed around the unit to the handrails that were in disrepair. On 10/08/21 at 11:35 AM, Surveyor #1	F 689	conduct rounds and assess all handrails weekly for three months and then monthly thereafter for three months. The results of the rounds shall be reported to the administrator weekly for three months. Quarterly the Maintenance Director will report audit findings and actions taken to the QAPI committee for review and further direction as appropriate. Part B - IJ Removal Actions Root cause analysis was conducted, and a QAPI performance improvement project was implemented to assure all electrical outlets and light fixtures properly covered and in good repair to prevent resident injury. The maintenance director/designee will conduct rounds and assess all outlet covers and light fixtures each week for three months and then monthly thereafter for three months. The results of the rounds shall be reported to the administrator weekly for three months. Quarterly the Maintenance Director will report audit findings and actions taken to the QAPI committee for review and further direction as appropriate. Root cause analysis was conducted, and a QAPI performance improvement project was implemented to assure all closet that store hazardous materials have functional self-closure devices and working locking mechanisms and are kept locked to prevent resident injury. The maintenance director/designee will F689 Element Four – Quality Assurance	

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F 689	Continued From page 129 interviewed the Licensed Practical Nurse (LPN) who had been employed in the facility for [redacted] years and who worked on the [redacted] Unit. The LPN stated that she reported concerns to the maintenance staff directly about the broken handrails and they "don't fix them". On 10/08/21 at 11:40 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) who had been employed at the facility for one week. She stated that she was not educated on how to enter maintenance concerns into the computer but that she would verbally tell the maintenance staff about the issues concerning the broken, loose handrails in the hallways on the [redacted] unit. She added that "nothing happens". On 10/08/21 Surveyor #3 reviewed three randomly selected facility investigations for resident accidents. Surveyor #3 reviewed an investigative report (IR) dated [redacted]. The IR report reflected under "Nursing Description" the following documentation was noted: "Resident [referring to Resident [redacted]] stood up out of wheelchair and attempted to hold onto rail outside of his/her room to close his/her door, when the rail fell causing him/her to lose balance and fall on his/her buttocks to the floor". The IR indicated that the nursing supervisor was notified. The IR also indicated that the resident had no injury apparent and that the "Resident did not hit his/her head". A statement obtained from Resident [redacted] on [redacted], the day of the fall indicated the following: "I was trying to close my room door and grabbed hold of the rail to support me and it fell,	F 689	conduct rounds and assess all closet that store hazardous materials each week for three months and then monthly thereafter for three months. The results of the rounds shall be reported to the administrator weekly for three months. Quarterly the Maintenance Director will report audit findings and actions taken to the QAPI committee for review and further direction as appropriate. Part C - IJ Removal Actions Root cause analysis was conducted, and a QAPI performance improvement project was implemented to assure there are no gas leaks and all dryers are thoroughly cleaned and maintained in safe operating condition. The housekeeping director/designee will conduct rounds and monitor for gas odors and check all dryers to ensure they are thoroughly cleaned and maintained in safe operating condition each week for three months and then monthly thereafter for three months. The results of the rounds shall be reported to the administrator weekly for three months. Quarterly the Housekeeping Director will report audit findings and actions taken to the QAPI committee for review and further direction as appropriate. Part D - IJ Removal Actions Root cause analysis was conducted, and a QAPI performance improvement project was implemented to assure all medication rooms have functional self-closure devices and working locking mechanisms and are kept locked to prevent resident injury. The DON/Unit Manager will	

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F 689	Continued From page 130 causing me to fall". The "causal factor" on the IR form identified by the facility was a faulty handrail and the intervention indicated on the IR was to notify maintenance to fix the handrail. A review of the medical record of Resident [redacted] revealed the resident was admitted to the facility with diagnoses which included [redacted]. The quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that Resident [redacted] was awake, alert, and able to make his/her needs known. Resident #[redacted] scored [redacted] on the Brief Interview for Mental Status (BIMS) which indicated the resident was [redacted] Resident [redacted]'s Care Plan (CP) for [redacted] was initiated on [redacted] The goal was for Resident [redacted] to resume usual activities without further incident. The interventions were as follows: 1. Continue the interventions on the at-risk plan. 2. Educate Resident [redacted] to call for assistance when attempting to close doors. 3. For no apparent acute injury, determine and address causative factors of the falls. On 10/08/21 at 2:30 PM, Surveyor #1 interviewed the Licensed Nursing Home Administrator (LNHA) who stated that he was unaware about the exposed electrical outlets in rooms [redacted], or about the bathroom light that uncovered in room [redacted] with exposed live wires. He also denied having any knowledge that some of the hallway handrails were loosely mounted to the walls and that a lot	F 689	conduct rounds and assess all medication rooms each week for three months and then monthly thereafter for three months. The results of the rounds shall be reported to the administrator weekly for three months. Quarterly the DON/designee will report audit findings and actions taken to the QAPI committee for review and further direction as appropriate. Part A – Continuation Root cause analysis was conducted, and a QAPI performance improvement project was implemented to assure incidents are thoroughly investigated, reported, and the physician and responsible party notified of assessment findings. The DON/Unit Manager will audit charts of residents who experience incidents each week for three months and then monthly thereafter for three months. The results of the audits shall be reported to the administrator weekly for three months. Quarterly the DON/designee will report audit findings and actions taken to the QAPI committee for review and further direction as appropriate. Root cause analysis was conducted, and a QAPI performance improvement project was implemented to assure residents are assessed and care plans reviewed and revised as needed when an incident occurs with all information documented in the medical record. The DON/Unit Manager will audit charts of residents who experience incidents each week for three months and then monthly thereafter for	

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F 689	Continued From page 131 of the handrails were broke with sharp jagged edges. The LNHA stated that he made "environmental rounds" on [redacted], with the facilities Regional Director of Operations (RDO) and Regional DON. He revealed that the MD was not included in the environmental rounds. He then added that they found a few "dirty" rooms, but admitted that he did not go into every room. At this time, the LNHA viewed pictures that the surveyor had taken of the environmental hazards on Court 2 Unit. The LNHA admitted that the aforementioned areas of concern were a hazard to the residents' safety on the [redacted] Unit and that a resident could get hurt. When the surveyor asked the LNHA why they could get hurt on the [redacted] unit, he verified that the residents were [redacted] On 10/12/21 at 9:42 AM, Surveyor #1 interviewed the RDO who provided the surveyor with an email that he gave the LNHA concerning the environmental rounds that the RDO and LNHA conducted on [redacted]. The email was titled, "Housekeeping Rounds" and was dated [redacted] 1 at 11:13 AM. There were no maintenance issues documented on the email. When the surveyor asked the RDO about the maintenance issues, he stated that they did not see any broken, loose, or jagged sharp handrails nor did they see any uncovered electrical outlets or light fixtures. He then admitted that they had to do a better job and that lack of staff was a huge part as to why things were not getting done. "We are trying to hire more staff and a higher rate." He then stated that this was no excuse and that these aforementioned concerns should have been identified and fixed.	F 689	three months. The results of the audits shall be reported to the administrator weekly for three months. Quarterly the DON/designee will report audit findings and actions taken to the QAPI committee for review and further direction as appropriate.	

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F 689	Continued From page 132 On 10/12/21 at 12:45 PM, Surveyor #3 conducted a tour of the [redacted] Unit where Resident [redacted] resided. Surveyor #3 conducted an interview with Resident [redacted] at that time, while Resident [redacted] was seated in the hallway across from Resident room [redacted]. Resident [redacted] stated to the surveyor that he/she recalled the incident when he/she fell, and proceeded to point to the handrail where the incident occurred. At that time, Surveyor #3 touched the handrail identified by Resident [redacted], and the handrail fell from the wall to the floor. Resident [redacted] further stated "the nurse can tell you all about the incident. On 10/12/21 at 1:15 PM, Surveyor #3 interviewed the Licensed Practical Nurse (LPN) who revealed that maintenance staff attempted to re-attach the handrail on the morning of [redacted] Upon further inquiry the LPN indicated that the handrail was never repaired after Resident [redacted] fell. The LPN could not elaborate on whether or not a work order was generated for the repair of the handrail after it fell from the wall on [redacted] On 10/12/21 at 2:10 PM, Surveyor #3 interviewed the MD who indicated that he was not aware that a broken handrail on the [redacted] Unit needed to be repaired. He further stated that he was not aware that Resident [redacted] had sustained a fall on [redacted], due to a faulty handrail. The surveyor inquired about the process for repair and escorted the MD to the [redacted] Unit where both observed the handrail on the floor. The MD stated to the surveyor that he did not have a work order for the handrail and he stated that he toured the [redacted] Unit twice weekly. The MD stated there was no maintenance book as the facility implemented an electronic reporting system and	F 689		

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F 689	Continued From page 133	F 689		

he would review the electronic report, look at the timeframe and request the materials needed to complete the work. He further added, "If you can get the material, the work would be completed". The MD stated he was clearly not aware of the broken handrail.

The hand rail identified as the causal factor for the fall of [redacted], was not repaired until [redacted] at 3:00 PM.

The facility's failure to identify the environmental hazards posed a serious and immediate threat to the safety and wellbeing of all residents on all the units and resulted in an immediate jeopardy situation that began on 7/18/21, when Resident [redacted] on the [redacted] Unit had a fall caused by a broken handrail which was not corrected by the facility and the facility handrails continued to be in disrepair until [redacted], during the standard survey.

On 10/18/21 to 10/19/21, Surveyor #14 observed the following:

1. On 10/18/21 At 09:41 AM, the surveyor observed a 1-foot linear section of handrail located by the Medical Supply room and Resident room [redacted] that was loose and not anchored securely to the wall when tested. The edge of the handrail was missing its protective cover and produced a sharp edge.

2. On 10/19/21 at 01:52 PM, the surveyor observed a loose corner handrail by Resident rooms [redacted] and [redacted].

3. On 10/19/21 at 03:28 PM, the surveyor observed the closed section of unoccupied

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F 689	Continued From page 134 resident rooms #[redacted], [redacted], and [redacted], the corridor was still maintained as an active exit in the event of an emergency. The entire top protective cap to the handrails was missing approximately 50' on each side. The missing protective cap now produced sharp edges and would hinder residents that used that exit in the event of an evacuation. These findings were acknowledged and confirmed by the Maintenance Director in an interview during the observation. He stated that the section of handrail cap was missing as the protective caps were being used in other areas of the facility. On 10/18/21 at 11:00 AM, Surveyor #5 observed the handrail by room [redacted], on the [redacted] Unit. The handrail had a piece of broken molding-type wood that had exposed nails located inside of the resident handrail, and the handrail outside of the residents room was broken and was not securely fastened to the wall. At that time, the facility IP was on the unit and Surveyor #5 interviewed the IP about the broken handrail and wood with exposed nails in the handrail. The IP stated she was unaware of the broken hand rail, looked at the piece of wood with the nails and removed it and stated "yes it is" confirming the handrail was broken and confirmed there was ambulatory residents on the unit and stated Resident [redacted] and [redacted] were ambulatory. On 10/18/21 at 12:31 PM through 12:55 PM, Surveyor #1 and #5 observed the following on the [redacted] Unit: 1. The handrail near the staffing office near the dining room, lifted off of the wall when the	F 689		

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F 689	Continued From page 135 surveyor touched it. 2. There was an unstable, loose handrail near the fire door by the nurses station. 3. The push panic bar on both fire doors had pieces missing and there was sharp edges on both doors. 4. There was a broken handrail with sharp edges located in between the janitors closet and the soiled utility room. The facility's failure to ensure that electrical outlets in 6 of 6 resident rooms [redacted] and [redacted]) and exposed live wiring in 1 resident room ([redacted] posed a serious and immediate threat to vulnerable residents and resulted in an immediate jeopardy situation was identified on 10/08/2021 at 5:14 PM. The facility provided an acceptable IJ Removal Plan on 10/12/2021 at 4:00 PM. The IJ removal plan was verified on-site on 10/12/2021. Part B 1. On 10/19/2021 at 9:45 AM, Surveyor #15 and Surveyor #16 observed an unlocked room labeled "supply closet" during a tour of the [redacted] unit. The surveyors observed a lock was present and attached to the door, in a locked position, but was not in a fixed position to lock and secure the door. The supply closet was found to be unsafe, and with unsanitary conditions. The supply closet was in disarray. The following was observed upon entry: a. A used housekeeping cart with wet mop bucket. b. A wet vac type of vacuum with the hose was lying across the entry way which the surveyor tripped over upon entry into the closet.	F 689		

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F 689	Continued From page 136 c. A mop bucket containing a soiled mop. d. Trash and gloves were located on the floor throughout the room. e. Open boxes of toilet paper and paper towels f. 2- Cleaning chemicals located on the shelving. g. A large trash can without a liner, that contained used gloves. i. Boxes that contained broken equipment. j. (2)- 5-gallon unopened drums of an undetermined cleaning chemicals. k. The air conditioning/heating unit was uncovered with exposed metal and internal parts. l. Boxes turned upside down strewn around the room. m. Exposed wood pallets that had closed and opened boxes of paper towels and toilet paper. n. Sharp metal objects were observed in a box near the window. Another door was observed across the hall from the supply closet. The surveyors opened the un-secured door, which was not locked and observed multiple boxes that were not intact and appeared to have been previously wet, then dried which were labeled [redacted], daily disinfectant cleaner, used for [redacted] 96 ounce (oz). OXYCIDE DAILY DISINFECTANT CLEANER was, according to the MSDS (Material Data) sheet, toxic if swallowed or if inhaled. The surveyor also observed an open gallon of [redacted] and window cleaner, an open container of "[redacted]", an odor eliminator, and a ladder propped against the supplies. A basket was observed on the floor that contained a bag of potato chips in a plastic bag, an open box of tea was also observed on the floor. The floor was covered in unidentified debris.	F 689		

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F 689	Continued From page 137 During an interview on 10/19/2021 at 9:50 AM, the Housekeeping Director (HD) was shown the aforementioned and he confirmed the surveyor's findings. He stated that the supply closet was supposed to be locked. He revealed "it has been broken since a week ago." He stated that the facility had not had a working vacuum since he started in [redacted] In addition, he revealed that the facility did not have working buffers to thoroughly clean the floors. When asked why he didn't have working equipment, he revealed that he didn't have what he needed to do his job, and he keeps "getting the run around" from administration. He stated that when he "took over in [redacted]" the floors had not been done "in forever." The HD revealed that you can see that they are yellow. The HD director had no explanation as to the condition of the supply rooms and confirmed it was an infection control issue, combining clean supplies with soiled supplies. The surveyors then reviewed the medical records for the following residents that had access to the unlocked/unsecured closet which contained caustic chemicals. These residents had [redacted] and were ambulatory (walked independently): A review of Resident # [redacted]s Minimum Data Set (MDS), dated [redacted], reflected the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated a [redacted] The MDS reflected the resident ambulated independently. According to the resident's current care plan (not-dated), the resident has diagnoses which included but were not limited to; [redacted].	F 689		

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F 689	Continued From page 138 On 10/27/21 at 12:38 PM, the surveyor observed the resident seated on the edge of his/her bed with the resident's tray table in front on him/her. The surveyor observed the resident eating lunch. A review of Resident [redacted]'s MDS, dated [redacted], reflected the resident had a BIMS score of [redacted] which indicated a [redacted]. The MDS reflected the resident ambulated independently. On 10/27/21 at 1:11 PM, the surveyor observed Resident [redacted] lying in bed, bed in low position, with his/her eyes closed. The resident's legs were bent at the knees and the resident's right arm was placed up above his/her head. A blanket covered the resident's body. The surveyor did not attempt to interview the resident because the resident appeared to be sleeping. According to the resident's current care plan (not-dated), the resident had diagnoses which included but were not limited to, [redacted] This presented an immediate jeopardy (IJ) situation for the identified residents for the likelihood that the residents would access the unsecured supply closets. The facility administrator was made aware of the IJ on 10/19/2021, a removal plan was submitted on 10/20/2021 and verified by the surveyors onsite on 10/20/2021. On 10/24/21 at 10:51 AM, two surveyors toured the [redacted] Unit in a hallway where multiple residents resided. Close to a vacant resident	F 689		

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room (Room [redacted]) there was an unlocked closet labeled as a "Housekeeping " closet. The door was fit with a standard door knob and a key-lock system. The two surveyors entered the housekeeping closet and immediately observed four (4) one-gallon bottles of chemicals, one of them was empty. There was one bottle of window cleaner, one bottle of a multi-surface cleaner plus disinfectant with a label that read, "keep out of reach of children," and one bottle of a concentrated floor cleaner. In addition, in the Housekeeping closet was also a utility sink which was connected to a chemical release system which had three additional chemicals, an odor eliminator, a floor disinfectant and a window cleaner. The chemicals were easily accessible to any resident who may wander into the unlocked Housekeeping closet.

At 10:54 AM, the two surveyors observed the LNHA #2 enter the hallway of the unlocked Housekeeping closet. The LNHA stated that the Housekeepers are the ones responsible for locking the doors to the Housekeeping closets. He stated that he checked all the doors last night and all of them were locked. The surveyors requested that he check the Housekeeping closet on the [redacted] Unit together. As the surveyors and the LNHA walked down the hallway toward the Housekeeping closet, the LNHA walked past the unlocked Housekeeping closet. The surveyors summoned him back and he stated that he didn't realize this door was here and that he "missed this one" during his door check last night. He then opened the door and confirmed that there were chemicals stored in the housekeeping closet and that the door should always be locked if not in use. He then locked the Housekeeping closet and the surveyors

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tested the door and it locked properly. He could not speak to why it was unlocked or for how long.

On 10/24/21 at 11:22 AM, the two surveyors toured the [redacted] Unit together and observed the following:

At 11:25 AM, the two surveyors accessed an unlocked Soiled Utility room. Upon entry through the door was a standard dining chair with two large pieces of metal that were later identified to be Self-Closing door hinge devices (which could potentially be used as a weapon or could cause other injury). The unlocked Soiled Utility room was easily accessible to any ambulatory resident on the unit.

At 11:28 AM, the surveyors interviewed a CNA who stated that the soiled utility room door was "usually unlocked" and that it could be locked. The CNA confirmed it was not locked. The surveyor's showed the CNA the two self-closing door devices in the Soiled Utility Room, and she stated that the surveyors should notify the Housekeeper down the hallway to handle it, indicating that he would be able to better answer why they may be there. She could not speak to how long they may have been there.

At 11:30 AM, the surveyors interviewed the housekeeper who was mopping the floor and he introduced himself as the Floor Technician. The surveyors took him to the unlocked Soiled Utility room on the [redacted] Unit. Upon opening the door he acknowledged that there was a self-closing door device left on the chair there. He stated that he would remove it immediately and place it in his locked janitor closet on the other end of the unit.

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He further added that he was not sure how long it had been there, but that it probably should not be there because it could pose a hazard. He stated that the Soiled Utility Room should be locked in this particular unit due to the various needs of the residents on the unit. The surveyors observed him take the two metal devices down the hallway and store it in his locked janitor's closet.

At 12:18 PM, the surveyor observed in the presence of the LNHA Resident [redacted] in his/her wheelchair self-propelling as he/she exited the unlocked Soiled Utility Room where the metal door hinges were stored. The resident stated that he/she was looking for the bathroom. The surveyor observed the LNHA redirect the resident out of the unlocked Soiled Utility Room so he/she could be toileted. At that time, the LNHA acknowledged that the Soiled Utility room was to be locked and that he would have the contractor fix it right now. The surveyor discussed that there were two metal door devices (self closing door hinge) stored in that unlocked Soiled Utility room that had been removed by the housekeeper previously in there. The LNHA stated that they were working on restoring the function of all the locks on the unit.

On 10/24/21 at 12:26 PM, the two surveyors observed on the [redacted] unit a door easily accessible to residents in the resident area adjacent to the nurses station. The door was labeled as a "Restroom" and was marked for male or female use. The door was unlocked and there was a small hole in the door. There was also a [redacted] sitting in the wedge of the molding next to the door. The surveyors easily entered the bathroom and observed that there was no emergency pull cord installed in the

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bathroom. It was not labeled as a staff bathroom either. At that time, the DON came around the corner and the surveyors pointed it out to her. The DON acknowledged that it was not labeled as a staff bathroom, but she believed it was intended for staff. She confirmed that if it was not locked and had no functioning lock residents would be able to easily access it. She could not speak to why there was a tongue blade on the wall next to the door, except that maybe it was just because "staff are lazy" and left it there. She then removed the [redacted]. She stated that they would have to get a new lock for that bathroom, so it would not be accessible to residents especially since it did not have an emergency pull cord installed. She stated that they would relabel the door to indicate it was for staff use only because there was no emergency call bell system installed. The DON was unsure if any residents had entered or used the bathroom in the past, adding that she had only been working here for a few weeks.

Part C

1. On 10/19/21 at 9:10 AM, Surveyor #14 conducted a tour of the facility laundry room with the Maintenance Director (MD). The large laundry room contained four commercial clothes dryers. There was a small enclosed room in the back of the four dryers that was vented with outside air. The surveyor identified an odor of what seemed like natural gas. The surveyor in the presence of the MD, who had been employed by the facility for 6 months, initially stated he did not smell the odor of natural gas, but then confirmed he did smell something, but was not sure what it was. Surveyor #14 smelled the distinct additive known as '[redacted] (additive that is added to natural

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gas to make it easier to detect in case of a leak).

On 10/19/21 at 11:28 AM, The MD was then instructed by the surveyor to immediately notify [name redacted-gas company] the natural gas provider for that area of New Jersey. The surveyor instructed the laundry staff to shut off the clothes dryers that were currently in operation.

During an interview with laundry staff indicated that 3 of 4 commercial clothes dryers were in operation at the time of survey. The 4th dryer was not in operation for some time due to the rotating drum damaging clothes. The Laundry staff also indicated that they may have noticed an odor of natural gas, but they may need to be re-educated on the procedure of what to do, and what natural gas smells like.

The representative for the [name redacted-gas company] arrived on the scene at approximately 11:52 AM and was directed to the laundry area of the facility by the Maintenance Director. The gas company technician investigated the area behind the dryers and determined there was a gas leak to the flex line connection of the "out of service dryer" by using a gas meter that activated an audible signal, which indicated a gas leak. The gas company technician then shut off the valve feeding gas to the dryer. The technician then issued a red violation tag indicating "DO NOT OPERATE THIS APPLIANCE OR SECTION OF GAS PIPING". The tag indicated leak at appliance (gas dryer) and was shut off at the branch line.

The violation reflected the following:
"This appliance or section of gas piping has been

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SHUT OFF due to an unsafe condition. DO NOT operate until the noted condition(s) have been corrected and RE-INSPECTED by [gas company name redacted] or your local building code official."

REMARKS: Replace flex connection on dryer

The Maintenance Director was then interviewed during the observation as to when he last inspected the small room behind the clothes dryers. He stated he was aware of the # 4 dryer being out of service and he could not provide any documents and or log that indicated how or when the area was last inspected.

On 10/21/21 at 10:06 AM Surveyor #5 interviewed the MD regarding a manufacturer manual for the maintenance of the dryers. The MD stated the dryers were so old that he could not locate a manual for them and he would look on the Internet. The MD stated that when he came to the facility a few months prior, along with the new company, that nothing was done regarding the dryer drums. He stated the dryer drums were not properly cleaned or grinded down and he explained how the drums are usually ground down to do a complete cleaning. The MD stated a company was coming to the facility today and that they were supposed to do a full cleaning.

On 10/21/21 at 2:01 PM, the MD provided Surveyor #5 with a copy of a [redacted] Dryers, Installation/Operation/Maintenance Manual dated April 2019. The Maintenance Section of the manual revealed, "Daily"; 1. Inspect the area surrounding tumble dryers, remove all combustible materials, including lint, before

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operating the machines, "Bi-Annually"; 2. Check gas connections for leakage.

On 10/22/21 at 9:25 AM, Surveyor #5 interviewed the contracted maintenance technician (MT) in the presence of the Housekeeping Director (HD) in the laundry department. The surveyor inquired to the MT regarding the state of the dryer drums. The MT stated "cleaning is a nightmare". He referred to the imbedded debris on the dryer drums and stated that it is "hours and hours of debris" and it was plastic at one point, "now melted on there". The MT stated he would not recommend to use the dryers, "they are past the point of being cleaned". The MT stated he has not cleaned the drums in the state they were in and recommended to replace the drums on the dryers or replace the dryers because the debris blocked the heat source. The MT stated he could not clean the drums when they were in the condition they were in.

Surveyor #5 reviewed a Laundry Report (LR), dated [redacted], which was completed by the MT. The LR revealed "the dryer baskets were covered with melted plastic", we will give an estimate to replace baskets or replace drums.

The faulty ill-maintained conditions of the dryers in combination with the active gas leak posed the likelihood of a serious and immediate threat to all residents who resided in the facility. This resulted in an Immediate Jeopardy (IJ) situation that began on 10/19/21 at 9:10 AM and continued until 10/19/21 at 10:15 AM when the gas company responded and a violation from the gas company was subsequently issued.

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F 689	Continued From page 146 PART D 1. Two surveyors conducted a tour of the [redacted] Unit on 10/24/21 at 11:55 AM. The Surveyors interviewed a staff member who identified herself as the Licensed Practical Nurse (LPN) on the Unit. The LPN stated that the [redacted] Unit was comprised of all [redacted]) residents and some residents that had [redacted] and [redacted] diagnoses. She stated that the census at this time was 31 residents. During the tour the surveyors identified the following: 1.) The Medication Room was located next to the break room and labeled as such. The door to the Medication Room was unlocked and open and no staff were present. 2.) The 2 surveyors observed over the counter cabinets with unlocked doors containing stock medications in the unlocked medication room. The liquid medications were: [redacted] and [redacted] 3.) Upon opening the bottom unlocked cabinet drawers inside the medication room, the surveyors observed that there were two chef [redacted]. One (1) [redacted] was approximately twelve (12) inches the other [redacted] was approximately an eight (8) inch [redacted]. Both were located in a bottom drawer in the lower cabinet. The drawer was labeled "miscellaneous"	F 689		

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and easily accessible to any resident that enters the unlocked, unsupervised area. This poses an immediate risk to resident safety due to population on that unit.

4.) At 12:00 PM - During an interview with the Agency LPN (who had worked there in the past), confirmed that the Medication Room was unlocked. She showed the 2 surveyors that when the door closes it does not set into the door frame unless it is physically lifted and manipulated. She stated that the only way to unlock the Medication Room door once it is closed is from the inside. The surveyors tested the lock of the Medication Room, one surveyor stayed inside and the other surveyor with the LPN on the outside. The LPN manipulated the door to close it in it's frame, using the pad lock and locked the door. An attempt to unlock the door from the outside was unsuccessful. The surveyor inside the Medication Room was able to unlock the door from the inside. The Agency LPN stated that this is not a new occurrence and has always happened, which was why the door had remained unlocked and open.

The LPN confirmed there were unlocked medications in the cabinet and the finding of the 2 [redacted] in the bottom drawer. When questioned why they were there, the LPN stated she did not know that they were in there, and confirmed it could be a major safety risk with the resident population. As the surveyor exited the Medication Room, the LPN instructed the surveyors to keep the door unlocked.

On 10/24/21 at 11:22 AM, the two surveyors toured the [redacted] Unit together and observed the following:

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At 11:25 AM, the two surveyors accessed an unlocked Soiled Utility room. Upon entry through the door was a standard dining chair with two large pieces of metal that were later identified to be Self-Closing door hinge devices (which could potentially be used as a weapon or could cause other injury). The unlocked Soiled Utility room was easily accessible to any ambulatory residents on the unit.

At 11:28 AM, the surveyors interviewed a CNA who stated that the soiled utility room door was "usually unlocked" and that it could be locked. The CNA confirmed it was not locked. The surveyor's showed the CNA the two self-closing door devices in the Soiled Utility Room, and she stated that the surveyors should notify the Housekeeper down the hallway to handle it, indicating that he would be able to better answer why they may be there. She could not speak to how long it may have been there.

At 11:30 AM, the surveyors interviewed the housekeeper who was mopping the floor and he introduced himself as the Floor Technician. The surveyors took him to the unlocked Soiled Utility room on the [redacted] Unit. Upon opening the door he acknowledged that there was a self-closing door device left on the chair there. He stated that he would remove it immediately and place it in his locked janitor closet on the other end of the unit. He further added that he was not sure how long it had been there but that it probably shouldn't be there because it could pose a hazard. He stated that the Soiled Utility Room should be locked in this particular unit due to the various needs of the residents on the unit. The surveyors observed him take the two metal devices down the hallway

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F 689	Continued From page 149 and stored it in his locked janitor's closet. At 12:18 PM, the surveyor observed in the presence of the LNHA Resident [redacted] in his/her wheelchair self-propelling as he/she exited the unlocked Soiled Utility Room where the metal door hinges were stored. The resident stated that he/she was looking for the bathroom. The surveyor observed the LNHA redirect the resident out of the unlocked Soiled Utility Room so he/she could be toileted. At that time, the LNHA acknowledged that the Soiled Utility room was to be locked and that he would have the contractor fix it right now. The surveyor discussed that there were two metal door devices (self closing door hinge) stored in that unlocked Soiled Utility room that had been removed by the housekeeper previously in there. The LNHA stated that they were working on the restoring the function of all the locks on the unit. On 10/24/21 at 12:26 PM, the two surveyors observed on the Pavilion unit a door easily accessible to residents in the resident area adjacent to the nurses station. The door was labeled as a "Restroom" and was marked for male or female use. The door was unlocked and there was a small hole in the door. There was also a tongue blade sitting in the wedge of the molding next to the door. The surveyors easily entered the bathroom and observed that there was no emergency pull cord installed in the bathroom. It was not labeled as a staff bathroom either. At that time, the DON came around the corner and the surveyors pointed it out to her. The DON acknowledged that it was not labeled as a staff bathroom, but she believed it was intended for staff. She confirmed that if it was not locked and had no functioning lock residents	F 689		

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would be able to easily access it. She could not speak to why there was a tongue blade on the wall next to the door, except that maybe it was just because "staff are lazy" and left it there. She then removed the blade. She stated that they would have to get a new lock for that bathroom, so it would not be accessible to residents especially since it did not have an emergency pull cord installed. She stated that they would relabel the door to indicate it was for staff use only because there was no emergency call bell system installed. The DON was unsure if any residents had entered or used the bathroom in the past, adding that she had only been working here for a few weeks.

The facility failed to securely safeguard hazardous chemicals, [redacted], over-the-counter medications, and potentially dangerous equipment (self-closing door device) and devices (belts) from vulnerable and ambulatory residents by ensuring a functional locking mechanism was installed, maintained, or utilized on the respective doors to keep residents on 3 of 5 units ([redacted] Unit) safe and free of serious injury, harm, impairment, or death.

This resulted in an immediate jeopardy situation that was identified on 10/19/21 and continued until 10/25/21. This resulted in an Immediate Jeopardy (IJ) situation that began on 10/24/21, when the two (2) knives were observed, by the surveyor in the unsecured drawer in the unlocked Medication Room.

The facility administration was notified of the Immediate Jeopardy situation on 10/24/21 at 4:00 PM.

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The IJ continued facility alleged complete implementation of the elements of their removal plan accepted on 10/29/21 and verified by the survey team.

It was determined that the F689 deficiency continued at no actual harm with the potential for more than minimal harm that is not immediate jeopardy.

Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to a.) implement interventions from a fall risk care plan for a resident that was identified as a risk for for falls b.) document fall incidents in the resident's medical record, and c.) complete incident reports related to falls for 1 of 7 residents (Resident [redacted]) reviewed for accidents.

This deficient practice was evidenced by the following:

On 10/21/21 at 8:46 AM, Surveyor #9 observed Resident [redacted] lying in bed asleep. There were no floor mats to either side of the bed and the bed was positioned perpendicular to the wall, not up against the wall.

On 10/21/21 at 10:56 AM, Surveyor #9 observed Resident [redacted] lying in bed awake. The resident stated he/she fell in the room two nights ago and hit his/her [redacted]/side during the fall. There were no floor mats to either side of the bed and the bed was positioned perpendicular to the wall, not up against the wall.

On 10/22/21 at 8:58 AM, Surveyor #9 observed

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the resident sitting up on the side of the bed eating breakfast. There were no floor mats to either side of the bed and the bed was positioned perpendicular to the wall, not up against the wall.

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

Review of the Resident's Quarterly Minimum Data Set (MDS), and assessment tool used to facilitate the management of care dated [redacted], included the resident had a Brief Interview for Mental Status of [redacted] which indicated the resident's [redacted]. Further review of the MDS included that the resident required limited assistance of one staff for bed mobility and transfers and that the resident had one fall since the last MDS assessment.

Review of the resident's Care Plan (CP), revised [redacted], included that the resident was a risk for [redacted] related to confusion, gait/balance problems, poor safety awareness, and [redacted] drug use. The CP also included an intervention for bilateral floor mats next to the resident's bed, dated [redacted], and for the resident's bed to be against the wall for safety, dated [redacted]. The CP further included that the resident had the following falls:
"[redacted] - Found on floor next to bed"
[redacted] - Rolled out of bed to floor"
"[redacted] - Actual Fall"
[redacted] - Rolled [Out of Bed]"

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Review of the resident's revised CP, revised [redacted], included that the resident fell on [redacted].

Review of the resident's Kardex Report, as of [redacted], included a safety precaution of bilateral floor mats next to bed, dated [redacted] The Kardex did not include that the resident's bed should be positioned against the wall.

Review of the Progress Notes (PN) for Resident [redacted] included the following:
A PN dated [redacted] at 2:30 PM, included that the resident was found on the floor next to the bed in the resident's room.
A PN dated [redacted] at 3:33 AM, included that the resident was found on the floor next to the bed in the resident's room.
A PN dated [redacted] at 3:44 AM, included the resident was found sitting on the floor next to the bed in the resident's room.
There was no PN dated [redacted] with specific details pertaining to the fall mentioned on the resident's CP. There was a PN dated [redacted] at 11:37 PM, that included the Nurse Practitioner was notified of the resident's fall.
There was no PN dated [redacted], with specific details pertaining to the fall mentioned on the resident's revised CP. There was a Post Incident Follow-up note dated [redacted] at 2:16 AM, that included the resident was day 1 status post fall.

Review of the Incident Reports (IR) for Resident [redacted] included the following:
An IR dated [redacted] at 2:52 PM, did not include written staff statements.
An IR dated [redacted] at 2:25 AM, did not include written staff statements.
An IR dated [redacted] at 3:15 AM, did not include

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written staff statements.
The facility was unable to provide an IR for the [redacted] and [redacted] falls.

During an interview with Surveyor #9 on 10/21/21 at 9:10 AM, the Certified Nursing Assistant (CNA) stated that Resident [redacted] is unsteady on his/her feet and requires assistance to transfer from the bed to the wheelchair. The CNA further stated that the resident has had one fall since [redacted] but that the CNA was not present at the time of the fall and could not provide further details.

During an interview with Surveyor #9 on 10/21/21 at 11:00 AM, the Licensed Practical Nurse (LPN #1) stated that she was an agency nurse and that she received report that Resident [redacted] fell recently. When asked if the LPN knew of any fall interventions in place for the resident, the LPN stated she was not informed of any interventions.

During a follow-up interview with Surveyor #9 on 10/21/21 at 11:03 AM, the CNA stated she was unsure what fall interventions were in place on Resident [redacted]'s CP. At that time, the CNA accompanied the surveyor to the resident's room and confirmed that the resident did not have any floor mats in the room and that the bed was not positioned against the wall.

During an interview with the Surveyor #9 on 10/21/21 at 11:30 AM, the Maintenance Director stated that if a resident's bed had to be moved against the wall, the maintenance staff would be responsible. The Maintenance Director further stated that the maintenance staff had not received any requests to move a bed against the wall on the unit that Resident [redacted] resided.

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During an interview with Surveyor #9 on 10/22/21 at 12:26 PM, the Infection Preventionist (IP) stated that if a resident fell, the nurse should assess the resident, notify the supervisor, doctor, and family, fill out an incident report, and update the resident's CP. The IP further stated that when the resident's CP is updated with new interventions, all staff should follow the revised CP to ensure it is pertinent and effective for the resident. The IP also stated that the CNAs should know what fall interventions are in place because they have access to the Kardex.

During an interview with Surveyor #9 on 10/22/21 at 1:21 PM, the interim Director of Nursing (DON) stated that if a resident fell, the nurse should do a physical assessment, notify the physician and resident representative, update the resident's care plan, gather staff statements, and complete an incident report. The DON further stated that a progress note should be written in the resident's medical record pertaining to the incident. The DON also stated that the CP and Kardex should be updated with new interventions and that staff should carry out the interventions on Resident [redacted] CP and Kardex. The DON added that if the interventions were no longer appropriate, the staff should have revised the CP to no longer include those interventions.

During a follow-up interview with Surveyor #9 on 10/25/21 at 12:41 PM, the DON stated after a fall occurs, all staff on the unit at the time of the fall should fill out a statement for the incident report.

During a follow-up interview with Surveyor #9 on 10/26/21 at 11:27 AM, the DON stated that if written statements were missing from an incident

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report, it would be considered incomplete.

Review of the facility's Changes in a Resident's Condition or Status policy, dated 01/05, listed examples of a change in a resident's condition or status which included "The resident is involved in any accident or incident" and that "all changes in the resident's medical condition will be recorded in the resident's medical record."

Review of the facility's Accident and Incident Reports policy, dated 01/05, included, "Definition of Accident/Incident is any unusual occurrence, e.g. fall" and "When dealing with an unusual occurrence do the following ... Complete the Accident/Incident report." The policy further included "all unusual occurrences need to be documented in the interdisciplinary notes" and "State all information about the incident, who was notified and what was done about the incident."

Review of the facility's Care Plans policy, dated 01/05, included, "Care plans are also reviewed and updated as changes in the resident's condition dictates."

A review of the job description titled, "Facility Administrator" with a date of May 2020 indicated that the primary purpose of the position is to direct the day-to-day functions in the facility in accordance with current federal, state, local standards, guidelines, and regulations that govern long-term care facilities to assure that the highest degree of quality of care can be provided to residents at all times. The duties and responsibilities include the following:
-Review the policies and procedures that govern the operations of the facility.
-Review job descriptions and performances

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evaluations of each staff position.
-Create and maintain an atmosphere of warmth, personal interest, positive emphasis, as well as a calm environment throughout the facility.
-Make routine inspections of the facility to assure that established policies and procedures are being implemented and followed.
-Consult with department directors the operation of their departments and assist in eliminating/correcting problem areas, and/or improvement of services.
-Assure that the building and grounds are in good repair.
-Assist the Maintenance Director in developing and implementing waste disposal policy and procedures.
-Assure that the facility is maintained in a clean and safe manner for resident comfort and convenience.
-Assure that all residents receive care in a manner and in an environment that maintains or enhances their quality of life without abridging the safety and right of other residents.

A review of the job description titled, "Maintenance Director" and dated May 2020 indicated that the primary purpose of this position is to maintain the orderly functioning of all equipment in the facility including the kitchen, laundry, heating, air conditioning and elevators as well as purchasing the necessary supplies for repair, maintenance, and emergencies within the budgetary guidelines. The main duties include the following:
-Assure the proper maintenance and running of all electricity and plumbing in the entire building.
-Assure the proper maintenance and running condition of all equipment in the building.
-Perform all repairs that do not fall under the

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F 689	Continued From page 158 purview of housekeeping. -Supervise repairs and routine maintenance of the building and all departmental equipment. The undated "Maintenance and Repair" policy provided to the surveyor on 10/12/21 at 3:46 PM indicated the following: -existing structures should be replaced or repaired as needed. N.J.A.C 8:39-27.1(a), 31.2(e), 33.1(d)	F 689		
F 700 SS=K	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by:	F 700		12/28/21

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F 700	Continued From page 159 Based on observation, interview, and record review, it was determined that the facility failed to: Part A.) ensure side rails were installed and maintained in a safe, secure manner and without gaps between the side rails and the mattress to prevent entrapment risks for 3 of 38 residents reviewed for quality of care (Resident and on 2 of 5 units (and Unit). In addition, the facility failed to reduce additional entrapment risks when durable medical equipment (a and a wheelchair) were locked and adjacent to the bed frames on the low ends of the bed. The surveyors observed one of the residents with their in the gap between the mattress and the side rail, the side rail was covering their and the resident was . None of the residents were assessed for an entrapment risk with the use of the side rails. This posed a serious and immediate risk for all residents who used side rails for 2 of 5 units. On 10/19/21 at 10:25 AM, Surveyor #5 entered Resident 's room with the resident's attending physician (MD). At that time, the surveyor and MD observed the resident was lying in bed, and the resident's right side rail was not in vertical alignment with Resident 's mattress. Surveyor #5 and the MD further observed that the side rail was diagonally positioned to the resident's mattress, and there was a gap between the mattress and the side rail. Surveyor #5 observed that the resident's was positioned about three to four inches from the right edge of the gap between the side rail and the mattress. Surveyor #5 questioned the MD regarding the position of the resident's side rail and the gap observed between the side rail and bed. The MD acknowledged that the side rail was leaning away	F 700	F 700 Element One – Corrective Actions Part A - IJ Removal Actions • Resident was immediately repositioned safely, and the geri-chair was immediately removed from the lower part of the bed. Resident was immediately assessed for entrapment risk by the DON and Occupational Therapist. This resident prefers her bed against the wall and this was added as an intervention on the care plan. The side rails are down when the resident is out of bed. The MDS assessment and care plan for this resident was reviewed to ensure side rail use is properly coded and addressed as an intervention on the care plan. • Resident was immediately repositioned safely, and the wheelchair was immediately removed from the lower part of the bed. Resident was immediately assessed for risk by the DON and Occupational Therapist on and padding correctly placed on the side rail. A was immediately placed between the rail and the mattress of the Resident on to prevent a gap or risk of . The bed was repositioned and removed from placement along the wall. Resident was on and expired of natural causes on 1. • The side rails on the bed of Resident were immediately removed and the care plan revised following an order from the physician to discontinue the rails. The physician ordered floor mats to be placed on the floor on both sides of the bed and the bed in lowest position on	

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F 700	Continued From page 160 from Resident [redacted]s bed, and at that time, Surveyor #5 inquired to the MD if the side rail posed a risk for [redacted]. The MD stated "yes" and said Resident [redacted] had [redacted] and a history [redacted] and the side rails should have been protected. This deficient practice placed this resident at risk for the likelihood of serious harm or death and posed a serious and immediate risk for all residents who use side rails. This situation resulted in an Immediate Jeopardy (IJ) situation identified on 10/19/21 and again on 10/24/21; Resident [redacted] and Resident [redacted] The department received an acceptable removal plan on 10/29/21 that was verified that day by the survey team. The evidence was as follows: On 10/21/21 at 11:03 AM, Surveyor #5 interviewed the Director of Maintenance (DM) regarding the process for the placement of side rails on residents' beds. The DM stated that was "kind of a gray zone" and further noted that when he received a request for side rail installation, not all the facility beds supported side rails and that there were no side rail manuals available. The DM stated that he "usually" went and checked that the side rail was correctly installed because if the incorrect side rails were installed, it "would put a resident in jeopardy." He also stated that when he assessed the appropriateness of the side rails, the side rails could be changed to different beds if they needed to. Additionally, that manual beds are currently used in the facility, and the manual beds did not have the ability to have side rails affixed to them. Surveyor #5 asked the DM if there was a process for a side rail assessment to determine the appropriate side rail for the bed.	F 700	The care plan was revised to reflect the new orders on [redacted]. Staff received re-education about the use of floor mats and the bed in lowest position when the resident is in bed in lieu of side rails. The MDS assessment and care plan for this resident was reviewed to ensure side rail use is properly coded and addressed as an intervention on the care plan. • Staff involved were immediately re-instructed in the proper use of side rails and the policy on physical restraints. Element Two – Identification of at Risk Residents All residents with side rails have the potential to be affected by this practice. Element Three – Systemic Changes Part A - IJ Removal Actions • Side rail use and [redacted] risk assessments of Residents on the [redacted] were conducted by the DON and OT on 10/24/21. Additional side rail use and [redacted] risk assessments were conducted on [redacted] and [redacted] on 11/12/21, 11/17/21, and 11/18/21. • Additional education was provided to staff on the [redacted] unit on 10/27/21 regarding proper use of side rails and proper positioning. • Side Rail education was provided to staff on [redacted] and [redacted] regarding [redacted] risks, proper use of side rails as enablers when ordered, alternatives to side rails and obtaining consent prior to use of side rails. • Beds and mattresses were replaced as needed and [redacted] was placed on	

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F 700	Continued From page 161 The DM replied that there was "no" formal mechanism for an assessment. The DM stated that when an order for side rails was received, because the owners were not allowing him to purchase any needed supplies for the past three months, he did "what he needed to do" regarding the side rails. That same day, Surveyor #5 inquired to the DM regarding the leaning right side rail on Resident [redacted]'s bed observed by the physician and Surveyor #5 on 10/19/21 at 10:30 AM. Surveyor #5 showed the DM a photograph of Resident [redacted]'s bed taken by Surveyor #5 on 10/19/21 at 10:30 AM. The DM stated the side rails on Resident [redacted]'s bed were universal side rails that were not adjusted appropriately. He noted the universal rails were supposed to be fitted tightly against the bars on the side rail and should only allow for one fingertip to be inserted between the side rail and the bed. The DM referred to Resident [redacted]'s bed and stated, "there was no assessment done on the bed" and, "I was never even told about [the resident's] bed doing that." Surveyor #5 reviewed a "Bed Safety" policy with the DM. The policy was titled from another healthcare company and was provided to Surveyor #5 on 10/19/21 at 1:10 PM by the facility Infection Preventionist Nurse. The DM said that was not the facility policy and stated, "I had a different procedure." On 10/21/21 at 12:50 PM, Surveyor #5 interviewed an Occupational Therapist (OT) regarding whether or not rehabilitation is involved with an assessment for side rail use. The OT stated if she thought a resident would benefit from side rail use for mobility and transfers, she	F 700	side rails when needed to ensure Residents using side rails had no gaps or entrapment risks. • Consents were obtained for Residents who have side rails as enablers or who wish to use them for their own sense of security. Residents and responsible parties were provided with bed rail use safety information prior to obtaining consents. • Ongoing evaluation of the need for side rails is being completed by nursing and therapy to reduce the use of side rails. F700 Element Three – Systemic Changes • A policy related to the use of side rails was implemented that addresses entrapment risk, consent for side rails prior to use, assessment prior to use of side rails, alternatives to side rail use, resident and family education, and side rail reduction. Staff received education regarding the policy. • A side rail performance improvement project has been initiated to focus on safe side rail reduction. Element Four – Quality Assurance Part A - IJ Removal Actions Root cause analysis was conducted, and a QAPI performance improvement project was implemented to identify residents for side rail reduction and to assure residents with side rails are reassessed for continued use and for entrapment risks and where side rails are used a consent is properly completed and the MDS and the	

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F 700	Continued From page 162 could request them from maintenance. The OT further noted that she knew Resident [redacted] and stated the resident was very confused and that she had not completed a side rail assessment on the resident. She provided a side rail assessment for Resident [redacted], dated [redacted], completed by a Physical Therapist. The assessment revealed, referred by nursing for a bedrail [side rail] assessment, and the side rails were an enabler for the patient for independence with bed mobility. Surveyor #5 reviewed the medical record for Resident [redacted], which revealed the following: An admission record revealed Resident [redacted] had diagnoses that included lack of coordination and aftercare following [redacted] A quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], revealed the resident had scored a [redacted] on the Brief Interview for Mental Status, which indicated the resident was [redacted]. The Functional Status section revealed the resident required limited assistance and a one-person physical assist for bed mobility and required extensive assistance of one person for transferring. The restraint section of the MDS was coded not used for side rails. A Physician's Order Form, with a review date of [redacted] and unsigned by the physician, revealed a Side Rails order, '[redacted] Side Rails UP X2 for Enabling, Positioning and Mobility." An electronic Order Summary Report dated [redacted] revealed an Active Verbal Physician Order for "May have two half side rails while in bed every shift" with a start date [redacted]	F 700	care plan properly reflects the use of the side rails. The DON/Unit Manager will audit the charts of residents who have side rails each week for three months and then monthly thereafter for three months to ensure the side rails in use comply with the facility side rail policy. The results of the audits shall be reported to the administrator weekly for three months. Quarterly the DON/designee will report audit findings and actions taken to the QAPI committee for review and further direction as appropriate.	

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A handwritten Treatment Record for Resident [redacted] revealed an order for "Side Rails Up X 2 For Enabling, Positioning and Mobility Start: [redacted], the 7-3 shift was left blank on [redacted]. The electronic Treatment Administration Record for [redacted], revealed an order for "May have two half side rails while in bed every shift, Start Date: [redacted] and D/C [redacted]. The 07:00 (7:00 AM) on 10/19/21 was left blank.

A review of Resident [redacted]'s Care Plan revealed the following focus Areas: [redacted]- Revised [redacted]-Revised [redacted]-Revised [redacted]-Revised 1 [redacted], Discharge-Revised [redacted], Incontinence-Revised [redacted]. The Care Plan did not include the intervention for side rails as an active or resolved intervention.

A review of an Physician's Progress note dated [redacted], at 10:58 AM, revealed the resident had side rails up at this time, falls discussed with nursing and discussed to apply protectors to bed rails. A [redacted], 18:02 (6:02 PM) Nurses Note authored by the Director of Nursing revealed a discussion with the resident's Physician regarding the side rails. The Physician agreed the bed rails were not needed and did not help with bed mobility for the resident. A [redacted], 11:49 AM Physician Progress note revealed the resident was seen for a follow-up "bed-side" rails removed as discussed with nursing yesterday and to continue with current care, post recent fall and that "side rails not needed at this time."

A Side Rails assessment completed on [redacted] at 12:31 PM signed by the former unit manager nurse revealed the side rails were indicated to

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F 700	Continued From page 164 provide safety. On 10/25/21 at 09:50 AM, Surveyor #5 observed Resident [redacted] in bed, eyes were closed. The resident's bed was in the lowest position, and there was a floor mat on the right side of the bed. The bed did not have side rails. The CNA who was present in the room told Surveyor #5 that the resident only needed the mat on the right side of the bed. On 10/25/21 at 11:39 AM, Surveyor #5 interviewed the DON and Social Worker regarding if a side rail consent was completed for Resident [redacted]. The Social Worker and DON were not sure and stated they would look into it. 2. On 10/24/21 at 11:45 AM, two surveyors, could hear screaming from the hallway coming from the semi-private room of Resident [redacted]. The surveyor observed Resident [redacted] in bed with the bed positioned against the wall. The bilateral upper half side rails were in the up position. There was a full-length padded side rail covering the resident's face, and the bottom end of the full-length [redacted] was [redacted] to a locked [redacted] positioned on the lower half of their bed. The surveyor observed that the resident was pulling at their incontinent brief, and the back of the resident's [redacted] was positioned in a gap between the upper side rail and mattress. The resident continued to scream unintelligible sounds. The surveyors further observed on the opposite side of the resident's bed against the wall, that there was a [redacted] positioning device tucked under the fitted mattress sheet. This positioning device positioned the resident in a	F 700		

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manner that kept the resident from accessing that side of the bed and closer to the side of the bed where the surveyor observed gapping between the mattress and side rail causing an [redacted] risk.

The surveyors observed more closely and noted that the [redacted] was also locked and positioned on the lower end of the bed while the resident was in the bed. The surveyor attempted to gently push the [redacted] to evaluate the chair's mobility, but it was securely locked and not easily moved. This situation created an unsafe gapping between the lower end of the bed frame, causing a further [redacted] risk if the resident rolled or attempted to get out of bed. There was no space at the end of the bed for the resident to safely get out of bed, and the gaps between the chair device and the bed frame and mattress created a further [redacted] risk for Resident [redacted].

At approximately 11:50 AM, the surveyors observed a Certified Nursing Aide (CNA) enter the resident's room. The surveyors asked the CNA about the resident, their positioning, and the screaming. The CNA indicated that the resident's screaming was typical and associated the screaming with the resident's known behaviors. She stated that Resident [redacted] was not originally on her assignment today but was given to her when an Agency CNA had to do a [redacted] observation for another resident on the same [redacted] unit (Resident [redacted]). She confirmed that the side rail padding was covering the resident's [redacted] the resident was positioned sideways, and the back of their [redacted] was in a gap between the mattress and side rail. The CNA then stated that she would reposition the resident. The CNA then began to remove the full-length side rail [redacted]

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from the resident's bed and [redacted]r. The surveyor asked about the locked [redacted] the CNA responded, "this was here" when she got on for the start of her shift and implied that the night shift had set it up for the resident this way. She stated the [redacted] gets locked at the end of her bed "to keep [Resident [redacted]] in bed." One of the surveyors then asked if the resident was fed breakfast that morning. The CNA replied, "yes," and the surveyor followed up with a second question regarding how the resident was fed breakfast if the [redacted] was positioned in that manner since the night shift? The CNA then stated that she fed the resident breakfast and backtracked to state that she moved the [redacted] back to the bottom of the bed and locked it (and not the night shift staff). She justified her statement by adding, "I do what everyone else is doing." She confirmed that the other staff set the resident up with the locked [redacted] in the same manner, to keep the resident from getting out of bed. The surveyors then observed the CNA reposition the resident, pulling them out of the gap between the mattress and side rail. The CNA then unlocked the [redacted] and moved it out of the way. The CNA could not speak to the gaps between the side rails and the mattress or the safety risk/entrapment hazard with having a locked [redacted] positioned at the bottom of the bed.

The surveyor then observed the resident's roommate, Resident [redacted] sitting up in bed with their [redacted] against the upper half side rails in the up position. The head of the bed was flat. The surveyor observed that the resident's bed was also positioned against the wall, preventing the resident from getting out on one side of the bed. The other side of the bed had the half-side rails in

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the up position, and there was a locked wheelchair on the bottom end of the bed, creating a gap between the mattress and the wheelchair. The surveyor attempted to gently push on the wheelchair to determine if it could easily move, and the wheelchair was firmly locked and unable to be easily moved. The surveyor observed the CNA remove the locked wheelchair from beside the lower end of the bed. The surveyor asked the CNA about this resident's locked wheelchair. The CNA could not speak to the potential entrapment hazard for the resident if the resident attempted to climb out of bed or fell out of bed with the wheelchair present.

The surveyor reviewed the medical record for Resident [redacted].

A review of the Admission Record face sheet (an admission summary) for Resident [redacted] revealed that the resident was admitted to the facility with diagnoses of [redacted].

A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] which reflected that the resident was [redacted] for a brief interview for mental status (BIMS), so staff assessed the resident's [redacted] status. The MDS revealed that the resident was assessed to have a [redacted] problem with a [redacted] It further revealed that the resident required an extensive one-person physical assist for bed mobility and transfers. The section to record if bed rails were used as a [redacted] indicated there were none used.

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F 700	Continued From page 168 A review of the resident's individualized, comprehensive care plan revised on 1[redacted] included that the resident was at high risk for [redacted] related to a [redacted] Interventions dated [redacted] included, "Bed against the wall to promote boundaries and floor mat next to the bed." The care plan also included that the resident had a history of [redacted]. In addition, the care plan revised on [redacted] included that the resident has a potential for [redacted] related to poor safety awareness and [redacted]. Interventions included [redacted] bed rails, wheelchair arms, or any other source of potential injury if possible... [Resident [redacted] rips off any and all [redacted] staff places on wheelchair. Attempt to replace as needed." The care plan for Side rails included that the resident utilized bilateral half side rails as an enabler for mobility and positioning initiated on [redacted]. Interventions included to "explain the risk and benefits to the resident or resident representative...Obtain a physician's order...Review of side rail use quarterly." It did not address assessing the bed rails and mattress for any [redacted] risks. A review of the most recent side rail assessment dated [redacted] included that the resident was non-ambulatory, had an altered safety awareness due to a cognitive decline, has difficulty sitting on or moving to the side of the bed, poor trunk control, and currently uses side rails for independent positioning or to assist with positioning. Under the section for alternatives, it was blank. The Recommendations included	F 700		

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bilateral half side rails are indicated at present to promote independence. The side rail assessment did not include a section to evaluate for [redacted] risk.

A review of the physician's Order Summary Report for [redacted] included a physician's order with a start date of [redacted] ordered nearly two months after the most recent side rail assessment, that indicated "May have two half side rails while in bed every shift."

A review of the electronic Assessments dated 8/1/18 (the date when the physician ordered the side rails) did not include evidence of an entrapment risk assessment.

The surveyor reviewed the medical record for Resident [redacted]

A review of the Admission Record face sheet revealed that Resident [redacted] had diagnoses that included [redacted]

A review of the resident's quarterly MDS dated [redacted] reflected that the resident had a BIMS score of [redacted] indicating a severely [redacted]. There was no staff assessment for [redacted] conducted. The MDS assessment further revealed that the resident required a total one-person physical assist for bed mobility and total dependence of two people for transfers. The section to record if bed rails were used as a [redacted] indicated there were none used.

A review of the resident's individualized,

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comprehensive care plan revised on [redacted] included that the resident has [redacted] in the wheelchair, and has [redacted] causing them to be at risk for [redacted]. A review of the care plan initiated on [redacted] included that the resident used bilateral half side rails as an enabler for mobility and positioning. Interventions included to "explain the risk and benefits to the resident or resident representative...Obtain a physician's order...Review of side rail use quarterly." It did not address assessing the bed rails and mattress for any [redacted] risks.

A review of the physician's Order Summary Report for [redacted] included a physician's order with a start date of [redacted] that indicated, "May have two half side rails while in bed every shift."

A review of a side rail assessment dated [redacted] included that the resident was non-ambulatory, had an [redacted] has difficulty sitting on or moving to the side of the bed, poor trunk control, and currently uses side rails for independent positioning or to assist with positioning. Under the section for alternatives, it was blank. The Recommendations included bilateral half side rails are indicated at present to promote independence. The side rail assessment did not include a section to evaluate for [redacted] risk.

A review of the electronic assessments dated [redacted] (date when the side rails were added to the resident's care plan) did not include evidence of an [redacted] risk assessment.

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F 700	Continued From page 171 On 10/24/21 at 1:30 PM, the surveyors requested any evidence of entrapment risk assessments or follow-up regarding the surveyor's findings with Resident [redacted] and [redacted] with the Interim Director of Nursing (DON) . The DON acknowledged that the locked [redacted] and locked wheelchair should not have been positioned at the lower end of the resident's beds due to an injury hazard or [redacted] hazard. It was confirmed that it wasn't addressed in a care plan or physician's orders to place the devices next to the beds in the manner they were observed. At 3:45 PM, no additional documentation or information was provided to the surveyors in response to the surveyor's findings from the DON or the LNHA. At 4:00 PM, the two surveyors notified the Interim DON and the LNHA of the facility's failure to ensure Resident [redacted] and [redacted] were assessed for the risk for [redacted] when side rails were ordered and in place, the failure to prevent equipment from being locked adjacent to the resident's beds which caused a potential [redacted] hazard, and the failure to ensure that Resident [redacted] who was known to remove side rail padding had no gaps between the bed rails and mattress when and if the [redacted] was removed. This failure caused Resident [redacted] to be observed by two surveyors to have their [redacted] positioned within the gap between the side rail and mattress, which posed a serious and immediate threat to the safety and well-being of both residents due to an [redacted] risk hazard. This resulted in an Immediate Jeopardy (IJ) situation that began on 10/24/21 when Resident #3 was observed to have their head in the gap	F 700		

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F 700	Continued From page 172 between the mattress and side rail; There was no side rail [redacted] assessment. The IJ continued until 10/25/21 when the facility alleged complete implementation of the elements of their removal plan was accepted on 10/29/21 and verified by the survey team. The facility administration was notified of the Immediate Jeopardy situation on 10/24/21 at 4:00 PM. On 10/26/21 at 4:07 PM, Surveyor #5 requested any entrapment risk assessments, side rail consent for Resident [redacted], and a copy of the current facility side rail policy, including maintenance, installation, and monitoring. On 10/27/21, the Administrator (LHNA) provided a Physical Restraint Policy, dated 01/05, which revealed: It is the policy of this facility to refrain from the use of physical restraints. Physical restraint is defined as the use of any device on or near the resident's body, which inhibits freedom of movement or free access to his/her person. The policy did not include the use of side rails as enablers, maintenance of side rails, installation, monitoring, or entrapment risk assessments. NJAC 8:39-27.1(a)	F 700		
F 730 SS=F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the	F 730		12/28/21

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F 730	Continued From page 173 requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to conduct yearly performance reviews of Certified Nursing Aides (CNA) and Nursing Aides (NA) in order to provide specific education based on the outcomes of the reviews. This deficient practice was identified for 21 of 44 CNAs or NAs eligible for a yearly performance review. The deficient practice was evidenced by the following: On 10/26/2021 at 10:15 AM, the Human Resources (HR) staff member stated she had been working at the facility for three years. HR stated she was unable to locate any CNA or NA performance reviews dated after 2018. HR further stated the CNA and NA performance reviews should be done every year to determine competency and the need for any additional education. HR further stated it was the responsibility of each department head to do the CNA and NA performance reviews. HR also stated the facility had no staff educator. On 10/26/2021 at 10:38 AM, the Director of Nursing (DON) stated CNA and NA performance reviews were done to evaluate the staff's competency. The DON stated that newly hired CNAs and NAs would be evaluated every month for three months and yearly. The DON stated the performance reviews would be kept in the HR office and conducted by the department supervisors. The DON further stated the Assistant Director of Nursing (ADON), which the facility did	F 730	F 730 Element One – Corrective Actions • The facility annual performance evaluation form was reviewed and revised to reflect specific job responsibilities for CNA's that can be linked to required education needs. The new evaluation tool was implemented on 11/5/21. • A second annual performance evaluation was created for licensed nurses with specific job responsibilities. The new evaluation tool was implemented on 11/5/21. • Nursing management provided instruction to nurse managers and supervisors regarding completion of the performance evaluations. • Annual performance evaluations are being completed by nursing management for nursing staff including CNAs and licensed nurses which will be placed in their employee file. Evaluations are being reviewed and an employee specific education plan will be implemented based on the results of the annual evaluations once completed. • A policy for the evaluation of Nurse Aides was developed to address the requirement for annual evaluations and targeted education based on the results of the evaluation. Element Two – Identification of at Risk Residents All Residents have the potential to be affected by this practice.	

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F 730	Continued From page 174 not have, or the DON would be responsible to oversee the performance reviews of the CNAs and NAs. The DON also stated it was important to have performance reviews to establish what areas the CNA or NA might be lacking in and who may need additional education on specific topics. On 10/26/2021 at 1:03 PM, the Staffing Coordinator provided a list of all full-time, part-time and per diem CNAs and NAs actively working at the facility. The list included 44 actively working CNAs and NAs with their dates of hire. Of the 44, 21 had worked at the facility long enough to have yearly performance reviews but did not have their yearly performance review completed. On 10/26/2021 at 12:05 PM, HR stated the facility had no policy and procedure for nurse aide performance reviews. NJAC 8:39-43.17(b)	F 730	Element Three – Systemic Changes • The HR Director created a tracking tool to ensure annual performance evaluations of nurse aides are completed timely and will maintain the record of all completed performance evaluations. The tracking tool will be shared with the DON/Staff Educator to ensure evaluation results are correlated with required education. Element Four – Quality Assurance Monthly the DON/Staff Educator will review the tracking tool for annual performance evaluations of CNA's, NA's, and licensed nurses to ensure they are completed timely per facility policy. The Staff Educator will use the results of the performance evaluations to plan individual and group in-service education. The Staff Educator will keep a copy of each nursing staff member's education records in a locked file cabinet. The DON/Staff Educator will provide an update of compliance with completion to the QAPI committee monthly for three months and then quarterly thereafter.	
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by:	F 759		12/28/21

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	315280	A. BUILDING _____ B. WING _____	C 11/01/2021

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F 759	Continued From page 175 Based on observation, interview, and record review, it was determined that the facility failed to administer medications without errors. During the medication pass the surveyor observed five (5) nurses administering medications to six (6) residents, there were 29 opportunities and five (5) errors observed which resulted in a 17.2% error rate. Four (4) of the five (5) errors included an attempted administration of four (4) medications to the wrong resident (Resident [redacted]. The deficient practice was identified for one (1) of five (5) nurses administering medications to two (2) of six (6) residents, (Resident [redacted] and Resident # [redacted]). The deficient practice was as follows: REFER to F760 Error #1 1. On 10/19/2021 at 9:45 AM, Surveyor #13 observed an agency Licensed Practical Nurse (LPN), during the medication pass on the [redacted] unit, obtain a [redacted] for Resident [redacted]. The agency LPN stated to Resident [redacted] that she needed to administer [redacted]) because the [redacted] was [redacted] At that time, the surveyor observed a breakfast tray with food that had been eaten in front of Resident [redacted] and the tray was being removed by a staff member. Surveyor #13 then observed LPN review the Medication Administration Record (MAR) which revealed a Physician's Order (PO) that indicated that LPN was to administer [redacted] of [redacted] in the body) for a [redacted] that was between [redacted] Surveyor #8 observed the LPN prepare and administer the [redacted]	F 759	F 759 Element One – Corrective Actions • Resident [redacted] had no ill effects from the administration of the insulin. Resident [redacted] transferred to another facility on [redacted]. The Agency LPN who administered the [redacted] at the wrong time is no longer providing services at the facility. The Agency was immediately notified of the issue. • Resident [redacted] did receive the correct medications without issue after the LPN checked the armband and verified [redacted] identity. The LPN was removed from the schedule at the end of the shift and is no longer being used at the facility. The Agency was immediately notified of the issue. Element Two – Identification of at Risk Residents All residents whose medications were administered by this nurse have the potential to be affected by this practice. Element Three – Systemic Changes • Med pass evaluations were requested to be sent by each Agency when a licensed nurse first provided services at the facility. An orientation packet was prepared to send to each agency to give to each nurse before they provide services at the facility. The nursing supervisor was provided with a copy of the packet as well to review with any new agency nurse on their first day. • A new Consultant Pharmacist (CP) was hired and began services on [redacted] and included completion of med pass	

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F 759	Continued From page 176 [redacted] into the resident's [redacted]. Upon returning to the medication cart, Surveyor #13 interviewed the LPN who stated that she should have checked the [redacted] for Resident [redacted] before breakfast because that was indicated in the PO. The LPN also stated that the resident should not have started eating breakfast and should have waited for [redacted]. The LPN explained that she administered the [redacted] because she felt the resident's [redacted] was high and the resident had just finished breakfast and was still eating, and she didn't want the resident's [redacted] to get any higher. Review of the resident's [redacted] PO's revealed an order dated [redacted] for [redacted] to be administered [redacted] and [redacted] according to the [redacted] results on a [redacted] as follows: from [redacted] and to call MD if [redacted] is less than [redacted] or greater than [redacted]. The facility was unable to provide a policy regarding proper [redacted] administration. Review of the facility's policy dated as reviewed/revised 6/2009 for "Medication Administration-Policy and General Guideline" that was provided by the Director of Nursing (DON), revealed that medications should be administered specifically as ordered for medications ordered	F 759	observations of nurses in addition to regularly scheduled chart audits. Additional med passes were completed by the CP on [redacted] and will continue monthly. • Med pass evaluations were initiated for both facility and Agency nurses by the new consultant pharmacist who provides one to one education as needed based on the med pass results. Nursing management is also conducting med pass evaluations of nurse on off-shifts. • The DON implemented a med pass checklist and nursing staff were provided with education and a copy was placed on each unit as a reference tool for all nurses who administer medications. • All licensed nurses will have a med pass observation completed on hire prior to administering medications and a minimum of annually thereafter. Element Four – Quality Assurance Monthly the consultant pharmacist is conducting med pass evaluations and providing one to one education on the spot as needed based on the results of the observations. Med pass results are provided to the DON along with the monthly CP report. The DON/designee reviews all med pass observations and based on the results confirms if the nurse is allowed to pass medications. Results are reported in aggregate by the DON at the quarterly QAPI meeting for action as appropriate on an ongoing basis.	

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F 759	Continued From page 177 before or after a meal. Error # 2,3,4 and 5 2. On 10/19/2021 at 9:50 AM, Surveyor #13 observed an agency LPN, during medication pass on [redacted] unit, prepare four (4) medications for Resident [redacted] who received [redacted]). The LPN was observed preparing the resident's medications to be administered which included [redacted] milligram (mg) (a medication used for [redacted]), [redacted] mg (a medication used for [redacted]), [redacted] mg (a medication that [redacted] and [redacted] and [redacted] mg (a medication used in [redacted] residents to [redacted]). Surveyor #13 observed the LPN turn to a resident who was seated in a wheelchair next to her medication cart and without identifying the resident by asking his/her name or checking the resident's identification (ID) bracelet, was about to administer the medications to that resident (Resident [redacted]), another resident's (Resident [redacted] medications that were listed above. Surveyor #13 stopped the LPN and asked if this was the correct resident. Surveyor #13 then observed the LPN ask Resident [redacted] their name, the resident identified himself/herself as a different resident. At that time, Surveyor #13 interviewed the LPN who stated that she should have identified the resident either by asking the resident for their name or checking the identification (ID) bracelet. The LPN also told Surveyor #13 that she was an agency nurse and that it was her [redacted] day at the	F 759		

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F 759	Continued From page 178	F 759		

facility. She further stated that she had not received an in-service or orientation prior to starting her shift. The LPN stated that she was confused with the paper medication administration records and that when she started her shift the 11 PM to 7 AM nurse just handed her the keys for the medication cart with no instruction.

On 10/19/2021 at 10:20 AM, Surveyor #13 reviewed the Admission Record for Resident [redacted] which indicated that the resident was admitted to the facility on [redacted] with diagnoses which included [redacted].

Review of the resident's [redacted] Physician's Orders revealed an order for [redacted] mg, 1 tablet by mouth three times daily for [redacted] mg, 1 tablet by mouth once daily for [redacted] mg 1 tablet by mouth twice daily for [redacted] mg, 1 tablet by mouth three times daily with food for [redacted].

On 10/19/2021 at 1:45 PM, Surveyor #13 interviewed the DON regarding an orientation package and in-services that were provided to the agency LPN prior to starting her shift. The DON stated that the LPN was provided no in-servicing or an orientation package prior to starting her shift.

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F 759	Continued From page 179 On 10/19/2021 at 2:40 PM, Surveyor #13, in the presence of the survey team, discussed the medication pass errors with the DON. The DON stated that she would have expected all nurses to read the PO's and follow them. In addition, the DON stated that the nurses must identify a resident prior to administering any medication. Review of the facility's policy dated as reviewed/revised 6/2009 for "Medication Administration-Policy and General Guideline" that was provided by the DON revealed that medications are to be prepared, administered, and recorded by licensed nurses who have successfully completed a "Medication Pass Observation" upon hire and annually. The policy also reflected that medications should be administered specifically as ordered for medications ordered before or after a meal. In addition, the policy revealed that "Positive resident identification should be ensured prior to medication administration." Refer to F760 The facility was unable to provide a policy regarding proper [redacted] administration. NJAC: 8:39-29.2 (d)	F 759		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review	F 760	F760	12/28/21

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F 760	Continued From page 180 and review of pertinent facility documentation, it was determined the facility failed to: a.) protect residents from the potential for significant medication errors by not following the standards of practice for the administration of medication, and b.) implement the facility policy for Medication Administration when 1 of 5 nurses (an Agency Licensed Practical Nurse) on 1 of 4 units ([redacted]) observed during a medication pass observation prepared and attempted to give high-risk medications to the wrong resident. On 10/19/21 the surveyor observed the Agency Licensed Practical Nurse (LPN #1) attempt to administer two medications that were specific for [redacted] medication, and a medication to [redacted]. The Agency LPN #1 did not follow the six rights of medication administration by identifying the correct resident with the correct medications. The six rights include the following: the right resident, the right drug, the right dose, the right route, the right time and the right indication for use. The surveyor intervened before the medications could be administered to Resident [redacted] Interviews with the Agency LPN #1 revealed it was her first day at the facility, and she was neither oriented to the facility's system of medication administration, nor had she completed a medication pass competency at the facility prior to an assignment on the [redacted] medication cart. This posed a serious and immediate threat for all the residents on [redacted] The immediate jeopardy (IJ) began on 10/19/21 at 9:50 AM and continued until 10/20/21. The Director of Nursing (DON) was notified of the IJ on 10/19/21 at 2:40 PM. The lack of orientation	F 760	Element One – Corrective Actions • The Agency LPN who failed to properly check a resident's identification prior to administering medication ordered for Resident [redacted] and was stopped by the surveyor was taken off the schedule and removed from building at the conclusion of the shift. This nurse is no longer allowed to provide services at the facility. • Resident [redacted] was administered the correct medications without issue. • The Agency that employed the LPN was immediately notified of the error the morning of [redacted] and told not to send this LPN to the facility in the future. Element Two – Identification of at Risk Residents All residents have the potential to be affected by this practice. Element Three – Systemic Changes • Agency nurses are required to provide proof of med pass competency prior to the first time they come to the facility. Contract staffing agencies must ensure licensed nurses have passed a med pass competency evaluation that includes checking resident identification band or picture of each resident prior to administering any medications. • Nursing Supervisors were informed about checking for a med pass competency evaluation for any new agency nurse that comes to the facility prior to assigning them to a med cart. • An orientation packet was prepared to send to each agency to give to each nurse before they provide services at the facility.	

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F 760	Continued From page 181 and training for an agency nurse that never worked at the facility previously and the failure of LPN #1 to follow the six rights of medication administration in accordance with professional standards of nursing practice that must be used to reduce the risk of medication errors and harm (identifying a resident prior to administering medications) constituted an Immediate Jeopardy situation. The failure to identify a resident prior to administering medications is likely to cause serious injury, harm, impairment or death to the residents on [redacted] unit due to the risk associated with a resident receiving the wrong high-risk medications not prescribed to to them by their physician or receiving a medication that may be associated with a medication allergy. An acceptable removal plan was received on [redacted] and verified by the survey team on [redacted] and throughout the remainder of the survey. This deficient practice was evidenced by the following: On 10/19/21 at 9:50 AM, the surveyor observed an agency LPN (LPN#1) during a medication pass on [redacted] unit. The surveyor observed her open to the Medication Administration Record (MAR) for Resident [redacted] and prepare four (4) medications for Resident [redacted] who went to the [redacted] center. The LPN #1 prepared [redacted] milligram (mg) (a medication used to [redacted] and treats [redacted]), [redacted] mg ([redacted]; a medication used to [redacted] mg	F 760	The nursing Supervisor was provided with a copy of the packet as well to review with any new agency nurse on their first day • Licensed nurses received re-education on [redacted] regarding checking resident identification to verify the right resident is being administered the right medication prior to any medication administration. • A new Consultant Pharmacist (CP) was hired and began services on [redacted] and included completion of med pass observations of nurses in addition to regularly scheduled chart audits. Additional med passes were completed by the CP on [redacted] and will continue monthly. • Med pass evaluations were initiated for both facility and Agency nurses by the new consultant pharmacist who provides one to one education as needed based on the med pass results. Nursing management is also conducting med pass evaluations of nurse on off-shifts. • The DON implemented a med pass checklist and nursing staff were provided with education and a copy was placed on each unit as a reference tool for all nurses who administer medications. Element Four – Quality Assurance • The DON/Supervisor/designee will request proof of med pass competency evaluation from all staffing agencies prior to a licensed nurse providing services at the facility. Med pass competency evaluations will be reviewed by nursing management and be maintained in the nursing department.	

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F 760	Continued From page 182 (a medication that [redacted]) and [redacted] mg (a medication typically used for residents that are dependent on [redacted] and aids in [redacted]). At that time at 9:50 AM, the surveyor observed Resident [redacted] sitting upright in bed eating breakfast. The surveyor then observed LPN#1 turn to a different resident (Resident [redacted] who was sitting in a wheelchair next to her medication cart. Without identifying the resident by asking their name or checking the resident's identification (ID) bracelet, she began to hand the medications to Resident [redacted], which were ordered and prepared for Resident [redacted] 1. The surveyor immediately stopped LPN#1 and asked her if this was the correct resident. The surveyor then observed LPN#1 ask Resident [redacted] their name. The resident correctly identified him/her-self by name as Resident [redacted]. At 10:00 AM, the surveyor interviewed LPN#1 who stated that she should have identified the resident either by asking the resident for their name or checking the ID bracelet. LPN #1 also told the surveyor that she was an agency nurse and that it was her [redacted] day at the facility. When asked by the surveyor, she also stated that she had not received an orientation or in-service training prior to starting her shift. LPN#1 stated that she was also confused with the facility's paper form of the Medication Administration Records and that when she started her 7 AM to 3 PM day shift, the night shift (11 PM to 7 AM) nurse just handed her the keys for the medication cart with no further instruction.	F 760	• Monthly the consultant pharmacist is conducting med pass evaluations and providing one to one education on the spot as needed based on the results of the observations. Med pass results are provided to the DON along with the monthly CP report. The DON/designee reviews all med pass observations and based on the results confirms if the nurse is allowed to pass medications. Results are reported in aggregate by the DON at the quarterly QAPI meeting for action as appropriate on an ongoing basis.	

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F 760	Continued From page 183 On 10/19/21 at 10:20 AM, the surveyor reviewed the Admission Record face sheet (an admission summary) for Resident [redacted] which indicated that the resident was admitted to the facility on [redacted] with diagnoses which included [redacted]. The Admission Record reflected that the resident had no known [redacted]. A review of the resident's [redacted] Physician's Orders (PO) sheet revealed the following physician's orders to be administered at 9 AM and all dated [redacted] a.) [redacted] mg one tablet by mouth three times daily for [redacted] b.) [redacted] mg one tablet by mouth once daily for [redacted] c.) [redacted] mg one tablet by mouth twice daily for [redacted] and d.) [redacted] mg one tablet by mouth three times daily with food for [redacted]. The surveyor reviewed the Quarterly Minimum Date Set (MDS), an assessment tool used to facilitate the management of care dated [redacted] for Resident [redacted], which reflected the resident had a brief interview for mental status (BIMS) score of [redacted] indicating that the resident had a [redacted]. The surveyor reviewed Resident [redacted] interdisciplinary care plan (IDCP) dated [redacted] that revealed under the focus area of potential [redacted] problem that the resident had a history	F 760		

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F 760	Continued From page 184 of [redacted]. On 10/19/21 at 10:30 AM, the surveyor reviewed the Admission Record face sheet for Resident [redacted] which indicated that the resident was admitted to the facility on [redacted] with diagnoses which included [redacted] The Admission Record revealed that the resident had no known [redacted] A review of the [redacted] Physician's Orders for Resident [redacted] revealed the following orders: a.) [redacted] mg one tablet by mouth daily for [redacted] dated [redacted] b.) [redacted] mg one tablet by mouth twice daily (a [redacted] dated [redacted] c.) [redacted]) three times weekly on [redacted] at [redacted] for [redacted]) due to [redacted] dated [redacted], d.) [redacted] medication) [redacted] mg) by mouth once daily for [redacted] dated [redacted]. e.) In addition, the PO revealed that Resident [redacted] went for [redacted] 5:30 AM. (There was no evidence from the corresponding PO sheets for [redacted] that Resident [redacted] was receiving any of the same morning medications as Resident [redacted]). The surveyor reviewed the Quarterly MDS dated [redacted] for Resident [redacted] which reflected the resident had a BIMS score of [redacted] indicating that the resident had a [redacted]	F 760		

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F 760	Continued From page 185	F 760		

The surveyor reviewed Resident [redacted]'s IDCP with a target date [redacted] had a focus area which included, "ADL self-care performance deficit, activity intolerance, [redacted] balance and [redacted]" with a Goal to "maintain current level of function in bed, mobility, transfers, eating, dressing, toilet use and personal hygiene." The resident also had a focus area that addressed the [redacted], unsteady [redacted] that had a target date of 1[redacted], the interventions revealed under mobility that the resident uses a wheelchair on [redacted] days for navigation on the unit for energy conservation.

A review of the electronic Progress Notes for the last six months ([redacted]) for Resident [redacted] and Resident [redacted] did not reveal any evidence of inappropriate medication responses.

On 10/19/21 at 1:45 PM, the surveyor interviewed the DON regarding an orientation package and in-services that was provided to LPN#1 prior to starting her shift. The DON stated that LPN#1 was provided no in-servicing or an orientation package prior to starting her day shift.

On 10/19/21 at 2:40 PM, the surveyor, in the presence of the survey team, discussed the medication pass errors with the DON. The DON stated that she would have expected all nurses to read the physician's orders and follow them. In addition, the DON stated that the nurses must identify a resident prior to administering any medication. She was unable to provide documented evidence of any in-service education or competency for medication pass prior to being assigned a medication cart on the unit for LPN

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SILVER HEALTHCARE CENTER	1417 BRACE ROAD CHERRY HILL, NJ 08034

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F 760	Continued From page 186	F 760		

#1. The DON acknowledged the serious risk associated with giving the wrong high-risk medications to a resident.

At that time, the DON was notified that the lack of orientation and training for an agency nurse that never worked at the facility previously and the failure of LPN#1 for not following the six rights of medication administration that should be used to reduce the risk of medication errors and harm (specifically identifying a resident prior to administering medications) constituted as an Immediate Jeopardy situation that could impact all residents on [redacted] unit due to the likelihood for serious injury, harm, impairment or death caused by improper administration of medication procedures.

A review of the facility's policy dated as reviewed/revised on 6/2009 for "Medication Administration-Policy and General Guideline" that was provided by the DON revealed that medications are to be prepared, administered, and recorded by licensed nurses who have successfully completed a "Medication Pass Observation" upon hire and annually. In addition, the policy revealed that "Positive resident identification should be ensured prior to medication administration."

An acceptable Removal Plan was received on [redacted] and verified by the survey team on and throughout the remainder of the survey. The Removal Plan included the following:

"The Agency nurse who failed to properly check a resident's identification prior to administering medication was stopped by the surveyor and the nurse was immediately removed from passing

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F 760	Continued From page 187 medications on the morning of [redacted], was taken off the schedule and removed from building. This nurse will no longer be allowed to provide services at the facility. The agency that employed the nurse was immediately notified the morning of [redacted] and informed of the error and not to send this nurse to the facility in the future. Agency nurses will be required to provide proof of med pass competency prior to the first time they come to the facility. Contract staffing agencies must ensure licensed nurses have passed a med pass competency evaluation that includes checking resident identification band or picture of each resident prior to administering any medications. Licensed nurses received re-education on [redacted] regarding checking resident identification to verify the right resident is being administered the right medication prior to any medication administration." On 10/20/21 at 9:45 AM, the survey team verified that the LPN #1 was not working at the facility and in-service education had begun. A review of the LPN#1 time card report indicated that she worked the entire day shift 7 AM to 3 PM shift on 10/19/21. On 10/21/21 at 10:30 AM, the surveyor conducted a Resident Council Group Meeting with five residents, including the resident council President. The residents did not address a concern in regard to medication pass administration or receiving wrong medications. N.J.A.C. 8:39-11.2 (b)	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		12/28/21

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F 761	Continued From page 188 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure properly labeling, storage and disposal of identified medications in six (6) of nine (9) medication carts, and two (2) of five (5) medication refrigerators that were inspected. This deficient practice was evidenced by the following: On 10/20/2021 at 10:55 AM, Surveyor #13, in the	F 761	F761 Element One – Corrective Actions • The pharmacy provider audited all carts for compliance with storage, labeling and destruction of expired or unused drugs. • Cart checks were completed by the new CP and staff instructed one on one regarding findings. • All mediations not properly labeled or stored were discarded including:	

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F 761	Continued From page 189 presence of the Licensed Practical Nurse (LPN), inspected medication cart [redacted] on the [redacted] unit. Surveyor #13 observed an opened bottle of [redacted] that was not dated. On 10/20/2021 at 10:57 AM, Surveyor #13, in the presence of the LPN, inspected medication cart [redacted] on the [redacted] unit. Surveyor #13 observed an opened bottle of [redacted] that was not dated. At that time, Surveyor #13 interviewed the LPN who stated that when a bottle of [redacted] were opened there should be the date when the bottle was opened indicated on the bottle. On 10/20/2021 at 11:10 AM, Surveyor #13, in the presence of the LPN, inspected the medication room on the [redacted] unit. Surveyor #13 observed four (4) unlabeled [redacted] attached that contained [redacted] s (ML) of an [redacted] The [redacted] had no label identifying the name of the medication, dose, resident's name, expiration date or lot number. At that time, Surveyor #13 interviewed the LPN who stated that she did not have knowledge as to the contents of the syringes. The LPN added that the [redacted] should be disposed immediately. The LPN explained that all medications should be properly labeled and without proper labeling the medication must be disposed. On 10/20/2021 at 11:20 AM, Surveyor #13, in the presence of a Registered Nurse (RN), inspected the medication cart [redacted] on the [redacted] unit. Surveyor #13 observed an opened bottle of [redacted] that was not dated when opened, an	F 761	o [redacted] med cart [redacted] – undated [redacted] o Unlabeled [redacted] in med room on [redacted] o [redacted] unit med cart [redacted] undated opened [redacted], [redacted], and [redacted] vial without resident name. o Med cart [redacted] on [redacted] opened [redacted] vials with expired dates, [redacted] not dated when opened, two bottles of [redacted] not dated when opened. o Med cart [redacted] on [redacted] - undated [redacted] o [redacted] room – unlocked refrigerator with unlabeled [redacted] Element Two – Identification of at Risk Residents All residents have the potential to be affected by this practice. All med carts and med rooms were immediately checked for any expired, undated when opened or improperly stored or labeled medications. Element Three – Systemic Changes • A new Consultant Pharmacist (CP) was hired and began services on [redacted] that include completion of med pass observations of nurses, required med cart inspections, and monthly chart audits. • CP reports were reviewed with licensed nursing staff as part of re-education regarding their responsibility to address any concerns in the reports. A	

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F 761	Continued From page 190 opened bottle of [redacted] that was not dated when opened and an [redacted] vial that was not labeled with the resident's name. At that time, Surveyor #13 interviewed the RN who stated that the opened bottle of [redacted] and the opened bottle of [redacted] liquid should have been dated when the products were opened. The RN also stated that al[redacted] vials should have a label with the resident's name. On 10/20/2021 at 12:05 PM, Surveyor #13, in the presence of the LPN, inspected the medication cart [redacted] on the [redacted] unit. Surveyor #13 observed two (2) opened [redacted] vials labeled for two (2) unsampled residents with the dates the vials were opened: [redacted] and [redacted]. Surveyor #13 interviewed the LPN who stated that [redacted] vials once opened have an expiration date of 28 days. The LPN acknowledged that both vials of [redacted] were expired and should have been removed from the refrigerator and disposed after 28 days of being opened. At that time, Surveyor #13 also observed an opened [redacted] that was not dated when opened, and two (2) bottles of [redacted] (an [redacted] that were labeled for an unsampled resident. Surveyor #13 interviewed the LPN who stated that the Symbicort inhaler should have been dated when opened and that the two (2) bottles of [redacted] had been discontinued and should have been removed from the medication cart when the medication was discontinued. The LPN added that all expired, discontinued, and undated when opened medications should have been removed	F 761	copy of the CP recommendations was placed on each unit for licensed nurses to act upon. • Nursing staff received re-education about storage, labeling, dating of multidose meds when opened and proper disposal of expired medications. • The DON implemented a medication storage reference document for easy reference by nursing staff who received education. A copy of the reference tool was placed on each nursing unit. Element Four – Quality Assurance • Unit Managers are checking medication and treatment charts each week to be sure all medications, [redacted] and treatment products are properly labeled and stored. Findings are acted on by the Unit Manager and reported at morning clinical meeting. • Monthly the consultant pharmacist is conducting med pass evaluations and providing one to one education on the spot as needed based on the results of the observations. Med pass results are provided to the DON along with the monthly CP report. The DON/designee reviews all med pass observations and based on the results confirms if the nurse is allowed to pass medications. Results are reported in aggregate by the DON at the quarterly QAPI meeting for action as appropriate on an ongoing basis.	

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F 761	Continued From page 191 from the medication cart. On 10/20/2021 at 12:20 PM, Surveyor #13, in the presence of the LPN, inspected the medication cart [redacted] on the [redacted] unit. Surveyor #13 observed an opened bottle of Glucose test strips that was not dated. Surveyor #13 interviewed the LPN who stated that the opened bottle of [redacted] should have been dated when the bottle was opened. On 10/20/2021 at 12:40 PM, Surveyor #13, in the presence of the LPN, inspected the medication cart [redacted] on the [redacted]. Surveyor #13 observed an opened bottle of [redacted] that was not dated. Surveyor #13 interviewed the LPN who stated that the opened bottle [redacted] should have been dated when the bottle was opened. On 10/20/2021 at 12:45 PM, Surveyor #13, in the presence of the LPN, inspected the medication room refrigerator on the [redacted] unit. The medication room refrigerator was not locked. The surveyor also observed a [redacted] that was not labeled for a resident. Surveyor #13 attempted to interview the LPN regarding the unlocked refrigerator and the unlabeled [redacted], but the LPN did not respond to any questions from Surveyor #13. On 10/20/2021 at 1:10 PM, Surveyor #13, in the presence of the Director of Nursing (DON), returned to the medication room on the [redacted] unit. The DON stated that the medication room refrigerator door should be locked, and the [redacted] should be labeled with a resident's name. The DON added that the	F 761		

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F 761	Continued From page 192	F 761		

unlabeled [redacted] should be remove from active inventory and disposed.

On 10/20/2021 at 1:00 PM, Surveyor #13, in the presence of the survey team, met with the DON and reviewed the above findings during the inspections of medications that were not dated when opened, expired medications, and discontinued medications in active inventory. The DON had no further information to provide.

On 10/26/2021 at 12:21 PM, Surveyor#12 interviewed the DON who stated that she would expect any nurse to check medications for proper labeling, date medications when they were opened and dispose of expired medications.

Review of the "Monthly Nursing Station Review" dated 1[redacted], completed by the Consultant Pharmacist (CP) revealed that there were findings identified by the CP for medications that were expired, missing labels and not dated when opened. The documented review by the CP also revealed that information was provided to the facility that insulin vials once opened would expire after 28 days and [redacted] once opened would expire after 90 days.

On 10/25/2021 at 3:26 PM and 10/26/2021 at 8:46 AM, Surveyor#12 attempted to interview the Consultant Pharmacist (CP) via telephone but was unable to speak with the CP.

Review of the facility policy for "Storage of Medications" dated May 2002 provided by the Administrator revealed that medications were to be stored safely, securely, and properly following the manufacturer's recommendations. In addition, a multidose medication container will be dated

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F 761	Continued From page 193 and initialed on the label on the vial. The policy also revealed that outdated, contaminated, or deteriorated medications were to be immediately removed from stock and disposed. In addition, corrective action would be taken for any medication storage conditions identified monthly. Review of the Manufacturer's Specifications for the following medications revealed the following: 1. [redacted] vials once opened have an expiration date of 28-days. 2. [redacted] once opened have an expiration date of 90-days. 3. [redacted] once opened have an expiration date of 90-days. 4. [redacted] once opened have an expiration date of 42-days. NJAC: 8:39-29.4 (a)(g)(h), 29.7(b)	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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.	F 812		12/28/21

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F 812	Continued From page 194 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation it was determined that the facility failed to: a.) maintain sanitation in cooking areas in a safe consistent manner; b.) label, date, and store potentially hazardous foods appropriately to prevent food borne illness; c.) discard potentially hazardous foods past the date of expiration; d.) practice acceptable hand hygiene; e.) ensure that two of the three resident unit refrigerators were maintained in a safe and sanitary manner; and, f.) ensure that dishwasher temperature checks and sanitizer levels were performed and recorded prior to use at each meal service during Phase Zero of a COVID-19 Outbreak at the facility. This deficient practice was evidenced as follows: 1. On 10/8/2021 at 10:13 AM, the surveyor interviewed the Infection Control Nurse (ICN) who stated that resident meals were served on disposable dishware on the units that were placed on isolation for Persons Under Investigation (PUI) after exposure to COVID-19 ([redacted] Unit), or [redacted]) [redacted]r Unit) (machine used to provide [redacted]) and regular dishware was served on the remaining three units. The surveyor requested copies of three months of dish machine temperature logs dated through 10/8/2021. At 1:28 PM, the surveyor reviewed the Dish	F 812	F812 Element One – Corrective Actions The following corrective actions were implemented in the kitchen: • Both the dishwasher final rinse injector and the tubing from the sanitizer canister were immediately checked and a service call was made to the vendor to return to the facility to recheck the system. The vendor repaired the system on 10/9/21. In the interim residents were provided with disposable products for meals until the dishwasher and sanitizer system were fully operational. • A log of dishwasher temps was placed by the dishwasher and staff re-educated about testing & logging temps as well as sanitizer level prior to each meal service. • The AFSD was re-educated about the timeframe for washing hands and how to properly load paper towels into the dispenser after first properly washing hands. • The scoop was removed from the powdered liquid thickener container. • The meat slicer was properly cleaned and covered as was the mixer and were labeled out of order until replaced. • Items in the reach in refrigerator discarded included: o Undated cubed cheddar cheese o Expired coleslaw o Undated Deli sandwich spread	

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F 812	Continued From page 195 Machine Temperature Logs provided by the ICN which included logs for the months of July, August and September 2021. An October 2021 Dish Machine Temperature Log was not provided as requested. At 1:49 PM, the surveyor went to the kitchen and interviewed the Assistant Food Service Director (AFSD) who stated that facility had a low temperature dish machine which utilized a chlorine sanitizer to clean and sanitize the dishes. He stated that both the wash and rinse temperatures were required to be at least 120 degrees or higher and the [redacted] reading should be at 50 parts per million (PPM) to ensure that the dishes were properly sanitized. The AFSD stated that he was unable to locate the October 2021 Dish Machine Temperature Log when the surveyor requested to view it. He further stated that Dietary Aide (DA) #1 washed the dishes after the breakfast meal and was not available for interview. At 1:59 PM, DA #2 demonstrated the use of the Low Temperature Dish Machine. The wash temperature was 160 degrees, and the rinse temperature was 140 degrees. When the wash was completed the DA obtained a [redacted] paper strip (used to test for sanitation) and dipped it into the water that collected in the reservoir of a meal tray lid that was run through the dish machine and removed it immediately. He stated that the [redacted] test paper should have changed in color from white to light purple to indicate that the reading was at 50 PPM as indicated by the legend on the side of the vial that contained the chlorine paper test strips. At 2:07 PM, DA #2 ran the dish machine a	F 812	o Container of potato salad undated o Undated containers of macaroni salad o One gallon container of unlabeled and undated barbeque sauce o One gallon container of unlabeled and undated duck sauce o Expired Storage pan of melted butter o Expired container of cottage cheese o Expired garlic o Opened bag of mozzarella cheese with no open date • Items in the walk in freezer discarded included: o All food boxes encased in ice o Box of grilled chicken on the floor o Sausage links undated o Box of frozen beef patties not sealed • Items in the walk in freezer discarded included: o Chicken breasts o Pork under the defrosting turkey o Signage was placed on the rack depicting defrosting order for meats to prevent contamination o The case of celery o Undated onion partially sliced o Green celery not dated o Eight peanut butter & jelly sandwiches • The walk in freezer was defrosted and a freezer truck provided for storage of frozen foods until the freezer parts on order are received. • Items in the stainless steel prep refrigerator discarded included: o Undated Sour cream • The bottom shelf of the prep table was thoroughly cleaned F812	

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F 812	Continued From page 196 second time and the wash temperature were 158 degrees, and the rinse temperature was 140 degrees. When DA #2 dipped the chlorine test paper strip into the water that collected in the reservoir of the meal tray lid the [redacted] paper strip did not change color. DA #2 pulled the tubing out of the sanitizer dispenser and pressed his thumb over the opening of the tubing. He stated that he wanted to see if there was a blockage that prevented the [redacted] sanitizer from being dispensed into the dish machine and then returned the tubing to the sanitizer canister. He stated that there was no sanitizer coming out of the dispenser, "None at all." He stated that no sanitizer was detected during both wash and rinse cycles that he demonstrated for the surveyor. The AFSD who was present during the observation, stated that a technician was out to perform a monthly maintenance check on the dish machine two days prior and did not identify an issue with the sanitizer dispenser. He stated that staff were required to check the sanitizer levels weekly and were not required to document the readings. He stated that the DAs were responsible to check the dish machine temperatures and the [redacted] sanitizer levels with the use of the [redacted] test paper strips. He stated that he reviewed the October dish machine temperature log today and agreed to locate it for the surveyor. He further stated that he would place the dish machine out of service and institute disposable dish ware throughout the building until the machine was repaired. At 2:37 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) in the presence of the survey team. He stated that	F 812	Element One – Corrective Actions • The scoops were removed from the beef and chicken base and properly stored and staff immediately re-educated. • The Resident refrigerator on [redacted] was cleaned, a thermometer placed in the refrigerator and freezer sections and a temperature log placed beside the refrigerator with staff educated about checking temps. o Styrofoam containers discarded o Churches chicken discarded o Whole milk discarded • The Resident refrigerator on [redacted] was cleaned, a thermometer placed in the refrigerator and freezer sections and a temperature log placed beside the refrigerator with staff educated about checking temps. o Half pints of milk discarded o Grocery store bags of items discarded Element Two – Identification of at Risk Residents All residents have the potential to be affected by this practice. Element Three – Systemic Changes • Dietary staff received re-education about their responsibility to label, date and store all food products following safe food handling practices to prevent food borne illness. • Nursing staff were re-educated about monitoring all resident refrigerators and labeling and dating any resident food items being stored in the refrigerators and logging refrigerator and freezer temps daily. • [redacted] was contracted with to help	

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F 812	Continued From page 197 he was not aware of any issues with the dish machine. He stated that he thought that the [redacted] sanitizer test paper strips should be used to confirm the sanitation of the dishes and should be utilized to do so "as often as the kitchen staff were able to do it." He further stated, "If the dishes were not sanitized, it could result in an infection issue." He stated that the FSD was not working today, and he would call her to see if she had the October 2021 Dish Machine Temperature Log. At 3:59 PM, the LNHA provided the surveyor with the October 2021 Dish Machine Temperature Log. He stated that staff mistakenly placed the document on the wrong clip board in the kitchen. The surveyor reviewed the log which revealed that staff failed to document that the sanitizer level was checked prior to washing the dinner dishes from 10/1/2021 through 10/7/2021. Further review of the log revealed that on 10/8/2021, the staff did not document the wash temperature, rinse temperature or sanitizer levels and the fields that corresponded to both the breakfast and lunch meals were blank. The LNHA stated that staff may have checked the temperature and sanitizer readings and did not document them as they could not locate the dish machine log. He stated, "You do not have to document the chemical sanitizer result, it is just good practice to document it." He explained that disposable dishware was in use on the PUI units and regular dishware was used on the units that were not on isolation as those residents were not exposed to COVID and disposable dishware was not as home like. On 10/12/2021 at 8:19 AM, the surveyor interviewed the LNHA who stated that the dish	F 812	oversee kitchen sanitation, repairs, and dietary staff supervision and education. • Kitchen equipment was evaluated and as needed either repaired, replaced., or discarded as appropriate. Element Four – Quality Assurance The FSD conducts weekly inspections of the kitchen to assure compliance with all sanitation, food storage, labeling and dating, and food handling and preparation regulations. The FSD will provide a copy of the weekly inspections to the Regional Administrator monthly on an ongoing basis for review and action as needed. Any deviations will be reported to the Administrator and QA Committee quarterly on an ongoing basis for further action as needed.	

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machine was repaired on 10/9/2021. He provided the surveyor with the Customer Service Report (CSR) dated 10/9/2021 which revealed that: "No sanitizer was going into problem dip line to machine..." Further review of the CSR revealed that both the Dip line and Sq tube were replaced with vehicle stock and the dish machine was documented as functional. The LNHA also provided the surveyor with a Warewashing Preventative Maintenance Report dated 10/11/21 which indicated that the wash temperature of the machine was 150 degrees, the rinse temperature was 150 degrees, and the low temperature chlorine was adjusted to 70 PPM. Further review of the document revealed that a Final Rinse Injector Fitting was replaced, and the dishwasher and dispenser were, "working good."

At 9:59 AM, the surveyor interviewed the Food Service Director (FSD). She stated that Dish Machine Temperature Log should be kept on the clipboard on the wall near the dish machine. The FSD provided the surveyor with a copy of the log which had not been filled in since 10/7/2021. DA #2 was present during the interview and stated that dish machine temperature readings and sanitizer levels should be documented prior to dish machine use at each mealtime. He demonstrated use of the machine and the wash temperature was 140 degrees, the rinse temperature was 148 degrees, and the sanitizer level reading was 50 PPM. The FSD stated that staff were required to document the sanitizer level on the log prior to each meal service as they could not determine if the dishes were sanitized if the sanitizer level was not recorded. She stated that the facility would continue to utilize disposable dish ware on all units until the issue with the dish washer was determined to be fully

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resolved.

The surveyor reviewed the facility policy titled, "Dish Machine" (updated 05/07/21) which revealed the following:

Policy:

All utensils, dishware and service ware will be cleaned and sanitized prior to each use. The dish machine will be monitored prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitizing.
Dish machine temperatures should be monitored and recorded on the Dish Machine Temperature Log prior to use. Staff will report any problems (mechanical and/or temperature) with the dish machine to the Food Service Director as soon as they have been identified. The Food Service Director will promptly address any dish machine problems and take appropriate action to assure proper cleaning and sanitizing of dishes.

At 3:47 PM, the surveyor interviewed the LNHA who stated that he was not sure if the ICN was required to document the contact tracing. He stated that sometimes it was hard to document everything that that we did.

2. On 10/18/2021 at 8:16 AM, surveyor #2 toured the kitchen accompanied by the Assistant Food Service Director (AFSD), who wore a beard restraint and surgical mask. He stated that standard dishware was utilized throughout the facility.

On 10/18/2021 at 8:22 AM, the AFSD washed his hands in the presence of surveyor #2 for 14

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seconds. There were no paper towels in the paper towel dispenser. He obtained additional paper towels and failed to utilize the key that hung above the handwashing sink to fill the paper towel dispenser and instead stuffed the paper towels into the paper towel dispenser from the bottom opening of the dispenser.

On 10/18/2021 at 8:24 AM when interviewed, the AFSD stated that there was no key for the dispenser. He further stated, "Oh, here is the key." When interviewed further, he stated that he was required to wash his hands for 40-60 seconds per facility policy and sung happy birthday twice to ensure that he washed his hands long enough. He stated that there was a chance of cross contamination if paper towels were improperly loaded into the paper towel dispenser with hands that were not properly washed.

On 10/18/2021 at 8:27, AM surveyor #2 observed that there was a plastic scoop stored within the plastic like container where powdered liquid thickener was stored. The AFSD stated that the scoop should not have been in there. He stated that he would get rid of it. He stated that the scoop was not supposed to be stored in the powdered liquid thickener because there was a chance of cross-contamination.

A lunch meat slicer was observed in the food prep area that was not covered. The AFSD stated that it did not work and neither did the mixer bowl which also remained uncovered.

On 10/18/2021 at 8:30 AM, in the reach-in refrigerator the following was observed:

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1. On the second shelf from the top, a 1/3 pan that contained cubed cheddar cheese was not dated. The AFSD stated that it was utilized for chef salad yesterday on 10/17/2021.
2. An 8 lb. container of Cole slaw located on the top shelf of the refrigerator that had a received date of 10/7/2021 expired on 10/30/2021.
3. A jar of deli sandwich spread located on the second shelf was undated and opened. There was no opened date.
4. On the second shelf a 10 lb. container of potato salad was opened and had no expiration date or opened date.
5. Two 10 lb. containers of macaroni salad were opened and had no received date, opened date or expiration date. The AFSD stated that there was usually an expiration date from the manufacturer.
6. On the bottom shelf a one-gallon container was opened and failed to contain an opened date.
7. On the bottom shelf a one-gallon container of an unidentified brown liquid, identified by the AFSD as BBQ Sauce no opened date or received date.
8. On the bottom shelf a one-gallon container of honey mustard salad dressing failed to contain an opened and received date.
9. On the bottom shelf a one-gallon container of Italian dressing failed to contain a received date and was not marked with an opened date.
10. On the bottom shelf an opened one-gallon container of duck sauce was marked with a received dated of 9/9/2021 and was not marked with an opened date and failed to contain an expiration date.
11. On the bottom shelf an opened storage pan of melted butter was dated 7/28/2021. The AFSD stated that that must be the wrong date as the date gun was broken. He further stated that the

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melted butter was used for grill cheese on the grill.
12. On the top shelf a 5 lb. container of cottage cheese expired on 10/7/2021.
13. On the top shelf a 5 lb. container of peeled garlic that was opened and half full, expired on 10/17/2021.
The AFSD stated he was going to discard the garlic, cottage cheese and BBQ sauce.
14. An opened five lb. bag of mozzarella cheese had a received date of 10/14/2021 and failed to contain an opened date.
15. On the top shelf, an opened 5 lb. bag of peeled garlic was opened, not dated, and failed to contain an expiration date. The surveyor noted a white, thick, patchy substance on the garlic. The AFSD stated, "I am unsure what that is on the garlic."

When interviewed, the AFSD stated that the facility did not date food items with opened date. He stated that the facility instead went by the expiration date.

On 10/18/2021 at 8:56 AM, in the walk-In freezer the following was observed:

Surveyor #2 noted a large, thick coating from the middle to the rear of the walk-in freezer. The ice buildup was noted to cover food items located on the second shelf and bottom shelf of a three-tiered wired rack. The AFSD was unable to identify the food items that were encased in ice on the bottom shelf of the walk-in freezer.
The AFSD stated that the leak was reported in February. He further stated that the facility could not use anything under the waterfall.
16. A box was observed directly on the floor which contained two bags of grilled chicken. The

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AFSD stated that the box should not have been stored on the floor and must have fallen off the milk crate that was on the floor behind it.
17. On the second shelf from the top of a three-tiered wired rack a meat that was identified as sausage links by the AFSD was not marked with a received date or expiration date.
18. On the second shelf from the top of a three-tiered wired rack a 20 lb. box of frozen beef patties were opened to air.

At 9:03 AM, surveyor #2 interviewed the FSD (Food Service Director) who stated that the freezer was leaking since February. She stated that it was fixed, and it broke again. She stated that a work order was placed, and the repairmen never came out; "We put in a work order."

On 10/18/2021 at 9:06 AM, surveyor #2 observed the following in the walk-in refrigerator:

A seven-tiered rolling rack contained the following:

1. On the fifth shelf from the top, two bags of boneless chicken breasts that were being defrosted and pink liquid was noted within the bag.
2. On the sixth shelf from the top, a 10 lb. package of ground turkey breast (pulled 10/17/2021) was being defrosted and was placed above a 10 lb. package of pork that was being defrosted.

The AFSD told surveyor#2 that the chicken should have been placed on the bottom shelf because if it dripped onto the meat below it could cause contamination.

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On a four-tiered wired rack located on the posterior wall of the walk-in refrigerator the following was observed:

1. On the second shelf from the top a five-pound sealed package of turkey breast, an opened 13 lb. package of cooked ham and two sealed 13 lbs. packages of cooked ham were stored above a case of celery. The AFSD stated that the main refrigerator had been out of service for months. He further stated that we must work with what we have.

When interviewed, the FSD stated, " I am not even supposed to be here today." She stated that we reported that the freezer was broken. At 9:20 AM the tour of the kitchen concluded.

On 10/21/2021 at 8:45AM, surveyor #6 toured the kitchen in presence of the Assistant Food Service Director (AFSD) and observed the following:

In the stainless walk-in refrigerator, the following was observed:

1. One half of a white onion wrapped in clear plastic wrap, not dated.
2. Eight stalks of green celery wrapped in clear plastic wrap, not dated.
3. One cardboard box with 16 red and green peppers. The box was open to air, not covered, no received date, no use by dates. The surveyor asked the AFSD how long fresh produce was kept, and he told the surveyor, "we just eyeball it".
4. A stainless-steel tray in a stainless tiered rack with eight peanut butter and jelly sandwiches with an expiration date of 10/20/2021. The AFSD said he would discard them.

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In the stainless prep refrigerator, the surveyor observed the following:

1. One three-pound opened plastic container of sour cream, no opened or use by date. The AFSD told surveyor "we just go by the expiration date".

On the bottom shelf of a stainless-steel prep table surveyor #6 observed the following:

1. Multiple food particles on the bottom shelf of the table and white splattered substance. Surveyor #6 asked the AFSD if it appeared soiled, he responded "yea it does".
2. Two 40-pound white plastic drums, one beef base and one chicken base, both half full and both with plastic scoops in the product. The AFSD told surveyor #6 they should not be in the product.

On 10/21/2021 at 9:58 AM, surveyor #6 observed the resident refrigerator on [redacted] in the presence of a Certified Nurse Assistant (CNA). The surveyor asked who was responsible to maintain cleanliness of the resident pantry refrigerators and checking the temperatures and she told surveyor, "I'm not sure, probably maintenance." There was no thermometer in the refrigerator or freezer and no temperature logs. The freezer was empty, and the refrigerator contained the following:

1. Two small white Styrofoam containers with clear lids that had mashed potatoes and gravy. No dates or residents name on the products.
2. One white cardboard box that had "[redacted]" printed on it. No dates or resident name.
3. One gallon of whole milk, no dates or resident

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name.

On 10/21/2021 at 10:10 AM, surveyor #6 observed the refrigerator on the Atrium unit kitchen with a unit Certified Nursing Assistant (CNA). The CNA said it was for resident food or snacks. The refrigerator did not have a temperature log and there was no thermometer in the refrigerator or freezer.

The following was observed in the Atrium Unit refrigerator:

1. Three fat free half pint milks with use by date of 10/20/2021.
2. Two plastic grocery store bags that contained items wrapped in paper. They were not dated and did not have residents' names on them.

The surveyor asked the CNA who was responsible for maintaining the refrigerators with stocking, checking dates and monitoring temperatures and the CNA told surveyor, "maybe maintenance."

On 10/21/2021 at 10:22 AM, surveyor #6 interviewed the Acting Food Service Director (AFSD) regarding unit refrigerators/kitchens, maintenance/cleaning, temperature logs, stocking, checking dates on products. The AFSD told surveyor, "it must be maintenance or the unit managers who do that".

On 10/22/2021 at 10:07 AM, surveyor #6 reviewed the policy titled "Food Storage", there was no effective date or revision date on the policy. Under the cold storage section, number 4, it indicated all foods will be stored either wrapped or in a closed storage container and be clearly

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F 812	Continued From page 207 dated and labeled. On 10/27/2021 at 10:30 AM, surveyor #6 reviewed the policy titled, "Food Brought in From the Outside", the policy had a revision date of 05/17/21. Under the procedure section, number 3, it indicated food and beverages brought in from the outside sources that require refrigeration will be labeled with the resident's name, date and stored in common areas for resident use. Number 6, under the procedure section said all refrigerator and freezer units will have internal thermometers to monitor for safe food storage temperatures. Assigned staff will monitor temperatures in resident/employee use units. Number 7, also under procedure section, indicated dietary staff will also be responsible to check resident units for food that is outdated, unlabeled, or not stored properly and discard. NJAC 8:39-19.4 NJAC 8:39-17.2, 19.7	F 812		
F 835 SS=L	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 F689, F700, F760, F880, F908. Based on observations, interviews, review of medical records and review of facility documents,	F 835	F 835 Element One – Corrective Actions • Resident [redacted] was administered the correct medications without issue.	12/28/21

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F 835	Continued From page 208 it was determined that the facility Licensed Nursing Home Administrator (LNHA) failed to ensure: a.) the residents environment was safe and free from accidents/hazards by ensuring all handrails were properly secured throughout the facility after the LNHA was made aware that improperly secured handrails caused a fall on [redacted], and during survey on [redacted], surveyors observed the handrail that caused the fall on [redacted] remained improperly secured. A total of 15 of 25 handrails were observed as not secured to the walls, and 26 of 50 handrails had jagged edges; b.) exposed outlets and electrical wires were covered to prevent serious injury; c.) provide effective environmental, housekeeping, pest control measures to limit the spread of infections; d.) ensure staff follow a system to inform the [redacted] Center of contagious infection diseases upon resident transfer; e.) staff adhered to the appropriate transmission based precautions during resident care and environmental cleaning for the [redacted] Unit; f.) ensure a system to install and maintain bed rails in a safe and secure manner was followed; g.) a system for identifying an active gas leak was in place in the facility laundry room; and, h.) the facility clothes dryers were maintained in a safe operating manner. The failure of the LNHA to ensure the facility operated in manner that ensured residents were cared for in a manner and in an environment that enabled residents to maintain or attain their highest practicable physical, mental, and psychosocial well-being posed a serious and immediate threat to the health, safety and welfare of all residents who resided in the facility, as well as ensure the staff followed Policy & Procedures for the above, as outlined in the Facility	F 835	• The Agency that employed the LPN was immediately notified of the error the morning of 10/19/21 and told not to send this LPN to the facility in the future. • The care plan and Aide Kardex for Resident [redacted] was reviewed and revised to reflect updated interventions to minimize the risk of falls. Staff that provide care for Resident [redacted] received re-education regarding the care pan and Kardex changes. • Staff received re-education about the procedure to document in the medical record assessment findings after a resident experiences a fall or other incidents, notification of the physician and responsible party and documentation of same in the medical record and how to complete an investigation including obtaining written statements and completing investigation documents. • The new Administrator expanded all housekeeping and maintenance audits facility-wide and initiated daily rounds with housekeeping and maintenance staff to evaluate progress with all corrections for all areas noted in F584 and those identified during daily environmental rounds. • The new Administrator ordered housekeeping equipment and supplies, new blinds, cubicle curtains, and contracted with vendors to repair or replace non- functional air conditioning units. to ensure the resident environment was maintained in a clean, safe and sanitary condition. • The new Administrator in conjunction with the management company retained	

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F 835	Continued From page 209 Administrator Job Description, resulted in an initial immediate jeopardy (IJ) that was identified on 10/08/21 at 5:00 PM. Additional deficient practices that rose to the IJ level were identified during the on-site visit on 10/12/2021, and the facility was notified on 10/14/21 at 1:30 PM. The facility submitted a removal plan by e-mail on 10/14/2021 however, the LNHA administrator of record resigned on 10/19/2021 and a new administrator of record was in place on 10/22/2021. The survey team conducted a removal plan revisit on 11/1/2021 and verified the removal plan. Part A Refer to F689J, F880L, F700J, 760J. On 10/12/2021, The LNHA further failed to ensure that effective housekeeping and environmental services were provided in the facility to prevent the transmission and spread of infectious disease on 1 of 5 units reviewed ([redacted] unit where 58 residents resided and 33 were ambulatory) by ensuring: hallway floors, walls, resident rooms ([redacted]) and bathrooms on [redacted] were free from dried feces on surfaces throughout the unit, loose trash was removed and discarded, individual resident HVAC (Heating, Ventilation & Air Conditioning) units (room [redacted] and [redacted]) had covers to prevent the excessive buildup of dust and debris within their filters, privacy curtains were free from stains and dirt, and resident rooms were on a carbolization (deep cleaning) schedule (this was not occurring for months per staff interviews due to a lack of functioning cleaning equipment). This immediate jeopardy was identified on 10/08/2021 and the	F 835	the services of multiple vendors to assist with corrective actions implemented to address all IJ citations including F689, F880, F700, and F760. Please refer to these tags for more specific actions implemented. • Housekeeping & maintenance staff received re-education to ensure the resident environment is kept clean and properly maintained. • The new Administrator assigned staff to audit all beds, mattresses, and resident furniture to identify what needed repair or replacement and coordinated with vendors for the needed repairs or replacement items. • Resident [redacted] was immediately repositioned safely, and the geri-chair was immediately removed from the lower part of the bed. Resident [redacted] was immediately assessed for entrapment risk by the DON and Occupational Therapist. This resident prefers her bed against the wall and this was added as an intervention on the care plan. The side rails are down when the resident is out of bed. The MDS assessment and care plan for this resident was reviewed to ensure side rail use is properly coded and addressed as an intervention on the care plan. • Resident [redacted] was immediately repositioned safely, and the wheelchair was immediately removed from the lower part of the bed. Resident [redacted] was immediately assessed for [redacted] risk by the DON and Occupational Therapist on 10/24/21 and padding correctly placed on the side rail. A [redacted] was immediately placed between the rail and	

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F 835	Continued From page 210 facility was notified of the IJ on 10/14/2021. The LNHA resigned on [redacted]. Findings included: 1. The facility administrator failed to protect residents from accidents hazards. The facility Administrator failed to ensure that the environment was safe and free of accidents hazards. During the tour on 10/08/2021, the surveyors observed that handrails used by residents on the [redacted] Unit were broken; that 25 of the 50 handrails on [redacted] (Hall[redacted] Hall[redacted]) were not properly mounted to the wall; and that 12 of the hand rails were observed with jagged sharp edges creating a potential for injury. Surveyor #1 conducted a tour of the [redacted] Unit on 10/8/21 at 9:15 AM. The surveyor interviewed a staff member who was sitting at the nursing station who identified herself as the Licensed Practical Nurse Unit Manager (LPN/UM). The LPN/UM stated that the [redacted] Unit was comprised of all [redacted]) residents and some residents that had [redacted] related to [redacted]. She stated that the census was 58 residents and that 33 of the residents ambulated independently. During the tour the Surveyors #1 and #3 identified the following: The surveyor observed residents' rooms: [redacted], and [redacted] had uncovered exposed electrical outlets accessible to residents. The surveyor also observed that in resident room [redacted] there was an uncovered bathroom electrical light fixture with exposed live electrical wires which was at ground level and accessible to	F 835	the mattress of the Resident [redacted] on [redacted] to prevent a gap or risk of [redacted] The bed was repositioned and removed from placement along the wall. Resident [redacted] was on [redacted] and expired of [redacted]. • The side rails on the bed of Resident [redacted] were immediately removed and the care plan revised following an order from the physician to discontinue the rails. The physician ordered floor mats to be placed on the floor on both sides of the bed and the bed in lowest position on 10/21/21. The care plan was revised to reflect the new orders on 10/21/21. Staff received re-education about the use of floor mats and the bed in lowest position when the resident is in bed in lieu of F 835 Element One – Corrective Actions side rails. The MDS assessment and care plan for this resident was reviewed to ensure side rail use is properly coded and addressed as an intervention on the care plan. • Staff involved were immediately re-instructed in the proper use of side rails and the policy on physical restraints. • The toilet in Resident [redacted]'s room was replaced • The toilets in Resident [redacted] and 99's rooms were replaced • The chair in Resident [redacted]'s room was cleaned Element Two – Identification of at Risk Residents All residents have the potential to be	

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F 835	Continued From page 211 residents. The surveyor observed that on hallway [redacted] and hallway [redacted] of the [redacted] unit there were [redacted] hallway handrails that were loose and not securely mounted to the walls. Some handrails were loose while others were hanging off the wall. There were also 26 out of 50 hallway handrails that were broken with sharp and jagged edges exposed. The surveyors also observed multiple residents ambulating through the halls and using the handrails as enablers for ambulation. On 10/8/21 at 9:30 AM, Surveyor #1 interviewed the Certified Nursing Assistant (CNA) who stated that she was assigned to provide care to the residents in rooms [redacted]. She stated that if she noticed any maintenance issues that she would report concerns to the nurse so that the nurse could notify the maintenance staff. She added that she was unaware that electrical outlets in rooms [redacted] needed to be covered. She also stated that she did not report it because she did not know about it. She revealed that the uncovered light fixture in room [redacted] had been that way and that she did not report it because she did not know that it needed to be covered. On 10/8/21 at 10:25 AM, Surveyor #1 interviewed that Maintenance Director (MD) who stated that he was unaware that there were uncovered electrical outlets in rooms [redacted], [redacted], and [redacted]. He also stated that he was unaware that there was an uncovered light fixture with exposed electrical wires in room [redacted]. He revealed that these issues would be a hazard because of the confused residents that resided	F 835	affected by these practices. All residents with side rails have the potential to be affected by this practice. All residents at risk for falls have the potential to be affected by this practice. Element Three – Systemic Changes • Staff received re-education about reporting any loose handrails or unsafe handrails to their supervisor and creating a work order for maintenance for immediate repair. • Staff received re-education about properly closing and locking all closet and utility storage doors where hazardous items are stored to prevent resident access. • Staff received re-education related to: o notification of the physician and responsible party with changes in condition and documentation in the medical record o Assessment of residents and documentation of findings in the medical record after incidents including falls and update the resident care plan o The process to investigate incidents, complete an incident report and obtain witness statements in accordance with facility policy • Contracts were signed with multiple vendors to assist the facility with all maintenance repairs and to provide ongoing preventive maintenance services. The new Administrator is coordinating all vendor services and directing the Maintenance staff to prioritize all repairs. • The new Administrator interviewed and hired a new Maintenance Director.	

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F 835	Continued From page 212 on the [redacted] Unit. At this time, the MD, Director of Nursing (DON), Infection Preventionist (IP) and LPN/UM accompanied Surveyor #1 on a tour of the [redacted] Unit and acknowledged that a lot of the handrails on the [redacted] and [redacted] hallways were not securely mounted to the walls, were loose and broken. The MD stated to the surveyor at this time, that he was not aware that so many handrails in the halls were broken with jagged, sharp edges. He admitted that the handrails were in disrepair and needed to be addressed right away to prevent someone from getting injured. He also revealed that the building was in "bad shape" when the new owner took over, but that was no excuse. The DON, IP and LPN/UM were all in agreement that the aforementioned areas of concern were a hazard to the residents safety on the [redacted] unit. On 10/8/21 at 11:30 AM, Surveyor #1 interviewed the CNA who stated that maintenance issues were reported through a computer system and the maintenance department was supposed to check the system and fix the concerns. She stated that she was unsure on how to enter the concerns in the computer system, but that she would report it to the nurse so the nurse could notify the maintenance department. She added that the environmental conditions on the [redacted] were "horrible" and that even when issues were reported nobody does anything about it. The CNA did not elaborate about the "horrible" conditions but made hand gestures and pointed around the unit to the handrails that were in disrepair. On 10/8/21 at 11:35 AM, Surveyor #1 interviewed the Licensed Practical Nurse (LPN) who had been employed in the facility for 7 years and who worked on the [redacted] Unit. The LPN stated that	F 835	• The new administrator is overseeing QAPI projects that have been implemented to address maintenance issues. • Contracts were signed with multiple vendors to assist the facility with housekeeping services while additional housekeeping staff are hired. Vendors will also provide ongoing oversight and supervisory assistance and train facility housekeeping staff. The new Administrator coordinated all vendor services and developed cleaning, carbolization, and stripping and waxing schedules with the housekeeping director. • The new Administrator interviewed and promoted the Ast. Housekeeper to the position of Housekeeping Director. • The new administrator is overseeing QAPI projects that have been implemented to address all housekeeping issues. • Fall interventions were reviewed and staff re-educated to minimize the risk of falls for Resident [redacted]. • Staff were re-educated about proper completion of incident reports and documentation per facility policy when a resident sustains a fall (Resident [redacted]) Element Three – Systemic Changes • Side rail use and entrapment risk assessments of Residents on the [redacted] were conducted by the DON and OT on 10/24/21. Additional side rail use and entrapment risk assessments were conducted on [redacted] and [redacted] on [redacted], [redacted], and 1[redacted]. • Additional education was provided to	

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F 835	Continued From page 213 she reported concerns to the maintenance staff directly about the broken handrails, however they "don't fix them". On 10/8/21 at 11:40 AM, Surveyor #1 interviewed the LPN/UM who had only been employed in the facility for one week stated that she was not educated on how to put maintenance concerns in the computer but that she would verbally tell the maintenance staff about the issues concerning the broken, loose handrails in the hallways on the [redacted] unit. She added that "nothing happens". She also denied knowing about the uncovered electrical outlets and uncovered light fixture with exposed live wires. On 10/8/21 at 2:30 PM, Surveyor #1 interviewed the Licensed Nursing Home Administrator (LNHA) who stated that he was unaware of the exposed electrical outlets in rooms [redacted], and [redacted] or about the bathroom light uncovered in room [redacted] with exposed live wires. He also denied having any knowledge that some of the hallway handrails were loosely mounted to the walls and that a lot of the handrails were broke with sharp jagged edges. The LNHA stated that he made "environmental rounds" on [redacted], with the facilities Regional Director of Operations (RDO) and Regional DON. He revealed that the MD was not included in the environmental rounds. He then added that they found a few "dirty" rooms but admitted that he did not go into every room. At this time the LNHA viewed pictures that the surveyor had taken of the environmental hazardous on [redacted] Unit. The LNHA admitted that the aforementioned areas of concern were a hazard to the resident's safety on	F 835	staff on the [redacted] unit on [redacted] regarding proper use of side rails and proper positioning. • Side Rail education was provided to staff on Court One and Court Two regarding entrapment risks, proper use of side rails as enablers when ordered, alternatives to side rails and obtaining consent prior to use of side rails. • Beds and mattresses were replaced as needed and [redacted] was placed on side rails when needed to ensure Residents using side rails had no gaps or [redacted] risks. • Consents were obtained for Residents who have side rails as enablers or who wish to use them for their own sense of security. Residents and responsible parties were provided with bed rail use safety information prior to obtaining consents. • Ongoing evaluation of the need for side rails is being completed by nursing and therapy to reduce the use of side rails. • Licensed nurses received re-education on [redacted] regarding checking resident identification to verify the right resident is being administered the right medication prior to any medication administration. • Contracts were signed with multiple vendors for new equipment, supplies, beds, mattresses, and furniture. The new Administrator coordinated with department directors for the timely distribution of all equipment, supplies, and furniture as it is delivered. • Residents [redacted], & [redacted] who were	

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F 835	Continued From page 214 the [redacted] Unit and that a resident could get hurt. When the surveyor asked the LNHA why they could get hurt on the [redacted] he verified that the residents on that unit had [redacted] During the complaint survey conducted on 10/12/2021, the surveyor reviewed three random investigations for accidents and hazards, for Resident [redacted] who was admitted to the facility with diagnoses which included [redacted] The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted], revealed that Resident [redacted] was awake, alert, and able to make his/her needs known. Resident [redacted] scored [redacted] on the Brief Interview for Mental Status (BIMS) which indicated [redacted]. On 10/08/2021 at 2:30 PM, Surveyor #1 reviewed a random investigative report dated [redacted]. Under Nursing Description the following was noted: " Resident [referring to Resident [redacted]] stood up out of wheelchair and attempted to hold onto rail outside of his/her room to close his/her door, when the rail fell causing him/her to lose balance and fall on his/her buttocks to the floor". Supervisor notified. No injury apparent. Resident did not hit his/her head". A statement obtained from the resident on [redacted], the day of the fall indicated the following:" I was trying to close my room door and grabbed hold of the rail to support me and it fell, causing me to fall".	F 835	positive for [redacted] and attended [redacted] were all placed on contact precautions and staff educated about the proper use of PPE. Signage was placed on the entrance to their rooms with pictures of required PPE. The [redacted] center was notified of the infectious disease and provided with instructions for cleaning and disinfecting equipment after use with these residents. • The RT and CNA on the vent unit who failed to use the correct PPE when caring for resident [redacted] were counseled and re-educated about contact precautions and the use of PPE for residents with a diagnosis of [redacted]. The RT and CNA both were fit tested for the correct size N95 mask. A sign was placed on the door to the room of Resident [redacted] noting contact precautions and depicting the PPE required before entering the room. • Housekeeping staff on the vent unit who failed to correctly clean and disinfect rooms of residents with [redacted] were counseled and re-educated about transmission based precautions, the use of PPE, and proper cleaning and disinfectant products to use when cleaning the rooms of residents with a diagnosis of [redacted]. • The contracted housekeeping staff were removed from the unit and signage in Spanish was also placed on the doors designating required PPE. • The aide who provided care to Resident [redacted] was re-educated about the proper use of PPE for a resident who is on [redacted] as a [redacted]. Proper PPE set ups were placed outside the room and	

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F 835	Continued From page 215 The causal factor identified by the facility was a faulty handrail and the intervention was to notify maintenance to fix the handrail. On 10/12/2021 at 12:45 PM, Surveyor #1 toured the Unit to ensure the handrail was fixed and interview the resident. The surveyor observed Resident [redacted] sitting in the hallway across from room [redacted]. The resident told the surveyor that he/she recalled the incident and pointed to the handrail where the incident occurred. The surveyor went and touched the handrail, and the handrail fell on the floor. The resident further stated that the nurse can tell you all about the incident. During an interview on 10/12/2021 at 1:15 PM, the LPN assigned to the unit revealed that staff attempted to re-attach the handrail this morning. Upon further inquiry the LPN indicated that the handrail was never repaired after the fall. The LPN could not elaborate on whether or not a work order was generated for repair. On 10/12/2021 at 2:10 PM, Surveyor #1 interviewed the Maintenance Director (MD) who indicated that he was not aware that a broken handrail on the [redacted] Unit needed to be repaired. He was not aware that a resident sustained a fall on [redacted], due to a faulty handrail. The surveyor inquired about the process for repair. The surveyor escorted the MD to the [redacted] Unit where both observed the handrail on the floor. The MD told the surveyor that he did not have a work order for the handrail. He went on to say that he toured the [redacted] Unit twice weekly. There was no maintenance book as the facility implemented an electronic report system.	F 835	signage moved so it was clearly visible before entering the room. Bins for disposal of contaminated PPE were placed in the room. The aide received education regarding the proper way to wear a N95 mask. The aide was also counseled about how to provide care between residents who are [redacted] and those who are not on precautions to prevent the spread of infection. • The LPNs who failed to wear correct PPE when providing care to residents on TBP were counseled and re-educated by the ICP. Element Three – Systemic Changes • The CNA who used his bare hands to tear apart a pancake for a resident was counseled and re-educated about sanitary food handling practices, washing hands, using gloves and proper utensils to prepare a resident's meal. • The staff that provided and/or directed the care of resident [redacted] and Resident # [redacted] including the LPN , UM, and ICP were provided with policies and protocols regarding the process to follow when treating a resident presumptive for scabies. • The LPN and UM were re-educated about proper documentation on the MAR/TAR at the time of providing a treatment. • The ICPP binder was reviewed, policies and procedures are in the process of being updated if necessary and the manual signed and dated. • Nursing staff received re-education about documenting vital signs and the	

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F 835	Continued From page 216 He will review the electronic report, look at the timeframe and requested the materials needed to complete the work. He further added, "If you can get the material the work would be completed". For the broken handrail he stated clearly he was not aware of it. Resident [redacted] had a care plan for fall initiated on [redacted]. The goal was for Resident [redacted] to resume usual activities without further incident. The interventions were: 1. Continue the interventions on the at-risk plan. 2. Educate Resident [redacted] to call for assistance when attempting to close doors. 3. For no apparent acute injury, determine and address causative factors of the falls. (The hand rail identified as the causal factor for the fall of [redacted], was not repaired until [redacted] at 3:00 PM.) On 10/12/21 at 9:42 AM, the surveyor interviewed the RDO who provided the surveyor with an email that he gave the LNHA concerning the environmental rounds that the RDO and LNHA conducted on 10/04/21. The email was titled, "Housekeeping Rounds" and was dated 10/5/2021 at 11:13 AM. There were no maintenance issues documented on the email. When the surveyor asked the RDO about the maintenance issues, he stated that they did not see any broken, loose, or jagged sharp handrails nor did they see any uncovered electrical outlets or light fixtures. He then stated that he believed, "someone was sabotaging us" and breaking the equipment on purpose. He then admitted that they had to do a better job and that lack of staff was a huge part as to why things were not getting done. "We are trying to hire more staff and a	F 835	evaluation for signs or symptoms of COVID19 for every resident every shift. Staff were provided with directions regarding documenting in the chart and using the COVID19 assessment tool under the assessment tab on 12/4/21. • The new Administrator immediately instituted daily morning operation meetings with all department directors held Monday – Friday weekly. • The new Administrator conducts weekly QAPI compliance committee meetings and is assisting department directors and staff with performance improvement projects during the week. • The new Administrator is overseeing QAPI projects that have been implemented to address all equipment, furniture, and supply issues. • The facility entered into a professional services contract with Care Perspectives Inc. on October 19, 2021, to work with the Administrator and facility management team and staff to assist with all QAPI processes, systems changes, policy development, and corrective actions. • The new management company placed a Regional Administrator in the facility to assist the Administrator of Record with all corrective actions related citations during the survey as well as issues identified during the global assessment provided by Care Perspectives Inc. who prepares the required weekly report for submission to NJDOH as per the DPOC. • The new Administrator is reviewing policies as they relate to citations and areas identified through audits.	

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F 835	Continued From page 217 higher rate." He then stated that this was no excuse and that these aforementioned concerns should have been identified and fixed. 2. During the tour Surveyor #1 identified the following: 1.) Hallway floors in front of the nurse's station on the [redacted] and [redacted] hallways were sticky, dirty with [redacted] substance that the staff identified as [redacted]. It appears that someone walked in the [redacted] and tracked it through the unit. There were pieces of trash, [redacted] covers, tissues and cups on the floors throughout the halls. 2.) The resident bathroom that was located on the [redacted] hallway had dried [redacted] on the toilet and cups and trash were on the floor. 3.) Room [redacted]'s floor was wet with [redacted] substance and debris and tissues were on the floor. The resident was confused and laying in bed and was not able to be interviewed. 4.) Room [redacted], there were [redacted] skid marks and scuffs over the entire floor and under the beds. There were [redacted] all over the floors and walls and some trash located on the floors. The mattress on the bed was faded, ripped with foam coming out the side. The trim on the wall behind the bed was broken and coming off the walls. Dried [redacted] were observed smeared on the walls. 5.) Room [redacted] and [redacted], the air conditioning unit covers were missing, and the inside of the air conditioning units were exposed and were full of dust and debris. 6.) Room [redacted], there was a [redacted] spill with dried drips running down the wall and the floor was covered in [redacted] dried debris, food particles and [redacted] stains. 7.) Room [redacted], there were deep gouges in the	F 835	• The new Administrator has conducted salary surveys and worked with ownership to establish incentive programs, bonuses, and recognition of staff to attract new employees and retain current employees. • The new Administrator has developed several committees to address staffing and employee retention and recognition programs to improve employee morale. • The new Administrator has hired a Resident Concierge who is responsible to meet daily with residents and families to address concerns and improve the quality of life in the facility. Element Four – Quality Assurance • A core team was established that includes the Administrator, DON, Regional Administrator, principal of the management company, and Care Perspectives associates to plan corrective actions, implement systems changes, and develop monitoring processes to ensure sustained compliance with regulations. A work grid was developed based on the CMS 2567 received on 11/22/21 and accountability for each area assigned to core team members. Daily the core team communicates through meetings, texts, and emails and are available 24/7 to department directors and staff so that any problems that arise can be quickly addressed and Element Four – Quality Assurance • resolved. The core team is also involved in the provision of on the spot staff education and ongoing daily observations of care and services.	

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F 835	Continued From page 218 walls and floors were dirty. 8.) Room [redacted] the walls had deep gouges. Some gouges were observed to be spackled but unpainted. 9.) Room [redacted], the walls had deep gouges and the wallpaper was torn in multiple areas. 10.) Room [redacted] the siderail at the top of the resident's bed on the left side near the top of the bed was loose and twisted. 11.) Room [redacted], the floor was dirty, discolored with scuff marks, [redacted] on the floor in multiple areas and there were [redacted] smears observed on the wall near the door. 12.) The furniture in residents' rooms such as beds, cabinets were worn, broken, chipped, and rust on the bedframes. 13.) The wallpaper located in front of the nurse's station and throughout the [redacted] and [redacted] hallways were torn and peeling off the walls. 14.) The resident's wheelchair in room [redacted] was dirty, dusty with a torn seat cushion and torn arm rest with foam coming out from the tears. 15.) Rooms [redacted] and [redacted], had broken blinds and bed sheets were being utilized as curtains. 16.) The privacy curtains in most rooms were stained, dirty and unclean. 17.) Room [redacted] had [redacted] in and around the toilet from [redacted] until [redacted]. On 10/8/21 at 9:30 AM, Surveyor #1 interviewed a CNA who acknowledged the uncleanliness and unsanitary condition of the [redacted] hallways floors and resident bathroom and stated that it was the housekeeper's responsibility to clean those areas. She identified that the [redacted] dried substance that was located on the floor of the hallway was dried [redacted]. She stated that it was there that morning and she reported it. During this interview the housekeeper for [redacted] hallways approached Surveyor #1 who conducted an interview with her	F 835	• Please refer to Element Four Quality Assurance throughout the POC for specific QAPI actions the Administrator coordinates and is directly involved in. • Root cause analysis was conducted, and a QAPI performance improvement project was implemented to identify residents for side rail reduction and to assure residents with side rails are reassessed for continued use and for entrapment risks and where side rails are used a consent is properly completed and the MDS and the care plan properly reflects the use of the side rails. The DON/Unit Manager will audit the charts of residents who have side rails each week for three months and then monthly thereafter for three months to ensure the side rails in use comply with the facility side rail policy. The results of the audits shall be reported to the administrator weekly for three months. Quarterly the DON/designee will report audit findings and actions taken to the QAPI committee for review and further direction as appropriate. • Monthly the consultant pharmacist is conducting med pass evaluations and providing one to one education on the spot as needed based on the results of the observations. Med pass results are provided to the DON along with the monthly CP report. The DON/designee reviews all med pass observations and based on the results confirms if the nurse is allowed to pass medications. Results are reported in aggregate by the DON at the quarterly QAPI meeting for action as appropriate on an ongoing basis.	

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F 835	Continued From page 219 at that time. The [redacted] hallway housekeeper confirmed that the hallway floors were dirty with food, debris, and dried areas of feces. She also accompanied Surveyor #1 to the resident's bathroom on the [redacted] hallways and confirmed that the toilet had dried feces all over the seat and trash on the floor. She explained that she came in late and did not have a chance to clean the unit. She added that she used a string mop to clean the floors but that it was the floor technician's responsibility to deep clean the floor with an electric floor scrubber, but they did not have a floor scrubber at this time. She also added that any staff member could have wiped up the dried feces that was located throughout the halls. (during the interview, Surveyor #1 observed multiple staff members walking throughout the halls and past the dried [redacted] that was located on the hallway floors). The housekeeper did not have an explanation about the cleanliness of the unit. On 10/8/21 at 10:15 AM, Surveyor #1 conducted a tour of the [redacted] hallways of the [redacted] Unit with the housekeeper from the [redacted] hallway and the Housekeeping Director (HD.) At the time of tour, the Housekeeping Director could not locate the housekeeper from the [redacted] hallway. During the tour, the HD confirmed that the hallways and the resident room floors were "very, very" dirty and unsanitary. He stated that he relayed his concerns to "corporate office" that he needed the proper supplies and assistance to sanitize and scrub the floors in the halls and the resident's rooms. He stated that he only had string mops instead of microfiber mobs. He said that the microfiber mobs were effective at preventing cross contamination. He also added that resident	F 835	• Root cause analysis was conducted, and a QAPI performance improvement project was implemented to assure incidents are thoroughly investigated, reported, and the physician and responsible party notified of assessment findings. The DON/Unit Manager will audit charts of residents who experience incidents each week for three months and then monthly thereafter for three months. The results of the audits shall be reported to the administrator weekly for three months. Quarterly the DON/designee will report audit findings and actions taken to the QAPI committee for review and further direction as appropriate. • Root cause analysis was conducted, and a QAPI performance improvement project was implemented to assure residents are assessed and care plans reviewed and revised as needed when an incident occurs with all information documented in the medical record. The DON/Unit Manager will audit charts of residents who experience incidents each week for three months and then monthly thereafter for three months. The results of the audits shall be reported to the administrator weekly for three months. Quarterly the DON/designee will report audit findings and actions taken to the QAPI committee for review and further direction as appropriate. • The IC clinical consultant reviews infection control issues and provides direction and oversight of infection control interventions in response to infection control issues on a daily basis with facility management, the interim IC preventionist,	

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F 835	Continued From page 220 rooms were supposed to be carbolized (deep cleaned), but that it has not been done for months. He said that when a resident's room was carbolized that all the furniture from the resident's room was removed, bedside curtains were cleaned and that floors were stripped and rewaxed. He revealed that this had not been done in months because he did not have the staff to do the job and he did not have a floor scrubber to be able to clean the floor properly. He added that the floor scrubber broke a few months ago and that he has been asking the cooperate office for a new one but has not received yet. On 10/8/21 at 10:25 AM, the Director of Nursing (DON), the Infection Preventionist (IP), the LPN/UM and the MD accompanied Surveyor #1 to tour [redacted] unit, [redacted] hallways. All staff members voiced that they were very concerned about the cleanliness of the hallway's floors and floor in the resident's rooms. All disciplines agreed and confirmed that the cleanliness of the floors and walls in the hallways and in resident rooms were unacceptable. The MD confirmed that the facility has not had a floor scrubber, but that it was ordered. The IP stated that it was an infection control issue because of the excessive amount of fecal matter present and urine on the floor within the resident's environment posed an infection control issue. On 10/8/21 at 11:30 AM, Surveyor #1 interviewed CNA#3 who stated that maintenance issues were reported through a computer system and the maintenance department were supposed to check the system and fix the concerns. She stated that she was unsure on how to enter the concerns in the computer system, but that she would report it to the nurse so the nurse could	F 835	the DON, department directors, and the Medical Director as appropriate. The IC consultant is also reviewing IC processes and assisting with systemic changes, updating protocols and policies as they are reviewed and providing staff education. • Root cause analysis was conducted and a QAPI performance improvement project team was formed to address maintenance issues. The maintenance director/designee will conduct rounds and inspect the condition of furniture, blinds, and PTAC unit filters to identify and correct any areas in need of cleaning or repairs. The results of the rounds shall be reported to the administrator weekly for three months. Quarterly the Maintenance Director will report inspection findings and actions taken to the QAPI committee for review and further direction as appropriate. Element Four – Quality Assurance • Root cause analysis was conducted and a QAPI PIP team formed to address the issue of cleanliness of resident rooms, bathrooms, and common space areas. The housekeeping director/supervisor shall conduct daily and weekly rounds for three months and report corrective actions taken because of the rounds to the Administrator weekly. Housekeeping issues will be discussed at daily operation meeting and at weekly management meetings. The Administrator will review and act upon issues reported. Quarterly the Housekeeping Director will report housekeeping inspection findings and actions taken to the QAPI committee for	

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F 835	Continued From page 221 notify maintenance. She added that the environmental conditions on the [redacted] were "horrible" and that even when issues were reported nobody does anything about it. On 10/8/21 at 11:35 AM, Surveyor #1 interviewed the Licensed Practical Nurse (LPN) who had been employed in the facility for [redacted] years and who worked on the [redacted] Unit. The LPN stated that she reported concerns to the maintenance staff directly about the broken handrails, however, they do not fix them. The LPN also revealed that the resident rooms have not been carbolized for months. On 10/8/21 at 2:30 PM, Surveyor #1 interviewed the Licensed Nursing Home Administrator (LNHA). The LNHA stated that he and the Regional Directors of Operations conducted an "environmental round" together on [redacted] The LNHA stated that a few "dirty" rooms were identified but admitted that they did not go into all the resident rooms. The LNHA provided Surveyor #1 with an email dated [redacted] at 11:13 AM from the Regional Director of Operations (RDO) and titled, "Housekeeping Rounds". The email contained the following information: 1.) Room [redacted] needs better floor cleaning. 2.) Room [redacted] needs cleaning. 3.) Room [redacted] needs to be carbolized (carb) ASAP (as soon as possible) 4.) Room [redacted] needs to be carbolized ASAP 5.) Room [redacted] total carb needs to be done ASAP 6.) [redacted] hallway needs to be stripped. 7.) Room [redacted] total carb needed ASAP. 8.) Room [redacted] total carb needed ASAP.	F 835	review and further direction as appropriate. • Root cause analysis was conducted and a QAPI performance improvement project team was formed to address the safety and condition of mattresses, bed frames, and side rails. A QAPI team was formed to conduct rounds and inspect the condition of beds, mattresses, and side rails to identify and correct any in need of repair or replacement. The results of the rounds shall be reported by the QAPI team leader to the administrator weekly for three months. Quarterly the Administrator will report inspection findings and actions taken to the QAPI committee for review and further direction as appropriate. • Weekly the Administrator and Housekeeping Director conduct walking rounds to monitor for compliance with cleaning schedules, trash, and linen removal are followed to ensure possible sources for flies are eliminated. Results of the rounds are discussed at morning operation meetings and reported at the weekly QAPI compliance committee meeting by the housekeeping director. • Monthly the pest control company routinely treats the facility to prevent infestations with pests and provides a report to the facility administrator. The reports are reviewed and acted upon and results reported at the QAPI committee meeting quarterly for action as appropriate.	

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F 835	Continued From page 222 9.) Room [redacted] total carb needed ASAP. The email indicated that the work needed to be done by the end of the week, however, this was not done and this was confirmed by the LNHA. The LNHA admitted that the environmental and housekeeping concerns identified by himself and the RDO were not rectified because the facility did not have the proper floor scrubber. The LNHA then provided Surveyor #1 with a receipt dated [redacted] for a floor scrubber. The LNHA could not provide Surveyor #1 with any documentation as to when the residents rooms on the [redacted] Unit were last carbolized. On 10/12/21 at 9:30 AM, Surveyor #1 interviewed the LNHA who stated that he did not have the staffing to carbolize resident rooms and stated that he was not a, "Slum Lord". He then stated that it would be important to assure that resident rooms were carbolized and deep cleaned to prevent the spread of "germs" and admitted that the rooms were dirty, but did not give a detailed explanation as to why. He did indicate that he felt that "someone" was doing it on purpose because he did make sure that things were fixed and cleaned but had no evidence to this claim. Surveyor #1 interviewed the RDO on 10/12/21 at 9:42 AM, who stated that when "environmental rounds" were conducted on 10/4/21, he provided the LNHA with a list of concerns. He could not answer as to why the environmental concerns were not fixed but felt that it was "sabotage" or "vandalism", but had no evidence to this statement. He then stated that the rooms should have been carbolized and cleaned as per the carbolization schedule and that a lack of staff was	F 835		

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a "huge" factor as to why the environment was not clean or sanitary. He then added that it was not an excuse and that a lot of work needed to be completed in the facility.

On 10/18/21 at 12:31 PM, Surveyor #1 observed the following on the [redacted] Unit:

1.) The handrail near the staffing office broke off from the wall when the surveyor touched it.
2.) There was an unstable, loose handrail near the fire door by the nurses station.
3.) The push bar on the fire doors had pieces missing and there was sharp edges on both doors.
4.) There was a broken handrail with sharp edges located in between the janitors closet and the soiled utility room.

On 10/08/2021 at 10:30 AM, Surveyor #3 conducted the tour after the breakfast meal and observed the following:

Hall [redacted] on the [redacted] Unit) the double door leading to the resident rooms, the Aluminum cover was missing exposing jagged sharp edges creating a potential for injury.

Observation on 10/08/2021 at 10:45 AM, Hall [redacted] revealed flooring with [redacted] stains, stained wallpaper, and furniture in disrepair.

Observations on 10/08/2021 at 11: 00 AM, revealed missing blinds in room [redacted].
Observations on 10/08/2021 at 11:15 AM, revealed hands rails not mounted properly to the wall. 15 of the 25 handrails on Hall A were not properly mounted to the wall. 12 of the 25 handrails were broken exposing jagged edges.

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F 835	Continued From page 224 Observations on 10/08/2021 at 11:30 AM, of room [redacted] and # [redacted] revealed 2 broken air conditioning units. The air conditioning covers were missing, large amounts of dust and debris were noted inside the air conditioning units. Observations on 10/08/2021 at 11:35 AM, of Resident rooms # [redacted] and # [redacted], revealed 2 uncovered electrical outlets. Observations on 10/08/2021 at 11:40 AM, of Resident room # [redacted], revealed a clogged toilet covered with feces. The toilet was observed in the same condition on 10/12/2021 at 08:30 AM. Observation on 10/08/2021 at 11:45 AM, revealed a discolored, torn mattress in room # [redacted] Observation on 10/08/2021 at 11:50 AM, of Resident room # [redacted], revealed a [redacted] substance splattered on the wall and [redacted] substance on the floor. Observations on 10/08/2021 at 11:55 AM, of Resident room # [redacted], a [redacted] substance on the floor. On 10/18/21 at 12:42 PM, Surveyor #5 observed that the panic door bar on the [redacted] Unit had sharp, jagged areas. Surveyor #1 conducted a tour of [redacted] Unit on 10/18/21 at 12:31 PM, and observed the following: 1.) The "staffing office" hallway had a broken handrail. The surveyor touched the handrail, and a piece of the handrail broke off.	F 835		

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2.) The surveyor observed that there were multiple loose handrails in the "staffing hallway".
3.) On [redacted] the surveyor observed a loose handrail near the nurse's station near the double fire doors.
4.) Both air conditioning units were broken in the small sitting room in front of the nurse's station.
5.) The push bar on fire doors had pieces missing which exposed sharp edges on both doors.
6.) The wallpaper in the dining room was peeling off the walls, cobwebs were observed in the corners of walls and water stains were observed on the ceiling tiles.
7.) The air conditioning unit in the TV room was broken on the wall.
8.) Broken handrail with sharp edges located between the janitor's closet and soiled utility room.
9.) The call bell system was not functioning in resident rooms and bathrooms in rooms [redacted], and [redacted]
10.) The toilet in room [redacted] was not flushing correctly. The resident in that room stated that he/she was manually pouring water down the toilet so that it would flush.
11.) The fish tank in the "staffing" hallway was without a proper filtration system. The water was stagnant and dirty with algae. There was a live fish in the tank.

10/18/21 at 1:00 PM Surveyor #5 interviewed the Registered Nurse (RN) on [redacted]. She stated she was the only nurse on the unit, responsible for 25 residents. She stated she knew the call bells did not work and the unit was shut down during covid, and then opened back up 1-2 months ago and the call bells were not functioning. She stated she has addressed this a couple of times and stated the LNHA's last day

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was on [redacted]. She stated that the maintenance told her they were getting a new system. She further stated that she tried to do rounds and "it gets a bit difficult". She stated other units have tap bells and "I have not seen any down on this unit". The RN further stated, it was a problem and repeated it was a problem. The surveyor interviewed a Certified Nurse Aide who stated staff complains of paper towels not being available in the staff bathroom, the residents do not have soap, linens and we do who shifts without towels.

On 10/18/21 at 3:47 PM Surveyor #5 interviewed the LNHA and the Operation Manager for the management company (OM) . The Surveyor discussed the concerns with the OM and LNHA. The OM stated all of the issues you have seen, "are issues, I totally agree and they need to be taken care of".

On 10/19/21 at 8:23 AM, Surveyor #5 entered the building and observed that the OM was at the LNHA's office an approached the surveyor. The OM stated "he was gone" and referred to the LNHA. The OM stated that the LNHA had given his notice a few weeks ago and he was not going to deal with the survey. The OM stated the LNHA sent an email last night to the State LNHA board and he pulled his LNHA license from the facility. The OM stated the LNHA has not reached out and that the OM was not listed as the current LNHA of the facility.

On 10/08/2021 at 12:05 PM, Surveyor #3 conducted an interview with a CNA assigned to the unit who stated, "Life is nasty here. Since I

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start working here, no trash bag to place the dirty linen. You cannot get clean linen every day. We do not have gown or wash cloth. We had [redacted] on the floor since [redacted]. We had asked housekeeping to clean the floor, we were told , 'I am not assigned to this hall.' We are working short of staff every day."

On 10/08/2021 at 12:15 PM, Surveyor #3 conducted an interview with the LPN/UM assigned to the [redacted] Unit. The LPN/UM stated that the [redacted] had been on the floor on [redacted] Unit since [redacted] The LPN/UM stated that the housekeeping staff were informed but she did not reach out to the Housekeeping Director (HD) for follow-up.

On 10/08/2021 at 12:30 PM, Surveyor #3 observed a housekeeping staff in the soiled utility room. An interview with the staff revealed that housekeeping staff were scheduled to work the day shift only. There was no staff assigned on the 3:00-11:00 PM shift. The housekeeping staff went on to state that the facility did not have the staff to perform the required cleaning, "We do not have the supplies."

On 10/08/2021 at 1:15 PM, Surveyor #3 interviewed the Housekeeping Director (HD). The HD stated that he scheduled eight staff for work that day, but only 4 staff reported to work. The HD further stated that housekeeping staff were expected to clean resident rooms and common areas daily and follow a cleaning schedule. However, he indicated that staff failed to report to work almost every day. He acknowledged that the floor had not been scrubbed because the facility did not have the equipment needed to clean the floor. Upon further inquiry, the HD revealed that

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he did not have the staff to complete the work.

During a follow-up interview on 10/08/2021 at 2:30 PM, the HD stated that he was aware of the condition of the unit and he kept requesting supplies from the Administrator and was left "empty handed." He went on to say, "It is a travesty, imagine having a family member that lived in that condition. Behavior or not, the condition of the room, fully operational things, the simple décor, cracking walls, and over all the customer service. The facility needs to be staffed better. These are nursing issues, cannot speak for them."

Additionally the HD stated, "I do not have the equipment needed, such as an auto scrubber. I had asked the corporate administrator and the Administrator for an auto scrubber it falls on deaf ears. I have been told numerous times, 'We are working on it.' It had been seven weeks."

Review of the Facility Administrator Job Description updated May 2020, indicated; "The primary purpose of the position is to direct the day-to-day functions of the facility in accordance with current federal, state and local standards, guidelines, and regulations that govern long-term care facilities to assure that the highest degree of quality of care can be provided to our residents at all times." The Facility Administrator's Job Description further indicated that it was the responsibility of the Administrator to delegate his/her authority and have accountability for carrying out the duties of the job description. The duties and responsibilities of the Administrator included:

1. Plan, develop, organize, implement, evaluate

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and direct the facility's programs and activities.
2. Review policies and procedures that govern the operation of the facility.
3. Review job descriptions and performance evaluations for each staff position.
4. Meet with department directors to discuss use of departmental policies and procedures and establish a rapport in and among departments so that each can realize the importance of team work.
5. Interpret the facility's policies and procedures to employees, residents, family members, visitors, government agencies, etc., as necessary.
6. Review the facility's policies and procedures periodically, at least annually, and make changes necessary to assure continued compliance with current regulations.
7. Create and maintain an atmosphere of warmth, personal interest, and positive emphasis as well as a calm environment throughout the facility.
8. Represent the facility at the participate in top level meetings.
9. Represent the facility in dealings with outside agencies, including government agencies and third party payers, or provide an authorized representative of the facility when unable to attend such meetings.
10. Oversee the facility's marketing and census development plans.
11. Make written and oral reports/recommendations to the appropriate VP concerning the operations of the facility.
12. Maintain an adequate liaison with families and residents.
13. Ensure that public information (policy manuals, etc.,) describing the services provided in the facility is accurate and fully descriptive.

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14. Review and develop a plan of correction for deficiencies noted during survey inspections and provide a written copy of such a plan to the appropriate VP and ombudsman representative as required.
15. Make routine inspections of the facility to assure that established policies and procedures are being implemented and followed.
16. Maintain a good relations program that serves the best interest of the facility and community alike.
17. Delegate a responsible staff member to act on your behalf when absent from the facility.
18. Assume the administrative authority, responsibility and accountability of directing activities and programs of the facility.
The Facility Administrator Job Description further outlined functions involved regarding serving as the chair member for the Quality Assurance Committee and providing written and oral reports to the committee meeting and to evaluate and implement recommendations from the facility's Quality Assurance Committee as necessary.

The survey team identified during the recertification survey that the Administrator had not had regular scheduled Quality Assurance Committee meetings to assess and improve the quality of care of the residents residing in the facility.

Personnel Functions for the Administrator included:

1. Recruit and select competent department directors, supervisors, consultants and other auxiliary personnel.
2. Consult with department directors concerning the operation of their departments to assist in

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eliminating/correcting problem areas, and or improvement of services.
3. Review and check competence of work and force and make necessary adjustments/corrections as required or that may be necessary.
4. Assure that an adequate number of appropriately trained professional and auxiliary personnel are on duty at all times to meet the needs of the residents.
5. Assist in standardizing the methods in which work will be accomplished.
6. Serve as a liaison to the appropriate VP, medical staff, and other personnel and supervisory staff.
7. Counsel/discipline personnel as requested or as it may become necessary.
8. Terminate employment of personnel when necessary.
9. Maintain an excellent working relationship with the medical profession and other health related facilities and organizations through formal working and transfer agreements.
10. Assure that appropriate identification documents are presented prior to the employment of personnel and the appropriate documentation is filed in the employee's personnel records in accordance with current regulations mandating such documentation.
11. Schedule and participate in departmental meetings.
12. Delegate administrative authority, responsibility, and accountability to other staff personnel as deemed necessary to perform their job duties.

The Facility's Administrator Job Description further indicated that it was the Administrator's job to participate in staff development. Schedule and

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attend meetings for on-the-job training and to keep abreast of current changes in the long-term care field.

Safety and Sanitation of the facility regarding the Administrative Duties included:

1. Assure that all facility personnel, residents, visitors, etc., follow established safety regulations, to include fire protection/prevention, smoking regulations, infection control, etc.
2. Assure that the building and grounds are maintained in good repair.
3. Review accident/incident reports and establish an effective accident prevention program.
4. Assure the personnel attend and participate in Hazardous Communication and Universal Precautions Training Program in accordance with current OSHA and CDC guidelines.
5. Assist the Maintenance Director in developing and implementing waste disposal policies and procedures.
6. Authorize the purchase of equipment/supplies in accordance with established purchasing policy and procedures.
7. Assure the facility is maintained in a clean and safe manner for resident comfort and convenience.
8. Assure that adequate supplies and equipment are on hand to meet the day-today operational needs of the facility and the residents.

Resident Rights regarding the Administrative Duties included:

1. Maintain confidentiality of all resident information compliant with HIPPA standards and

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serve as the facility's Privacy Liaison for Privacy HIPPA issues to the Privacy Officer.
2. Assure that the resident's rights to fair and equitable treatment, self-determination, individuality, privacy, property and civil rights, including the right to wage complaints, as well established and maintained at all times.
3. Review resident complaints and grievances and make written reports of action taken.
4. Assist in establishing and implementing Resident Council.
5. Assure the policies governing a timely notice for resident discharges and room or roommate changes are strictly followed by all personnel.
6. Assure that resident funds are managed in accordance with current federal and state regulations and that appropriate accounting records are maintained.

Miscellaneous Job Functions of the Administrator included:

1. Assure that all residents receive care in a manner and in an environment that maintains or enhances their quality of life without abridging the safety and rights of other residents.
2. Assure that each resident receives the necessary, nursing, medical and psychological services to attain and maintain the highest possible mental physical functional status, as defined by the comprehensive assessment and care plan.
3. Assist the Quality Assurance Committee in developing and implementing appropriate plans of action to correct identified quality deficiencies.
4. Assist the Director of Nursing Services in developing and revising the Nurses' Aide In-Service Training Program and curriculum used

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F 835	Continued From page 234 by the facility. 5. Assure Compliance related policies and procedures are followed and the facility remains compliant with all federal, state and local. Report any compliance issues to the Compliance Officer. NJAC 8:39-5.1(a) NJAC 8:39-9.2(a) NJAC 8:39-9.3(a) NJAC 8:39-27.1(a)(b) NJAC 8:39-31.2(b)(e) NJAC 8:39-31.4(a)(b)(c)(e)(f)	F 835		
F 836 SS=E	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of	F 836		12/28/21

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F 836	Continued From page 235 age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Complaint # NJ149176 Based on observation, interview, and review of pertinent facility documentation it was determined that the facility failed to provide nursing and related services to assure the residents safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident, as determined by resident assessments and individual plans of care in accordance with the facility assessment. This deficient practice was observed on 4 of 4 nursing units for care related to staffing. On 10/18/2021 at 10:20 AM, Surveyor #1 observed an unsampled resident in the [redacted] hallway who required help with grooming. The resident stated that because the facility was short staffed he/she did not get help when needed. The resident stated to the surveyor that the, "place should be shut down." On 10/18/2021 at 10:23 AM, Surveyor #1 interviewed an unsampled resident on the [redacted] hallway who stated that they had been residing at the facility for over a month and no one had offered him/her a bath.	F 836	F836 Element One □ Corrective Actions " Resident [redacted] □s room, including all floors, was immediately cleaned. " The [redacted] for the [redacted] and the [redacted] for the [redacted] were placed on Resident [redacted] Nursing staff who failed to put the required [redacted] and palm guard on Resident [redacted] were counseled and received re-education about using ordered [redacted], and [redacted] as ordered by the physician to prevent [redacted] Instructions for the use of the [redacted] was added to the CNA POC in the EHR. The care plan was reviewed and updated to reflect the use of these adaptive devices and nursing staff re-educated by therapy. On [redacted] the use of the [redacted] was discontinued by the PCP as recommended by therapy. " All units were audited beginning on October 25, 2021, by Administration and Housekeeping for cleanliness. Cleaning, carbolization and stripping and waxing schedules were implemented to address environmental concerns. Additional housekeeping staff were hired and a contract entered into with [redacted] to	

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F 836	Continued From page 236 On 10/19/2021 at 10:25 AM, Surveyor #5 observed Resident [redacted] room in the presence of the resident's Primary Care Physician (PCP) who stated that the cleanliness of the facility was lacking, and all a person had to do was look at the floors to notice. The PCP further stated that the nurses who worked at the facility had too many residents to take care of which was evidenced by dressings not getting changed and the resident's left soiled in their own [redacted] During the tour of the Ventilator Unit on 10/21/2021 at 9:49 AM, Surveyor #2 observed Resident [redacted] lying in bed asleep. Surveyor #2 observed that the resident's [redacted] (on both sides). Surveyor #2 did not observe [redacted] in the resident's room. Surveyor #2 interviewed the Registered Nurse (RN) who was present outside of the resident's room at that time. She stated that the resident was in a [redacted] wore [redacted] for a couple of hours per day and required [redacted] ([redacted]) assistance to transfer out of the bed. On 10/22/2021 at 9:48 AM, Surveyor #2 observed Resident [redacted] lying in bed asleep. Surveyor #2 observed that the resident did not have a [redacted] on the [redacted] or a [redacted] on the [redacted]. At 9:52 AM, Surveyor #2 interviewed the Certified Nursing Assistant (CNA) who stated that Resident [redacted] care entailed mouth care, full body wash, lotion, and a clean gown. She stated that the resident was required to wear [redacted] around the clock, and they were only removed during care. She stated that the resident had not	F 836	provide housekeeping management. " A direct care staffing analysis was completed to identify by shift the amount of direct care staff and licensed nursing staff required to meet the care needs of the residents based on the daily census in compliance with regulations. The staffing schedule was reviewed by the Director of Nursing (DON) with the staffing coordinator to identify by shift the required numbers of staff. " Additional Agencies were contacted to fill vacant direct care certified nurse aide and licensed nurse positions while the facility advertised for new staff. As a result of these additional contracts the facility has been able to meet requirements and on some days of the week overstaff with direct care staff until permanent positions can be filled. " When there are additional direct care staff these individuals are assigned to provide residents with additional bathing, grooming, and hygiene. The additional staff also are assigned to organizing resident rooms, clean high touch surfaces in resident rooms and spend time meeting the psychosocial needs of residents. " The facility hired a new permanent Director of Nursing (DON) who began at the facility on [redacted] The interim DON was retained to assist with Infection Control and staff education. " The facility hired two Unit Managers to fill vacant positions. Advertising, use of digital media and recruiters is ongoing to fill all vacancies " Assignments were reviewed to assure residents requiring total assistance were	

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F 836	Continued From page 237 had them on since [redacted] when they were sent to the laundry to be washed. She further stated that the resident had a [redacted] in the drawer and she did not put it on the resident because the resident was supposed to have two of them on, not one as the resident should have worn them bilaterally. She stated that the purpose of the [redacted] was to prevent [redacted] and to prevent the resident's [redacted]. She further stated that she was not required to document [redacted] use, it was just part of the resident's daily ritual. On 10/25/2021 at 8:52 AM, Surveyor #4 observed inside the room of Resident [redacted] his/her bedside commode (portable toilet) had [redacted] inside of it with flies in the room and on the bedside commode. On 10/25/2021 at 9:13 AM, Surveyor #5 interviewed a resident representative who stated that he/she would visit their family member who resided in the facility every other day, but now went to the facility two times a week due to visitation related to the Pandemic. The resident representative stated that he/she didn't like the facility because it was dirty and understaffed and he/she was in the process of moving his/her family member, "out of there." The resident representative further stated that the facility was dirty, things were hanging out of walls, the bathroom had clothes laying on the floor, and he/she did not receive updates of their family members condition from the nursing staff. On 10/25/2021 at 9:44 AM, Surveyor #4 interviewed the CNA. He stated the aides were responsible for cleaning the commode and then	F 836	not all on one assignment to assure resident grooming, hygiene, and personal care needs are met. " Performance evaluations are being completed so targeted education can be provided to staff to improve the care provided to residents. Element Two □ Identification of at Risk Residents All residents have the potential to be affected by this practice. Element Three □ Systemic Changes " Administration has formed a staffing committee and has conducted salary analyses and implemented creative strategies for attracting new employees to minimize the use of agency personnel. " Bonuses and incentive programs have been implemented to attract and to retain current staff. " An employee recognition committee comprised of front line workers was implemented to plan events to improve the morale of staff and recognize the exemplary services provided by staff. " Improvements in the environment and working conditions has helped attract new staff. Element Three □ Systemic Changes " The facility is utilizing all types of digital media as well as recruiters to identify and hire new staff. " Facility management team is working with the union to promote cooperation and minimize call outs. " Therapy conducted evaluations of all	

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F 836	Continued From page 238 housekeeping will also come in to clean it. He further stated he did not get to Resident [redacted]s room yet because he had to stop and assist with breakfast. He concluded, "it's just not enough staff." Review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report for the weeks of 9/12/2021 and 9/19/2021, revealed the facility was deficient in CNA staffing for 14 of 14-day shifts, deficient for total staff to residents on 1 of 14 evening shifts, and deficient in total staff to residents for 1 of 14 overnight shifts as follows: 09/12/2021 had 11 CNAs for 152 residents on the day shift, required 19 CNAs. 09/13/2021 had 11 CNAs for 152 residents on the day shift, required 19 CNAs. 09/14/2021 had 12 CNAs for 152 residents on the day shift, required 19 CNAs. 09/15/2021 had 15 CNAs for 151 residents on the day shift, required 19 CNAs. 09/16/2021 had 15 CNAs for 151 residents on the day shift, required 19 CNAs. 09/17/2021 had 16 CNAs for 151 residents on the day shift, required 19 CNAs. 09/18/2021 had 13 CNAs for 151 residents on the day shift, required 19 CNAs. 09/18/2021 had 8 CNAs to 17 total staff on the evening shift, required 9 CNAs. 09/19/2021 had 11 CNAs for 155 residents on the day shift, required 20 CNAs. 09/19/2021 had 11 total staff for 155 residents on the overnight shift, required 12 total staff. 09/20/2021 had 8 CNAs for 153 residents on the day shift, required 20 CNAs. 09/21/2021 had 13 CNAs for 153 residents on the day shift, required 20 CNAs.	F 836	residents in need of adaptive devices, instructed direct care staff about proper use, established a back up system when devices are being laundered to assure a replacement was readily available for use by direct care staff, and re-enforced contacting therapy if any replacement devices are needed. Element Four □ Quality Assurance " Daily staffing levels are reported to the core team and management company and additional incentives are provided for working an extra shift if needed. The success of bonuses and incentives is analyzed by the facility Administrator and Director of Nursing who make recommendations weekly to the QAPI compliance committee at the weekly meetings and to the management company regarding what incentives or bonuses are working. " Staffing is discussed at daily morning operations meetings and recommendations solicited from the management team about ways to attract new hires to fill vacant positions. " Staffing levels of direct care staff and recruitment efforts are discussed daily by nursing management and the administrator, are reported daily to the management company, and are reviewed at the weekly QAPI compliance meetings. Vacancy rates are reviewed weekly by the Director of Nursing and discussed with the Administrator. The effectiveness of strategies to attract and retain staff are discussed and strategies modified as needed. Findings are also discussed	

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F 836	Continued From page 239 09/22/2021 had 14 CNAs for 153 residents on the day shift, required 20 CNAs. 09/23/2021 had 17 CNAs for 153 residents on the day shift, required 20 CNAs. 09/24/2021 had 16 CNAs for 153 residents on the day shift, required 20 CNAs. 09/25/2021 had 15 CNAs for 153 residents on the day shift, required 20 CNAs. 09/25/2021 had 14 total staff for 153 residents on the evening shift, required 16 total staff. Review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report for the weeks of 9/26/2021, 10/03/2021, and 10/10/2021, revealed the facility was deficient for CNA staffing on 19 of 21 day shifts and were deficient for total staff for residents on 3 of 21 overnight shifts as follows: 09/26/2021 had 16 CNAs for 155 residents on the day shift, required 20 CNAs. 09/26/2021 had 10 total staff for 155 residents on the overnight shift, required 12 total staff. 09/27/2021 had 18 CNAs for 153 residents on the day shift, required 20 CNAs. 09/27/2021 had 10 total staff for 153 residents on the overnight shift, required 11 total staff. 09/28/2021 had 14 CNAs for 149 residents on the day shift, required 19 CNAs. 09/29/2021 had 16 CNAs for 149 residents on the day shift, required 19 CNAs. 10/01/2021 had 15 CNAs for 149 residents on the day shift, required 19 CNAs. 10/02/2021 had 12 CNAs for 149 residents on the day shift, required 19 CNAs. 10/02/2021 had 10 total staff for 149 residents on the overnight shift, required 11 total staff. 10/03/2021 had 10 CNAs for 144 residents on the day shift, required 18 CNAs.	F 836	weekly with the management company that provides direct assistance with recruitment efforts..	

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10/04/2021 had 14 CNAs for 142 residents on the day shift, required 18 CNAs.
10/05/2021 had 15 CNAs for 142 residents on the day shift, required 18 CNAs.
10/06/2021 had 16 CNAs for 141 residents on the day shift, required 18 CNAs.
10/07/2021 had 15 CNAs for 141 residents on the day shift, required 18 CNAs.
10/08/2021 had 13 CNAs for 141 residents on the day shift, required 18 CNAs.
10/09/2021 had 14 CNAs for 141 residents on the day shift, required 18 CNAs.
10/10/2021 had 14 CNAs for 141 residents on the day shift, required 18 CNAs.
10/11/2021 had 14 CNAs for 141 residents on the day shift, required 18 CNAs.
10/12/2021 had 15 CNAs for 143 residents on the day shift, required 18 CNAs.
10/14/2021 had 16 CNAs for 142 residents on the day shift, required 18 CNAs.
10/15/2021 had 16 CNAs for 142 residents on the day shift, required 18 CNAs.
10/16/2021 had 15 CNAs for 142 residents on the day shift, required 18 CNAs.

The surveyor reviewed the staffing during the re-certification survey from 10/18/2021 through 10/27/2021 which revealed the following concerns:

Monday, October 18, 2021. Census (number of residents who resided in the facility) was 142.

7:00 AM - 3:00 PM, 14 CNAs worked. 142 (census) / 14 (divided by the number of CNAs working = 10.1 (number of resident's the CNAs had on their direct care assignments).

3:00 PM - 11:00 PM, 8 CNAs worked. 142/8 =

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F 836	Continued From page 241 17.75 Tuesday, October 19, 2021. Census was 141. 7:00AM - 3:00 PM, 15 CNAs worked. 141/15 = 9.4 Wednesday, October 20, 2021. Census was 141. 11:00 PM - 7:00 AM, 10 CNAs worked. 141/10 = 14.1 Thursday, October 21, 2021. Census was 142. 7:00AM - 3:00 PM, 17 CNAs worked. 142/17 = 8.3 11:00 PM - 7:00 AM, 13 CNAs worked. 142/13 = 14.1 Sunday, October 24, 2021. Census was 140. 7:00AM - 3:00 PM, 15 CNAs worked. 140/15 = 9.3 Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10	F 836		

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residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and

(3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties

b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census.

c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place.

(2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher.

(3) All computations shall be based on the midnight census for the day in which the shift begins.

d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum...

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F 836	Continued From page 243 NJAC 8:39-5.1(a)	F 836		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.	F 838		12/28/21

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F 838	Continued From page 244 §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to: a.) develop and implement a comprehensive facility-wide assessment; b.) provide medical equipment necessary to care for residents; and, c.) staff competencies necessary for the quality standards of resident care. The facility was licensed for 256 beds which included specialized units including a [redacted] unit and a [redacted] unit. This deficient practice affected 142 of 142 total residents in the facility at the time of survey, and was evidenced by the following:	F 838	F838 Element One – Corrective Actions A global facility wide assessment was completed by the clinical consultant and management team in the facility. Information from the global assessment was used to update the required comprehensive facility-wide assessment. Facility specific data was updated and integrated into the assessment plan addressing medical equipment needed to care for residents, a list of staff by	

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F 838	Continued From page 245 On 10/18/2021, during the entrance conference, the Licensed Nursing Home Administrator (LNHA#1) provided a Facility Assessment. Review of the Facility Assessment dated [redacted] (18 months overdue for its annual update) revealed a document that outlined components that were to be included and had generic instructions of how to put together a Facility Assessment. The Facility Assessment had not indicated specific component data that related to the facility. On 10/25/2021 at 11:44 AM, Surveyor #12 interviewed the LNHA#2 who stated that he was the new administrator and had been assigned to the facility for approximately [redacted]. The LNHA#2 also stated that he was unaware that the Facility Assessment given on entrance was dated [redacted] and would have to look for an updated Facility Assessment. On 10/27/2021 at 10:50 AM, the LNHA#2 provided the survey team with a Facility Assessment dated [redacted]. The LNHA#2 stated that a binder with the [redacted] Facility Assessment was found in an office but he was unable to speak to the contents of the documents. Review of the Facility Assessment signed as reviewed and updated [redacted], included a "Hazard Vulnerability Assessment" and an "Emergency Management Assessment." The Facility Assessment signed as reviewed and dated [redacted] had not included an assessment of the facility resident population to provide a	F 838	department title, and employee competencies needed for day to day operations and in the event of an emergency. Element Two – Identification of at Risk Residents All residents have the potential to be affected by this practice. Element Three – Systemic Changes • The updated facility-wide assessment was reviewed with department directors and the governing body and serves a reference tool for the management team at the facility. A meeting of the Core Team is schedule for 12/9/21 to discuss and approve the updated 2021 facility assessment. • The facility assessment is a dynamic document and is being periodically updated in response to changes in policies and protocols, survey findings, and current guidance from CDC, CMS, NJDOH and local regulatory agencies. • Management staff are being educated about their role in the development and execution of the facility wide assessment. Department Directors will include their staff as appropriate in the development and implementation of the facility wide assessment and provide staff education. • Staff competencies are currently being reviewed to assure compliance with the facility wide assessment findings. • The all hazards assessment and emergency plan manual are also being reviewed and will be updated as needed because of changes to the facility- wide	

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F 838	Continued From page 246 foundation for the assessment to include pertinent information that may affect and plan for the services the facility must provide. There was no evidence in the assessment report to reflect the medical equipment necessary to meet the needs of the resident population, a list of staff by department, employee competencies necessary for day to day operations and employee competencies necessary in the event of an emergency. In addition, there was no facility resources identified. NJAC 8:39-5.1(a)	F 838	assessment update. Element Four – Quality Assurance Annually the facility wide assessment is reviewed by administration, department directors and the governing body and revised to reflect current standards of practice and regulations. The assessment is update more frequently based on QAPI activities and QAA committee recommendations. The governing body reviews and approves the facility-wide assessment plan annually.	
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on interview and a review of facility documents, it was determined that the facility	F 868	F868 Element One – Corrective Actions	12/28/21

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F 868	Continued From page 247 failed to: a.) coordinate and conduct a Quality Assessment and Assurance (QAA) committee meeting on a quarterly basis for 1 of 4 quarters reviewed (July 2021); and, b.) ensure the Medical Director or their designee was in attendance for the meetings. This deficient practice was identified as missing for 1 of 4 quarters reviewed (July 2021) and was evidenced by the following: On 10/25/2021 at 8:48 AM, Surveyor #12 reviewed the Quality Assessment and Assurance Committee (QAA)/Quality Assurance Performance Improvement (QAPI) binder for the facility provided by the Licensed Nursing Home Administrator (LNHA). The binder contained QAPI meeting attendance records and an agenda for 1/29/2021, 3/15/2021 and 4/26/2021. The meeting attendance record for 3/15/2021 was not signed by the LNHA as being in attendance. There were no further meeting attendance or agenda records provided. On 10/25/2021 at 11:16 AM, Surveyor#12 interviewed the LNHA#2 who stated that he had been the LNHA for approximately one week and the previous LNHA was not available. The LNHA was unable to speak to the contents of the QAPI binder. The LNHA#2 stated that he was well versed in QAPI and would be responsible for the QAPI meetings going forward. The LNHA #2 added that he was unable to provide any other documents regarding a QAPI meeting after 4/26/2021. Further review of the QAA/QAPI meeting agendas revealed that there was no discussion or reports on the topic of abuse.	F 868	• A Core Team comprised of the Administrator, DON, management company regional LNHA, Management company principal, and DPOC required clinical consultant are overseeing QAPI activities day to day. The team identified the need to have weekly qapi committee meetings until full compliance with regulations is achieved and/or all current QAPI activities related to survey findings have been resolved. • A QAPI Compliance meeting was held onsite and remotely using Zoom on 11/11/21 and is being held weekly until the Core QAPI Team feels the meeting can revert to monthly and then quarterly. This decision will be based on achieving full compliance with regulations and the status of QAPI Performance Improvement Projects. • In addition to the weekly standing QAPI Compliance Committee meeting, the Administrator is meeting individually with QAP PIP teams during the week to provide assistance and oversight with their projects. The clinical consultant required by the DPOC is also participating in meetings and providing education and assistance as needed. Element Two – Identification of at Risk Residents All residents have the potential to be affected by this practice. Element Three – Systemic Changes • The DPOC clinical consultant is overseeing QAPI activities and has provided a QAPI root cause analysis	

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F 868	Continued From page 248 On 10/25/2021 at 11:44 AM, Surveyor #12 interviewed the LNHA #2 who stated that a QAPI on abuse should be discussed at every QAPI meeting. The LNHA #2 added that the topic of abuse should be on the agenda at every QAPI meeting and he would have expected to see a report regarding abuse issues discussed at the meeting. The LNHA #2 was unable to speak to the past QAPI meeting agendas. On 10/26/2021 at 12:21 PM, Surveyor #12 interviewed the Director of Nursing (DON) who stated that she had been the interim DON for approximately four (4) weeks. The DON was unable to speak to the contents of the QAPI binder. The DON was unable to speak to whether there had been a QAPI meeting after 4/26/2021. The DON added that since she had been DON there were clinical meetings every morning and after that there was a general meeting with all department heads to discuss all issues. The DON stated that there were no attendance records or agendas for those meetings and the LNHA attended but was unsure if the Medical Director (MD) attended. At that time, the DON reviewed the attendance record for the 4/26/2021 QAPI meeting and stated that there were only two (2) staff members still employed, the Director of Admissions and the Director of Activities. On 10/26/2021 at 12:30 PM, Surveyor #12 interviewed the Director of Activities (DOA) who was able to verify that she was in attendance at the 4/26/2021 QAPI meeting. The DOA stated that there had not been another QAPI meeting for a while that she had knowledge of and thought that 4/26/2021 could have been the last QAPI	F 868	template that is being used by QAPI PIP teams. Education regarding the format was provided by the clinical consultant during the initial QAPI Compliance committee meeting on 11/11/21. • A global facility-wide assessment was completed by the clinical consultant as required by the DPOC and is the basis for many of the QAPI activities currently under way in the facility. Due to the extensive issues and staff limitations, QAPI activities are being rolled out incrementally prioritizing based on impact on resident safety and care to assure implementation of sustainable changes. • Weekly the DPOC clinical consultant provides NJDOH with an updated global facility-wide assessment report • Frontline staff are involved in QAPI PIPs and are being provided with input and assistance as needed by the facility administration team including the Administrator, DON, and clinical consultant. • All department directors, the facility IC Preventionist and Medical Director as well as the management company and clinical consultant are involved in weekly QAPI compliance committee meetings ensuring an interdisciplinary approach and support from the governing body. • A quarterly QAPI meeting is scheduled for 12/16/21 to include all disciplines as required by regulation and vendors including but not limited to Consultant Pharmacist, Pharmacy Provider, Laboratory, and X-ray providers and other consultants as requested.	

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F 868	Continued From page 249 meeting. The DOA thought that the LNHA was responsible for scheduling QAPI meetings in the past and was unsure at that time who was responsible. The DOA added that she was unsure if there had been QAPI meetings after 4/26/2021 because she may not have been included. The DOA stated that in the past she would be told by the LNHA a date to attend and would have her reports completed. The DOA added that she was unsure if she has had to complete any reports recently. The DOA further stated that there was a clinical meeting every morning and a general meeting after that she had attended but had not had to hand in reports. The DOA stated that usually there were all department heads at the general meeting but was unable to speak to whether the MD attended. On 10/27/2021 at 9:42 AM, Surveyor #11 interviewed the MD via telephone. The MD stated that he had not attended a QAPI meeting for a while and was unable to remember the date of the last QAPI meeting. The MD added that he had not attended morning meetings at the facility. Review of the facility "Quality Improvement Plan" dated 2021 revealed that the committee was to meet at least 10 times annually, preferably monthly, to identify issues and develop and implement appropriate plans of action to correct identified quality deficiencies.	F 868	Element Four – Quality Assurance A standing schedule for the weekly QAPI compliance committee meeting has been established and is being followed. This meeting includes all required individuals and disciplines required by regulations and will serve as the quarterly meeting until the Core team feels corrective actions have been F868 Element Four – Quality Assurance implemented to the extent that the facility can move to monthly and then quarterly meetings. Minutes of the meeting are being maintained and QAPI activities are addressed daily by the Core Team.	
F 880 SS=L	NJAC 8:39-33.1(a)(b) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		12/30/21

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infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(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

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SILVER HEALTHCARE CENTER	1417 BRACE ROAD CHERRY HILL, NJ 08034

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F 880	Continued From page 251 (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 operate in a manner to limit the spread of infectious disease by failing to ensure: a.) effective housekeeping, environmental services, and pest control program were provided for 5 of 5 units ([redacted] Unit). b.) a system for communication was followed to inform the [redacted] Center prior to transferring two residents who had a contagious infectious	F 880	F880 Element One □ Corrective Actions A contract for Infection Control consulting was signed with the management company and copies of the required Infection Control (IC) certificates submitted to NJDOH. Root Cause Analysis was completed in the following areas: All cited Environmental sanitation and	

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F 880	Continued From page 252 disease [redacted] for 2 of 2 residents (Resident [redacted] & Resident [redacted]) who were transferred from the facility [redacted] Unit to the [redacted] Center. c.) staff wore appropriate personal protective equipment (PPE) upon entering residents' rooms who were on transmission-based precautions (TBP) for 3 staff (Respiratory Therapist, Certified Nurse Aide and Housekeeping Staff), on 2 of 5 units ([redacted] and [redacted] Unit). d.) the Certified Nursing Assistant (CNA) went from a person under investigation (PUI) for COVID -19 to a non-PUI resident room wearing inappropriate PPE. Part A The facility's failure to identify the housekeeping and environmental hazards posed a serious and immediate threat to the safety and well-being of all residents who resided on the [redacted] Unit. A serious adverse outcome was likely to occur as the identified non-compliance occurred on a unit identified by the facility as having 58 residents diagnosed with dementia, and 33 out of the 58 residents that resided on the [redacted] Unit ambulated independently. This resulted in an Immediate Jeopardy (IJ) situation that began on 10/08/21 and continued during an on-site re-visit on 10/12/21. The facility was notified of the continued IJ situation after further investigation on 10/14/21 at 1:30 PM. On 10/18/21, during an on-site survey, the survey team determined the IJ situation continued.	F 880	infection issues as listed below A global Infection control RCA addressing use of PPE, transmission based precaution and COVID19 Signage, hand hygiene, facility cleaning and sanitation, outbreak management for COVID19, [redacted] signs and symptoms assessment, Infection control policies, procedures and protocols, and Infection control manual. An Infection Prevention and Intervention Program plan was implemented and included as part of the revised Infection control manual. Infection control practices in the facility were evaluated and the Long Term Care Infection Control Self-Assessment was completed. The following Nursing Home Infection Preventionist Training Course modules were viewed and completed by Top line staff and the facility Infection Control Preventionist (ICP) Nursing Home (NH) Infection Preventionist Training Course Module 1 □ Infection Prevention & Control Module 11B □ Environmental Cleaning and Disinfection Module 4 □ Infection Surveillance	

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F 880	Continued From page 253 The facility submitted an acceptable removal plan via electronic mail (email) on 10/22/21 at 5:38 PM. The IJ removal plan was verified as implemented during an on-site re-visit on 10/29/21. The non-compliance remained on 10/29/21 for no actual harm with the potential for more than minimal harm that is not immediate jeopardy based on the following; reference F880 The evidence was as follows: Two surveyors (Surveyor #1 and #3) conducted a tour of the [redacted] Unit on 10/08/21 at 9:15 AM. Surveyor #1 interviewed a staff member sitting at the nursing station and identified herself as the Licensed Practical Nurse Unit Manager (LPN/UM). The LPN/UM stated the [redacted] Unit comprised residents with [redacted] She stated that the unit census was 58, and 33 of the residents ambulated independently. The LPN/UM identified the two hallways as [redacted] hallway. The surveyors observed the following: 1. The hallway floors located in front of the nurse's station and on the [redacted] hallways had debris scattered throughout, and a sticky feel underfoot was noted, with [redacted] substances throughout, that was identified by the Certified Nurse Aides, the Licensed Practical Nurse, and unit housekeeper as [redacted]. The surveyors observed that it had appeared as if someone had walked through [redacted] and tracked it throughout the floors of the unit. There were	F 880	Module 7 □ Hand Hygiene Module 6A □ Principles of Standard Precautions Module 6B - Principles of Transmission Based Precautions Module 11A □ Reprocessing Reusable Resident Care Equipment The following infection control videos were viewed by Frontline staff CDC Covid19 Prevention Messages □ Keep COVID Out CDC Covid19 Prevention Messages □ Sparkling Surfaces CDC Covid19 Prevention Messages □ Clean Hands CDC Covid19 Prevention Messages □ Closely Monitor Residents CDC Covid19 Prevention Messages □ Use PPE Correctly for COVID19 The following Nursing Home Infection Preventionist Training Course modules were completed by Frontline staff: Module 6A □ Principles of Standard Precautions Module 7 □ Hand Hygiene The following corrective actions were	

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F 880	Continued From page 254 pieces of trash, orange-colored plastic-type needle covers, tissues, and plastic cups on the floors throughout the hallways. 2. The resident bathroom in the [redacted] hallway had dried feces on the toilet and cups and trash on the floor. 3. Resident Room [redacted] with an unsampled resident lying on the bed closest to the door, had a puddle of liquid on the floor with an unknown [redacted] substance between the resident's bed and nightstand. The resident did not respond to the surveyor at that time. Debris and tissues were on the floor. The unsampled resident's bedside table, directly adjacent to the wall, was covered with the [redacted] substance throughout the lower metal part of the table. The lower baseboard area of the wall that met the floor was lifted with an unknown [redacted] substance coming out of the seam, and the lower portion of the nightstand, adjacent to the floor, had the black substance on the area that touched the floor at the base of the nightstand. The resident was confused and was lying in bed. The surveyor was unable to conduct an interview. 4. Resident Room [redacted] had [redacted] marks and scuffs throughout the floor's entire surface and under both beds. There were multiple [redacted] substance, identified by the CNA, as [redacted] located on the floors and walls and trash located on the floor. The mattress on the bed by the door was uncovered, faded, and ripped at the side seams with foam coming out of the seams. As identified by the CNA, [redacted] was smeared on the wall to the left side of the bed. 5. Resident Room [redacted] and [redacted], with two	F 880	completed: Room [redacted] the nightstand and bedside table, were cleaned and the loose baseboard repaired. Room [redacted] the wheelchair was cleaned and repaired The recliner in the dayroom was replaced The floor and toilet in the room of Resident [redacted] was cleaned The toilet in the room of Resident [redacted] was cleaned and repaired Resident [redacted] □s room was cleaned and all debris and trash on the floor removed The pillow in Room [redacted] was replaced Resident #[redacted] □s room was cleaned and the floor stripped and waxed The air conditioners in the small sitting room and the dining room were cleaned and repaired F880 Element One- Corrective Actions The dining room wallpaper was cleaned and areas in need of repair completed The toilet in the room of Resident [redacted] was repaired and cleaned	

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F 880	Continued From page 255 unsampled residents in the beds, had missing air conditioning unit covers, and the inner workings of both air conditioning units were exposed and imbedded with dust and debris. 6. Resident Room [redacted] had a brownish beige splatter that extended from one wall to the other and had dried drips running down the wall to the floor, which was located next to the resident's occupied bed by the door. The entire floor was covered in [redacted] dried debris, food particles, and red stains. The unsampled resident from the door bed was ambulating in the room at the time and did not respond to the surveyor's interview. 7. Resident Room [redacted] was soiled with debris, discolored with scuff marks, [redacted] identified by the CNA at that time, were located on the floor in multiple areas and on the wall near the door. 8. Resident Room [redacted] had a resident's wheelchair soiled, covered with dust, had a torn seat cushion and armrest with foam sticking outside of the torn areas. 9. Resident Rooms [redacted] and [redacted] had bedsheets utilized as window coverings. 10. The privacy curtains in all the [redacted] hallway rooms were soiled, with visible stained areas throughout. 11. Room [redacted] had [redacted] on the toilet seat and throughout the exterior of the toilet. 12. On 10/8/21 at 10:15 AM, Surveyor #1 observed that the air conditioning units in room [redacted] and [redacted] covers were missing, and the	F 880	The toilet in the room of Resident [redacted] was repaired and cleaned Resident [redacted] □s room was terminally cleaned The floor in resident [redacted] □s room was cleaned, stripped and waxed The soiled linen closet was cleaned out and reorganized The vent unit was cleaned, floors stripped and waxed and all areas carbolized Part A The [redacted] hallways floors in front of the nursing station and down the hallways were washed, waxed` 1, and all trash removed. The resident bathroom in the [redacted] hallway was cleaned and trash removed from the floor. The floor in room [redacted] was leaned and all debris discarded. The skid marks on the floor in room [redacted] were cleaned and the walls were wiped clean. Trash on the floor was discarded. The mattress in room [redacted] was replaced. The trim on the wall behind the bed was repaired. The air conditioner unit covers in rooms [redacted] and [redacted] were immediately replaced and the units cleaned.	

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F 880	Continued From page 256 inner part of the units were exposed and covered with dust and debris. On 10/08/21 at 9:30 AM, Surveyor #1 interviewed a Certified Nursing Assistant (CNA) regarding the observations made on [redacted] hallway. The CNA acknowledged that the unit was unclean and unsanitary regarding the condition of the [redacted] hallways floors and resident bathroom. The CNA stated that the housekeeper's responsibility was to clean those areas and identified the [redacted] dried substance located throughout the hallway floor as [redacted]. She reported it to the nurse and maintenance and could not offer specifics as to when she reported it. During this interview, the housekeeper for the [redacted] hallway approached the surveyor, and the surveyor conducted an interview at that time. The [redacted] housekeeper confirmed that the hallway floors were dirty and had food debris and [redacted]. She accompanied the surveyor to the resident's hallway bathroom on the [redacted] hallway and confirmed that the toilet had [redacted] all over the seat and trash was on the floor. She stated that she came into work late and did not have a chance to clean the unit. The [redacted] housekeeper added that she used a string mop to clean the floors. The floor technician's responsibility was to deep clean the floor with an electric floor scrubber and stated the facility currently did not have a floor scrubber. She stated that "any staff member" could have wiped up the [redacted] that was located throughout the halls. During this interview, the surveyor observed multiple staff members walking throughout the hallway and directly past the [redacted] that was located throughout the hallway floors. The [redacted] housekeeper did not provide	F 880	The wall and floor in Room [redacted] were immediately cleaned and all debris discarded. The gouges in the walls in Room [redacted] & Room [redacted] were repaired. The floor in Room [redacted] was cleaned. The gouges in the walls and the torn wallpaper in Room [redacted] were repaired. The floor and walls in Room [redacted] were immediately cleaned. An audit of the furniture in resident rooms on each unit was completed to immediately replace and/or repair any beds, cabinets, or bedframes that were worn, broken, chipped, or rusted. The wallpaper in front of the nurse□s station and throughout [redacted] hallways that was torn, or peeling was repaired. The broken window blinds in Rooms [redacted] and [redacted] were replaced and the bedsheets removed. The privacy curtains throughout the facility were cleaned and/or replaced. The toilets in Rooms [redacted] & [redacted] were immediately cleaned. The sink in room [redacted] on [redacted] was cleaned The trash in Resident [redacted] □s room was	

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F 880	Continued From page 257 an explanation about the cleanliness of the unit. On 10/08/21 at 10:15 AM, Surveyor #1 conducted a tour of the [redacted] hallways of the [redacted] Unit with the [redacted] housekeeper and the Housekeeping Director (HD). The HD could not locate the housekeeper from the A hallway at that time. During the tour, the HD stated that the hallways and the resident room floors were "very, very dirty and unsanitary." He stated that he relayed his concerns to the "corporate office" that he needed the proper supplies and assistance to sanitize and scrub the floors in the hallways and the resident rooms. He stated that he only had string mops instead of microfiber mops. The HD stated that the microfiber mops were more effective at preventing cross-contamination. He also added that resident rooms were to be carbolized (deep cleaned) but had not been done for months. He stated that when a resident's room was carbolized, all the furniture from the resident's room was removed, bedside curtains were cleaned, and floors were stripped and re-waxed. He revealed that this had not been done in months because he didn't have the staff to do the work, and he didn't have a floor scrubber to be able to clean the floor properly. He added that the floor scrubber broke a few months ago and that he has been asking the corporate office for a new one, but it has not been provided. On 10/08/21 at 10:25 AM, the Director of Nursing (DON), the Infection Preventionist (IP), the LPN/UM, and the Maintenance Director (MD) accompanied the surveyors to tour the [redacted]-unit, [redacted] and [redacted] hallways. They all agreed and voiced that they were "very concerned" about the cleanliness of the hallway floors and floors in the resident's rooms. They confirmed that the	F 880	discarded The broken blinds in Room [redacted] were replaced The floor and toilet in Resident [redacted] □s bathroom were cleaned The chair Resident [redacted] was sitting in on the [redacted] was replaced Room [redacted] was terminally cleaned The housekeeper interviewed on [redacted] [redacted] received re-education regarding their role and responsibilities for cleaning resident rooms and bathrooms and common space areas. An audit of housekeeping equipment was completed, and all required equipment and supplies were ordered to effectively clean and carbolize resident rooms, bathrooms, and common space areas. The resident room floors and hallways on [redacted] were all terminally cleaned and carbolized and a monthly schedule set up for stripping and waxing of all floors. Blinds were purchased and installed in Room [redacted] The air conditioning units in Rooms [redacted] and [redacted] were cleaned and the covers were replaced. The clogged toilet in Room [redacted] was repaired.	

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F 880	Continued From page 258 cleanliness of the floors and walls in the hallways and resident rooms were unacceptable. The MD confirmed to the surveyors that the facility had not had a floor scrubber but it was ordered. The IP stated that it was an infection control issue because of the excessive amount of [redacted] and [redacted] on the floor within the resident's environment posed an infection control issue. The IP stated that the condition of the [redacted] was an infection control issue because of the excessive amount of [redacted] present and stated the [redacted] on the floor within the resident's environment posed an infection control issue. On 10/08/21 at 11:30 AM, the surveyor interviewed a CNA who stated that maintenance issues were reported through a computer system. The maintenance department was supposed to check the system and fix the concerns. The CNA stated that she was unsure how to enter the concerns into the computer system but would report it to the nurse to notify maintenance. She added that the environmental conditions on [redacted] were "horrible" and that even when issues were reported, nobody did anything about it. On 10/8/21 at 11:35 AM, Surveyor #1 interviewed the Licensed Practical Nurse (LPN) who had been employed in the facility for 7 years and who worked on the [redacted] Unit. The LPN stated that she reported concerns to the maintenance staff directly about the broken handrails; however, they don't fix them. The LPN also revealed that the resident rooms have not been carbolized for months. On 10/08/21 at 2:30 PM, the surveyor interviewed the Licensed Nursing Home Administrator	F 880	F880 Element One- Corrective Actions The mattress in Room [redacted] was replaced. The wall and floor in Room [redacted] was cleaned The floor in room [redacted] was cleaned Soiled linen bags were purchased and placed on all units for use by aides. Housekeeping supplies were ordered to ensure sufficient cleaning and disinfecting products are available in the facility to thoroughly clean and maintain a sanitary environment. The toilet in Room [redacted] was replaced. The Pest Control company was immediately called to treat again for flies. Treatments continued daily until the flies were eradicated. The pest control company assisted the facility to identify possible causes of the flies and recommended the use of fly lights and provided a plan that identified the 21 placement locations for the fly lights which were ordered on 1024/21, received on 11/21/21, and installed on 11/28/21. The fish tank was removed. The floors in rooms [redacted] and [redacted] were cleaned and trash discarded	

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F 880	Continued From page 259 (LNHA). The LNHA stated that he and the staff member who identified himself as the Regional Directors of Operations conducted an "environmental round" together on 10/04/21. The LNHA stated that a few "dirty" rooms were identified but admitted that they did not go into all the resident rooms. The LNHA provided the surveyor with an email dated [redacted] at 11:13 AM from the Regional Director of Operations (RDO) and titled, "Housekeeping Rounds." The email contained the following information: 1.) Room [redacted] needs better floor cleaning. 2.) Room [redacted] needs cleaning. 3.) Room [redacted] needs to be carbolized ASAP (as soon as possible) 4.) Room [redacted] needs to be carbolized ASAP 5.) Room [redacted] needs to be carbolized ASAP 6.) [redacted] hallway needs to be stripped. 7.) Room [redacted] needs to be carbolized ASAP 8.) Room [redacted] needs to be carbolized ASAP 9.) Room [redacted] needs to be carbolized ASAP The email further indicated that the work needed to be done by the end of the week. The LNHA admitted that the environmental and housekeeping concerns he identified along with the RDO were not rectified because the facility did not have the proper floor scrubber. The LNHA then provided the surveyor with a receipt dated [redacted] for a floor scrubber. The LNHA could not provide the surveyor with any documentation as to when the residents' rooms on the [redacted] Unit were last carbolized. On 10/12/21 at 8:30 AM, Surveyor #3 observed	F 880	The wheelchair of Resident [redacted] was cleaned The privacy curtain in Resident [redacted] room was replaced The toilet in Resident [redacted] □s room was cleaned The floor in room [redacted] was cleaned The bathroom in room [redacted] was cleaned The toilet in Resident [redacted] □s room was replaced The toilets in Resident [redacted] and [redacted] □s rooms were replaced The chair in Resident [redacted] □s room was cleaned The dayroom floor on [redacted] was cleaned The curtain in room [redacted] was cleaned The privacy curtains in rooms [redacted], [redacted] were cleaned. The mattress in resident [redacted] □s room was replaced The aide who left a soiled diaper and urine on the floor was counseled and re-educated and the floor was cleaned, and the diaper properly discarded.	

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F 880	Continued From page 260 the following on the [redacted] Unit: Room [redacted] toilet soiled with [redacted] Room [redacted] with [redacted] on the toilet seat, and the toilet remained clogged with feces as observed on 10/8/21. On 10/12/21 at 9:30 AM, the surveyor interviewed the LNHA, who stated that he did not have the staffing to carbolize resident rooms and stated that he was not a "slum lord." He then stated that it would be important to ensure that resident rooms were carbolized and deep cleaned to prevent the spread of "germs" and stated that the rooms were "dirty" but did not provide a detailed explanation as to why. The surveyor interviewed the RDO on 10/12/21 at 9:42 AM, who stated that when "environmental rounds" were conducted on 10/05/21, he provided the LNHA with a list of concerns. He could not answer as to why the environmental concerns were not addressed. He then stated that the rooms should have been carbolized and cleaned as per the carbolization schedule and that a lack of staff was a "huge" factor as to why the environment was not clean or sanitary. He then added that there was "no excuse" and that a lot of work needed to be completed in the facility. On 10/18/21, from 10:05-12:57 PM, during a tour of the [redacted] unit, Surveyors #3 and #4 observed the following: On the [redacted] unit in room [redacted] soiled sink with [redacted] stains. A black fly was observed on Resident [redacted] while	F 880	Part B Residents [redacted] & [redacted] who were positive for C. Auris and attended dialysis were all placed on contact precautions and staff educated about the proper use of PPE. Signage was placed on the entrance to their rooms with pictures of required PPE. The dialysis center was notified of the infectious disease and provided with instructions for cleaning and disinfecting equipment after use with these residents. Part C The RT and CNA on the vent unit who failed to use the correct PPE when caring for resident [redacted] were counseled and re-educated about contact precautions and the use of PPE for residents with a diagnosis of Candida Auris. The RT and CNA both were fit tested for the correct size N95 mask. A sign was placed on the door to the room of Resident [redacted] noting contact precautions and depicting the PPE required before entering the room. Housekeeping staff on the [redacted]t unit who failed to correctly clean and disinfect rooms of residents with [redacted] were counseled and re-educated about transmission based precautions, the use of PPE, and proper cleaning and disinfectant products to use when cleaning the rooms of residents with a diagnosis of [redacted].	

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	315280	A. BUILDING _____ B. WING _____	C 11/01/2021

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F 880	Continued From page 261 the resident was lying in bed in the resident's room, the floor was stained with dark substances, and the toilet was filled with [redacted]. Multiple flies were observed on Resident [redacted] hands, shoulder, and arms while seated in a recliner chair in the [redacted] side [redacted] day room. The room also had debris on the floor and a plastic cup on the floor which looked as if it contained [redacted] with smears of the same in several areas of the floor. The walls and molding of the room was soiled with various debris. An unoccupied resident room, Room [redacted], had a mattress on the floor, and the toilet was filled with [redacted] in the bow and on the seat. An unsampled resident's room, room [redacted], had a stained floor, had a [redacted] e odor, and multiple black flies were in the room. Resident [redacted]'s room had trash strewn on the floor, and the toilet was soiled with a dark substance. In room [redacted] an unsampled resident, had a torn floor mat on the floor, the floor was soiled with various colored debris, black flies were in the room, there was no blinds for the window. Resident [redacted]'s room had broken blinds and had a stained floor. Resident #1[redacted]s room had a stained floor, [redacted] were on the bathroom floor, and the toilet bowl. Resident [redacted] was sitting in a chair on the [redacted] side 1 day room. The back cover of the chair was missing, and the resident had a fly on his/her head.	F 880	F880 Element One- Corrective Actions The contracted housekeeping staff were removed from the unit and signage in Spanish was also placed on the doors designating required PPE. The dialysis center was notified of the two residents with [redacted] and the facility ICP provided the dialysis center with information about [redacted] and disinfecting agents to be used when cleaning equipment after treatment. The dialysis communication form was revised to include an area to document infectious diseases. Required swabbing of all facility residents was completed per NJDOH CDS requirements and all PCR test results are negative. [redacted] results are still pending. Correct precautions are in place to prevent spread. Part D The aide who provided care to Resident [redacted] was re-educated about the proper use of PPE for a resident who is on TBP as a PUI. Proper PPE set ups were placed outside the room and signage moved so it was clearly visible before entering the room. Bins for disposal of contaminated PPE were placed in the room. The aide received education regarding the proper way to wear a N95 mask. The aide was also counseled	

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F 880	Continued From page 262 On 10/18/21 at 10:41 AM, Surveyor #5 observed: An unsampled resident's room on the [redacted] unit, room [redacted]. The resident was in bed, with a ripped, uncovered bed pillow on the bed, and the stuffing of the pillow was exposed. There was debris, including paper towels and other debris on the floor, and multiple black flies were in the room. The floor was soiled with embedded marks of a [redacted] substance, and the walls and baseboard were stained and soiled with various colored debris throughout. The surveyor then observed Resident [redacted]s room, with garbage and debris strewn about the entire floor. There were wet areas throughout the floor, and the floor had a sticky feel. The surveyor brought the Unit Manager Licensed Practical Nurse (UMLPN) to observe the resident rooms. During the observation of room [redacted], the UMLPN stated, "I don't think it is clean. I am not gonna lie." During Resident #40's room observation, the UMLPN stated, "it is bad." On 10/18/21 at 8:28 AM- 9:20 AM, Surveyors #1, #3, and 4 observed the following on [redacted]: A large, approximately 200-gallon fish tank was located by the nursing station. The fish tank was not filtering, and there was brown, blackish-colored water in the tank with the top of the tank open to the air. There was a large fish observed at the bottom of the tank. At that time, the Maintenance Director and Surveyor #14 were present. Surveyor #1 interviewed the MD about the fish tank. The MD stated, "The facility is not taking care of the fish tanks, and the facility had no food for the fish. He stated, "I guess they are just letting the fish die."	F 880	about how to provide care between residents who are PUI and those who are not on precautions to prevent the spread of infection. The LPNs who failed to wear correct PPE when providing care to residents on TBP were counseled and re-educated by the ICP. Part One - Continuation Rooms [redacted] on the [redacted] unit were terminally cleaned and all debris discarded. The mattress in room [redacted] was replaced. Rooms [redacted], and both dayrooms and sunrooms were terminally cleaned. The broken furniture and mattress on the floor of room [redacted] were removed. The floor mats in rooms [redacted] and [redacted] were replaced. The broken chair in the sunroom was removed Part Two □ Continuation The CNA who used his bare hands to tear apart a pancake for a resident was counseled and re-educated about sanitary food handling practices, washing hands, using gloves and proper utensils to	

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F 880	Continued From page 263 Room [redacted] had debris was on the floor, and the floor was very sticky with splatters. Room [redacted] had debris on the floor, the floor underneath the bed was stained with a dark-colored substance. Room [redacted] had a stained, discolored floor with various trash strewn about the entire floor. Resident [redacted] was observed lying in bed with a fly on the resident. There was a strong odor of urine in the room and brown stains on the floor. On 10/18/21 at 12:16 PM, surveyor #3 observed Resident [redacted] on the [redacted] unit with flies on their pillow while the resident was lying in bed. On 10/18/21, during a tour of Court 1, from 10:50 AM to 1:00 PM, Surveyors #1 and # 5 observed the following: Both air conditioning units were visibly broken in the small sitting room in front of the nurse's station, and debris was embedded inside both units. A large, approximately 200-gallon fish tank was located by the nursing station. The fish tank was not filtering, and there was brown, blackish-colored water in the tank with the top of the tank open to the air. There was a large fish observed at the bottom of the tank. Resident [redacted] stated the toilet did not flush correctly, and they were manually pouring water down the toilet so that it would flush.	F 880	prepare a resident□s meal. Part Three □ Continuation The staff that provided and/or directed the care of resident [redacted] and Resident # [redacted] including the LPN , UM, and ICP were provided with policies and protocols regarding the process to follow when treating a resident presumptive for scabies. The LPN and UM were re-educated about proper documentation on the MAR/TAR at the time of providing a treatment. Part Four □ Continuation The ICPP binder was reviewed, policies and procedures are in the process of being updated if necessary and the manual signed and dated. Part Five - Continuation Nursing staff received re-education about documenting vital signs and the evaluation for signs or symptoms of COVID19 for every resident every shift. Staff were provided with directions regarding documenting in the chart and using the COVID19 assessment tool under the assessment tab on 12/4/21. F880 Element Two □ Identification of at Risk	

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F 880	Continued From page 264 At 12:45 PM, the dining room closest to the front of the unit was observed, with two unsampled residents consuming the lunch meal. There was a loosened piece of wallpaper a few feet away from the resident's table, and the loose piece of wallpaper exposed a wall covered with blackened areas under the wallpaper. There was a large cob-web and a water-type stain on the wall and ceiling tile, where the blackened area was located under the exposed wallpaper. There was a visibly broken air conditioning unit that was visibly soiled with embedded debris inside the unit's vents. Resident [redacted] was observed eating lunch with an unsampled resident in the second dining area. Resident [redacted] stated there was "bugs all over the place," the bathroom clogged, and the call bells did not work. The surveyors observed many flies in the day room where the residents were consuming lunch. At 12:55 PM, Resident [redacted] was observed watching television in their room and stated the call bell hasn't worked for over a year, "very, very uncomfortable," and there were flies all over the place. At that time, the surveyor observed flies in the resident's room. On 10/19/21, Surveyor #5 observed the following environmental concerns on [redacted] Unit: At 10:21 AM, Surveyor #5 conducted an interview with Resident [redacted] while the resident was seated in their wheelchair by the [redacted] nursing station. Surveyor #5 observed the resident's wheelchair was soiled with embedded soiled areas throughout the exterior of the wheelchair.	F 880	Residents All residents have the potential to be affected by these practices. Audits were conducted on all units to identify all areas in need of cleaning, all blinds in need of replacement, all air conditioners in need of cleaning, all bathrooms in need of cleaning and toilets in need of repair, all broken equipment in need of repair or replacement and all supplies needed. Call bell audits were conducted to identify any with functional issues and provide tap bells if needed. Blinds throughout the facility were checked to identify any in need of repair or replacement. Element Two □ Identification of at Risk Residents Bedding was checked to identify any beds or mattresses in need of repair or replacement on all units occupied by residents. Element Three □ Systemic Changes Part A	

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F 880	Continued From page 265 At 10:25 AM, during an observation of Resident [redacted]'s room with the resident's attending physician. The surveyor interviewed the physician regarding the cleanliness of the building, and the physician stated it was "lacking a little bit," and all you would have to do is look at the floor. At that time, the physician pointed to the floor located at the end of the resident's bed. The surveyor observed [redacted] stains on the floor, and what appeared to be white and orange crushed pill debris, the physician indicated that is what it looked like it was crushed pill debris. At that time, a fly landed on Resident [redacted], and the physician stated, "this is the type of thing," and shooed the fly away. On 10/19/21, Surveyor #3 observed the following environmental concerns on the [redacted] Unit: At 11:30 AM, Resident [redacted] had a stained privacy curtain. Surveyor #3 again observed Resident [redacted]s room on 10/21/21 at 10:51 AM, and the privacy curtain remained in the same condition. On 10/20/21 at 8:45 AM, Surveyor #3 observed the following on the [redacted] unit: Resident [redacted]'s bed was covered with flies, and the bathroom had dried feces on the toilet and the floor. In room [redacted] there was a strong odor of urine in the room. Room #[redacted] flies were covering the bed, and the bathroom had [redacted] on the floor and the toilet. On 10/21/21 at 8:50 AM- 9:08 AM, Surveyor #9	F 880	A room carbolization and cleaning schedule was established for each unit and staff re-educated to ensure compliance. Floor stripping and waxing schedules were implemented, and staff re-educated to ensure compliance. Daily housekeeping rounds are conducted by the housekeeping Director to ensure the facility is maintained in a clean and safe condition. Cleaning and housekeeping policies were reviewed and updated as necessary, and staff received re-education as appropriate. A new housekeeping director was hired and was trained by the housekeeping company who is contracted to provide oversight supervision and staff education. Root cause analysis was used to identify the possible sources of the flies. Trash pickup and soiled linen removal from the units were increased to minimize these as possible breeding areas for flies. Cleaning schedules for resident rooms and bathrooms and common space areas were reviewed and modified with assistance from the contracted Housekeeping company engaged to assist with housekeeping and dietary issues. The kitchen grease traps were cleaned the week of 11/2/21 and put on a	

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F 880	Continued From page 266 observed the following on [redacted] Surveyor #9 interviewed Resident [redacted] in the resident's room while the resident consumed the breakfast meal. The resident stated their toilet was clogged. The Surveyor observed [redacted] in the toilet with multiple flies around the toilet. Flies were flying around the resident while the resident was consuming the meal and flies were observed on the resident's water cup. Resident [redacted] was interviewed in the resident's room, and a fly landed on the resident's [redacted]. The resident stated that every time the toilet was fixed, it only worked for a day or two and overflows on the floor and stated the odor was terrible. The resident further stated that the flies have been bad all summer, there was no pest control. Resident [redacted] was interviewed in the resident's room while they were sitting up in bed. Resident [redacted] (resided in the same room as Resident [redacted]) stated the toilet was broken and could not be used, and they needed to use the bathroom across the hall, which was very inconvenient. The resident stated the flies were a pain in the [exploitive] and didn't know why the flies were there, and they never saw anyone from pest control spraying. On 10/21/21 at 9:14 AM, Surveyor #9 interviewed a CNA who stated she had been employed at the facility since [redacted]. The CNA stated the floor had an issue with flies mainly within the last few weeks. She stated that pest control was here the week before last, and there was a pest control book at the nurses' station. At that time, the surveyor reviewed the pest control book as	F 880	preventive maintenance schedule. New trash cans and additional liners were purchased and the kitchen was terminally cleaned with daily cleaning schedules revised by [redacted] the contract service providing dietary support to eliminate possible sources of flies. Daily rounds by the Administrator and Housekeeping Director and Maintenance Director were initiated in [redacted] to monitor the situation with the flies and the pest control company was contacted to come daily if needed to treat for flies. Ads have been running for housekeeping staff. In the interim additional contracted housekeeping staff were hired to clean all resident units. Additional housekeepers were hired for 3-11 and 11-7 shift to perform all required cleaning of resident rooms and common space areas. Nursing staff received re-education related to use of the TELS app for requesting work related to identified maintenance issues. Paperwork orders are also available to staff to complete. The F 880 Element Three □ Systemic Changes process for requesting work was reviewed and staff re-educated about how to	

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F 880	Continued From page 267 directed by the CNA. The log for [redacted] and [redacted]th had "No Reports." On 10/21/21 at 11:26 AM, Surveyor #9 interviewed the MD, who stated he worked at the facility for [redacted] months. The surveyor inquired as to how are issues were reported to maintenance. The MD stated there was a computer system, and anytime something was reported, it went to the maintenance phone, and staff were not supposed to report it any other way. The MD stated the computer system was used for three months, and staff were taught not to use the books. The surveyor inquired about the state of the toilets on [redacted] and for Resident's [redacted] #[redacted], and [redacted]. The MD stated Resident's #[redacted] [redacted], and #[redacted]'s toiled would be replaced soon and that the toilets jet had been corroded. The MD stated the [redacted] unit had not been used in over one year, and it was just opened two months ago. The Surveyor requested the computer maintenance logs from the MD at that time, and he stated he would print them tomorrow. On 10/21/21 at 9:30 AM through 10:30 AM, Surveyor #3 observed the [redacted] unit and observed: Resident #[redacted] was in bed on the [redacted] Unit. The resident was screaming and was covered with flies. The Surveyor accompanied the Director of Nursing (DON) to the room to observe the flies on the resident. The DON stated to the surveyor that she had never seen anything like that. The surveyor observed that Resident [redacted]7 sitting on a unit chair that was visibly soiled, and [redacted] were observed on the floor. Room [redacted] was observed with flies on the bed	F 880	request repairs or other maintenance services. The administrator of record during the surveyor has been replaced effective 10/22/21. A contract was entered into with a housekeeping company to provide housekeeping oversight and supervision and assist with staff education and systems corrections. Part B The dialysis communication form was revised to include information about the [redacted] Nursing staff received education about the changes to the [redacted] communication form. Part C The clinical consultant providing IC consulting per the DPOC provided the facility with an OSHA compliant [redacted] Protection Program that details the fit testing process along with all tools for implementation and provided education. The clinical consultant under the DPOC is providing IC consulting and has provided train the trainer education for fit testing as well as conducted fit testing with staff trained to ensure they properly fit test staff following the established process.	

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F 880	Continued From page 268 and in the room. The day room was observed with [redacted] substances on the floor. On 10/18/2021 at 10:30 AM, Surveyor #3 toured the [redacted] Unit and observed that the curtain in room [redacted] was visibly soiled and stained. The surveyor inquired about the soiled curtain on the [redacted] Unit. The nurse told the surveyor that she reported it to housekeeping staff six months ago, and nothing had been done about it. The surveyor requested the housekeeping log for review. The nurse informed the surveyor that there was no book on the floor. An interview with the Housekeeping Director (HD) on 10/19/2021 at 12:30 PM revealed that all housekeeping issues/work orders were documented in the QAPI book. The HD further stated that the QAPI book was replaced by an electronic version: TELS one month ago. The surveyor reviewed the QAPI book and could not find any documentation regarding a schedule to clean the resident's care equipment, including cleaning/ replacing curtains in the resident's room as needed. The HD was also asked to download any communication from the TELS that addressed all issues observed in the resident's environment during the tour, for example, resident's care equipment such as wheelchair cleaning, IV poles, room cleaning and carbolization schedule, none was provided. On 10/21/21 at 09:59 AM, Surveyor #2 observed in room [redacted] on the [redacted] Unit that the resident's privacy curtain was soiled with a large amount of [redacted] liquid splatter marks. The Registered Nurse (RN) stated it was pointed out	F 880	Staff throughout the facility are being re-fit tested and given re-education about proper mask placement and seal check. The clinical consultant providing IC consulting completed the ICAR assessment on 11/5/21. A copy of the assessment was reviewed with the prior IC preventionist and has been provided to the new DON and serves as a reference source for the current facility IC preventionist and facility staff. Housekeeping staff were provided with education about proper disinfectant products to use and proper cleaning procedures for rooms where residents live who have been diagnosed with [redacted] Part D Please see part A above Part 1 □ Continuation Please see part A above Part 2 □ Continuation Staff received re-education regarding hand hygiene, the use of gloves when setting up resident meal trays and the use of utensils to cut food. Part 3 □ Continuation Staff were re-educated about the proper	

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F 880	Continued From page 269 yesterday that the privacy curtain needed to be changed. "It has probably been here a while. It's dark and looks old." The RN indicated that she did not report it to anyone. The RN also stated that since the unsampled resident in that room had a [redacted] that it could cause [redacted] and [redacted] issues. She again revealed that she did not report it to housekeeping or maintenance. On 10/21/21 at 10:05 AM, Surveyor #2 interviewed a Respiratory Therapist (RT) who stated she personally did not report that the curtain was heavily soiled and stated that the former Unit Manager (UM) contacted the HD. She also added that the former "floor guy" used to change and wash curtains, but he left a long time ago. On 10/21/21 at 10:11 AM, Surveyor #2 interviewed the CNA, who stated she reported the soiled curtains in rooms: #[redacted] She stated that she reported it to the RN/UM "maybe twenty times." On 10/21/21 at 10:17 AM, Surveyor #2 interviewed the RN, who stated that the rooms on the Ventilator Unit were not terminally cleaned. To her knowledge and that room [redacted] and [redacted] were observed to have soiled curtains. The CNA stated that she just thought the other rooms should have the curtains washed even though they were not visibly soiled. On 10/21/21 at 10:33 AM, the CNA reported that room [redacted] had a soiled privacy curtain. She also revealed that the resident who resided in that room was positive for [redacted] The surveyor observed that the privacy curtain had dried, [redacted] splattered debris.	F 880	isolation, PPE, and steps to take prior to treatment for [redacted] and after treatment. Part 4- Continuation The IC Prevention Program binder will be reviewed a minimum of annually and updated with changes based on current IC standards of practice in conformance with CDC, CMS and NJDOH guidance. The current IC manual is under review by Nursing Management and the clinical consultant. Part 5 Continuation Re-education was provided to nursing staff to utilize the COVID19 assessment tool in PCC and during an active outbreak to complete this assessment every shift for every resident. Education required under the DPOC in the initial letter dated [redacted] has been scheduled for the week of [redacted] going forward until completed no later then [redacted] A tracking tool was developed to track compliance with all required IC education as outlined in the DPOC. F880 Element Four □ Quality Assurance The IC clinical consultant reviews infection control issues and provides direction and oversight of infection control interventions in response to infection control issues on a daily basis with facility	

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F 880	Continued From page 270 On 10/21/21 at 10:25 AM, Surveyor #2 interviewed the housekeeper who worked in the facility for [redacted] yrs. The housekeeper stated that she had worked on the [redacted] unit [redacted] yrs. She added that the HD usually took the curtains down and washed them. "Once I report it and let them know, it is up to him to get it done." She stated that she reported that the privacy curtain in room [redacted] needed to be cleaned because the resident went to the hospital and had [redacted]. She then revealed that the room should have been carbolized after the resident was discharged to the hospital. On 10/21/21 at 11:09 AM, Surveyor #2 interviewed the who stated that last [redacted], he was made aware and that he must have overlooked the soiled curtains on environmental grounds. "I must have overlooked it." He stated that the curtains have not been washed since [redacted]. He said that he thought the debris on the curtains were either [redacted] or possibly [redacted] secretions. He confirmed that it was a health risk and created an environment for pests. On 10/22/21 at 9:00 AM, Surveyor #9 conducted a follow-up interview with Resident [redacted] in the resident's room while the resident was in a wheelchair next to the bed. The surveyor observed two flies on the resident's bed and one on the resident's privacy curtain. On 10/22/21 at 10:51 AM, Surveyor #5 interviewed the DON in the presence of the survey team regarding the presence of the flies observed in the resident's food. The DON stated that flies were not acceptable to be on the resident's food because it was not hygienic. The	F 880	management, the interim IC preventionist, the DON, department directors, and the Medical Director as appropriate. The IC consultant is also reviewing IC processes and assisting with systemic changes, updating protocols and policies as they are reviewed and providing staff education. Root cause analysis was conducted and a QAPI performance improvement project team was formed to address maintenance issues. The maintenance director/designee will conduct weekly rounds and inspect the condition of furniture, blinds, and PTAC unit filters to identify and correct any areas in need of cleaning or repairs. The results of the rounds shall be reported to the administrator weekly for three months. Quarterly the Maintenance Director will report inspection findings and actions taken to the QAPI committee for review and further direction as appropriate. Root cause analysis was conducted and a QAPI PIP team formed to address the issue of cleanliness of resident rooms, bathrooms, and common space areas. The housekeeping director/supervisor shall conduct daily and weekly rounds for three months and report corrective actions taken because of the rounds to the Administrator weekly. Housekeeping issues will be discussed at daily operation meeting and at weekly management meetings. The Administrator will review and act upon issues reported. Quarterly	

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F 880	Continued From page 271 DON stated it was an infection control issue. On 10/22/21 at 9:08 AM, Surveyors #3 and #4 observed Resident [redacted] sitting in the dayroom [redacted] on the [redacted] unit eating breakfast. Both surveyors observed flies on their food and drink. There were flies on the resident's coffee cup, on the spoon inside the oatmeal, and on top of the oatmeal. In addition, there were flies on the resident's shoulder and the chair they were sitting in. On 10/22/21 at 10:51 AM, in the presence of the survey team, the Director of Nursing (DON) stated it was not acceptable for flies to be in the resident's food because "it is not hygienic." She acknowledged it posed an infection control issue but was unable to elaborate on it further. On 10/22/21 at 1:15 PM, Surveyor #3 conducted an interview with the facility Infection Preventionist Nurse (IPN) regarding the flies observed at mealtime throughout the survey. The IP stated that since she had started here, the flies were discussed with the former administrator, and it was a major concern. She stated, "nothing is being done," it was unacceptable to have staff swatting flies while feeding residents. She stated that flies could lay eggs, and that can cause [redacted]." On 10/25/21 at 8:40 AM, Surveyors #3 and 4 observed the following on the [redacted] Unit: Flies were flying around an unsampled resident while the resident consumed the breakfast meal in the dining room. The flies were on the resident's tray, the spoon located in the coffee, and the chair.	F 880	the Housekeeping Director will report housekeeping inspection findings and actions taken to the QAPI committee for review and further direction as appropriate. Root cause analysis was conducted and a QAPI performance improvement project team was formed to address the safety and condition of mattresses, bed frames, and side rails. A QAPI team was formed to conduct weekly rounds and inspect the condition of beds, mattresses, and side rails to identify and correct any in need of repair or replacement. The results of the rounds shall be reported by the QAPI team leader to the administrator weekly for three months. Quarterly the Administrator will report inspection findings and actions taken to the QAPI committee for review and further direction as appropriate. Root cause analysis was conducted and a QAPI performance improvement project team was formed to address Infection Control issues including PPE use, hand hygiene, signage, dialysis communication, Use of PPE, Cohorting of Residents based on Test Results, Contact tracing, COVID Protocols, Staff compliance with IC practices related to COVID, C. Auris, scabies, and Standard and Transmission Based Precautions (TBP). The PIP team conducts daily rounds to assure compliance with IC practices and provides immediate re-education if non-compliance is found. Results of these rounds shall be reported by the facility ICP to the DON	

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F 880	Continued From page 272 Resident #3 was observed in the common area. Surveyor #3 accompanied the resident's CNA to Resident [redacted]'s room. The CNA applied gloves to remove the sheets from the resident's bed, and the resident's mattress had a rip by the zipper. The CNA turned the mattress over, and it was stained/discolored and had holes. On 10/25/21 at 1:26 PM, the Licensed Nursing Home Administrator (LNHA) stated the facility had fly zappers but was unsure of the current number. The LNHA acknowledged since he started, the flies have been a "big issue." The LNHA stated he felt the main issue was the soiled utility rooms having soiled linens and trash, especially during the off shift. He concluded, there was currently no housekeeping schedule, but he was working with the HD. On 10/26/21, Surveyors #3 and 4 observed the following on the [redacted] Unit: On 10/26/21 at 9:40 AM, HD stated the nursing staff were supposed to put in the maintenance/housekeeping application (app) any issues. The HD concluded he conducted six (6) weeks of quality assurance rounds for the entire facility. On 10/26/21 at 9:50 AM, Surveyor #3 observed an unsampled resident eating at the dining room table with flies on the table, on the resident's plate, and the resident's toast. The surveyor asked the LPN to come and observe, and the LPN confirmed the same. On 10/26/21 at 9:51 AM, Surveyors #3 and #4 observed Resident [redacted] sitting at a table in the	F 880	weekly for three months. Quarterly the DON will report inspection findings and actions taken to the QAPI committee for review and further direction as appropriate. Weekly the Administrator and Housekeeping Director conduct walking rounds to monitor for compliance with cleaning schedules, trash, and linen removal are followed to ensure possible sources for flies are eliminated. Results of the rounds are discussed at morning operation meetings and reported at the weekly QAPI compliance committee meeting by the housekeeping director. Monthly the pest control company routinely treats the facility to prevent infestations with pests and provides a report to the facility administrator. The reports are reviewed and acted upon and results reported at the QAPI committee meeting quarterly for action as appropriate.	

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F 880	Continued From page 273	F 880		

dayroom #2 on the [redacted] unit, eating breakfast with flies on their food. The Licensed Practical Nurse (LPN) acknowledged to both surveyors that the flies were on the resident's toast. He further stated he believed the flies came from the soiled linen closet. At that time, the LPN took both surveyors to the soiled linen closet. Inside the soiled linen, the laundry was piled up. The LPN stated, "the laundry staff has not been coming down to collect the soiled linen." Furthermore he stated that he believed the last time the soiled linen was collected was four (4) days ago.

On 10/26/21 at 9:54 AM, the LPN continued the interview with Surveyor #4 and stated, "we just do it ourselves because housekeeping doesn't come here." He further indicated that housekeeping may come for 30 minutes, and then they're gone for the rest of the day. Surveyor #4 asked the LPN regarding a housekeeping logbook. He stated he was unaware of a housekeeping logbook but had informed the housekeeping staff of the flies. He further stated he verbally told the Unit Manager (UM) and the Director of Nursing (DON) about the flies. The LPN concluded there was an application (app) the facility used for maintenance, but he had only used it once since he was in-serviced on it on 10/12/21.

On 10/26/21 at 10:00 AM, surveyor #4 interviewed the HD, who stated an outside company picked up the linens from the facility every other day. He further stated that soiled linens were picked up by housekeeping staff "every two (2) hours starting at 7 AM." The HD acknowledged there was currently no scheduled log for picking and dropping linen for each unit.

On 10/26/21 at 10:06 AM, the surveyor

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F 880	Continued From page 274 interviewed the CNA, who stated he was unsure when the soiled linen was picked up from the [redacted], but he thinks it was around 8 AM. He stated that they brought "a little of linen today." He further stated he only had enough linen to do about three to four (3-4) beds. Surveyor #4 took the CNA inside the soiled linens closet, and he stated the soiled linen pile had been there since yesterday and had not been picked up. On 10/26/21 at 11:40 AM, in the presence of Surveyors #3 and #4, the IP acknowledged flies are still in the building and still an issue. A review of the housekeeping log for the [redacted] unit, the last entry was [redacted]. A review of the Quality Control Inspection - Housekeeping from [redacted] - [redacted], reflected for the [redacted] unit: [redacted]: one (1) room on the [redacted] unit checked with unsatisfactory for ceiling/walls, windows/blinds, curtains, and baseboard/edges. No comment was provided on the unsatisfactory rating. [redacted]: none checked on the [redacted] unit [redacted]: none checked on the [redacted] unit [redacted]: one (1) room on the [redacted] unit with unsatisfactory door/door sills, bedside table, baseboard/edges, and floors. No comment was provided on the unsatisfactory rating. [redacted]: one (1) room on the [redacted]	F 880		

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F 880	Continued From page 275 unit with unsatisfactory heating unit and floors. No comment was provided on the unsatisfactory rating. [redacted]: none checked on the unit [redacted]: one (1) room on the unit with satisfactory. [redacted]: one (1) room on the unit with unsatisfactory bed/mattress and baseboard/edges. No comment was provided on the unsatisfactory rating. [redacted]: none checked on the unit. [redacted]: one (1) room on the unit with unsatisfactory bedside table, pictures/paint, chairs, and floors. No comment was provided on the unsatisfactory rating. [redacted]: one (1) room on the unit with unsatisfactory windows/blinds, closet/shelves, bed/mattress, wastebasket, curtains, chairs, and baseboard/edges. No comment was provided on the unsatisfactory rating. [redacted]: none checked on the unit. [redacted]: none checked on the unit. [redacted]: none checked on the unit.	F 880		

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F 880	Continued From page 276 [redacted]: none checked on the [redacted] unit. [redacted]: none checked on the [redacted] unit. [redacted]: two (2) rooms on the [redacted] unit with unsatisfactory ceilings/walls, curtains, chairs, baseboard/edges, and floors for both rooms and the heating unit, door/door sills, closet/shelves, bed/mattress, wastebasket for one of the rooms checked. Resident [redacted] was observed eating breakfast at a table in the dayroom. There were flies on the plate and on the resident's toast. The nurse confirmed the surveyor's observation. The surveyor observed that there was a soiled diaper in Resident [redacted]'s room and what appeared to be urine on the floor. At 10:00 AM, Surveyor #4 observed the soiled utility room on the [redacted] with a large pile of soiled linen and flies around the soiled linen. The nurse observed the soiled linen and stated the flies came from the soiled linen room and that the soiled linen had not been picked up from housekeeping since 10/22/21. The surveyor interviewed the HD, who stated there was no log for the schedule of when soiled linens were picked up on the [redacted] unit. He stated the laundry staff was supposed to pick up the soiled linen every two hours. At 12:09 PM, Surveyor #3 again observed the soiled diaper and [redacted] on the floor in the resident [redacted]s bathroom. At that time, the surveyor interviewed the CNA, who stated she was the one that changed the resident in the morning.	F 880		

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The job description titled "Facility Administrator" with a date of May 2020 indicated that the primary purpose of the position is to direct the day-to-day functions in the facility in accordance with current federal, state, local standards, guidelines, and regulations that govern long-term care facilities to assure that the highest degree of quality of care can be provided to residents at all times. The duties and responsibilities include the following:

Review the policies and procedures that govern the operations of the facility.

Review job descriptions and performances evaluations of each staff position.

Create and maintain an atmosphere of warmth, personal interest, positive emphasis, as well as a calm environment throughout the facility.

Make routine inspections of the facility to assure that established policies and procedures are being implemented and followed.

Consult with department directors on the operation of their departments and assist in eliminating/correcting problem areas and/or improvement of services.

Assure that the building and grounds are in good repair.

Assist the Maintenance Director in developing and implementing waste disposal policy and procedures.

Assure that the facility is maintained in a clean and safe manner for resident comfort and

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convenience.

Assure that all residents receive care in a manner and in an environment that maintains or enhances their quality of life without abridging the safety and right of other residents.

Part B

The facilities failure to provide a safe environment to prevent the spread of infection after the facility failed to ensure that facility staff informed the Dialysis Center that two residents who resided on the [redacted] Unit had a contagious disease [redacted] (a newly identified [redacted] prior to transporting the residents to their scheduled [redacted] treatments resulted in an IJ situation that began on 10/18/21 at 10:36 AM and the facility was notified on 10/22/21 at 4:40 PM. This deficient practice was observed for 3 of 10 residents who resided on the [redacted] Unit (Resident #[redacted], Resident #[redacted], and Resident #[redacted] and was evidenced by the following:

The facility provided an acceptable IJ Removal Plan on 10/22/21 at 5:38 PM. The IJ removal plan was verified as implemented during an on-site re-visit on 10/29/21.

Surveyor #2 conducted a tour of the [redacted] Unit on 10/18/21 at 10:36 AM and interviewed the Agency Licensed Practical Nurse (LPN), who stated that the night nurse reported off to her that Resident [redacted] was positive for [redacted] and attended [redacted] on [redacted], [redacted] and [redacted] She stated that she was unsure if all the residents who resided on the unit were placed on enhanced precautions. Personal Protective

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Equipment (PPE) was required to enter the resident rooms, including gown and gloves. She needed to call the Infection Control Nurse (ICN) for clarification. The LPN stated that she had not worked on the unit for a long time and wore full PPE (gown, gloves, face mask) in all resident rooms.

At 11:01 AM, the surveyor interviewed Respiratory Therapist (RT) outside Resident [redacted]s room. RT stated that the ICN informed her that Resident [redacted] and Resident [redacted] were positive for [redacted]. She stated that both residents were [redacted] ([redacted] used to sustain respiration for one who cannot breathe independently of the [redacted] unit) and were presently at their [redacted] treatments (removal of excess toxins from the blood in people whose [redacted] can no longer perform these functions naturally). She stated that ICN also informed her that she was required to wear full PPE (gown, gloves, and face mask) and change all PPE between residents in shared rooms. She further stated that she did not know if the [redacted] Unit was notified that the residents tested positive for [redacted] before they were transferred for their [redacted] treatments. The surveyor interviewed the Agency LPN, who was present at that time. She stated that she had not documented that Resident [redacted] or Resident [redacted] were positive for [redacted] on their [redacted] Communication Record (a document used to communicate pertinent resident status). Furthermore, she had not verbally informed the [redacted] Unit that Resident [redacted] and Resident [redacted] tested positive for [redacted]. She stated that this was not new on this unit, and she thought they (the [redacted] Unit) would have known.

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F 880	Continued From page 280 At 11:08 AM, the surveyor interviewed the Infection Control Nurse (ICN), who stated the sending [redacted] Unit Nurse was required to complete a [redacted] Communication Record and fill out the top portion of the form with the resident's condition, which included pre-treatment vital signs. The nurse must have ensured that the resident wore a mask when they were transferred to [redacted]. She stated that the former Unit Manager (UM) was supposed to inform the [redacted] Unit that a resident on the [redacted] Unit previously tested positive for [redacted]. The ICN accompanied the surveyor to the [redacted] Unit located at the opposite end of the hallway. The surveyor interviewed the [redacted] Registered Nurse (HD/RN), who stated that he was not informed that Resident [redacted] or Resident [redacted] had [redacted]. He stated that he wore a standard gown, gloves, and surgical mask when he provided care to the residents during their [redacted] treatments. He stated that he routinely changed his gloves but did not change his gown between residents unless the gown became visibly soiled. He stated that no one told him that Resident [redacted] and Resident #[redacted] tested positive for [redacted] so he did not alter his PPE use from his normal routine. During an interview, the HD/RN provided the surveyor with the [redacted] Communication Records for Resident [redacted] and Resident [redacted], which failed to contain documented evidence that the sending [redacted] Unit Nurse included the resident's positive [redacted] status on the form. The surveyor requested that the HD/RN make copies of the forms. At that time, the ICN asked to view the forms before the copies were	F 880		

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made and documented, '[redacted] +" on the original form in the presence of both the surveyor and the [redacted] Nurse. The surveyor asked the ICN to write the date, time, and initials next to the witnessed late entry that she added to Resident [redacted]'s and Resident [redacted] [redacted] Communication Records. The ICN complied and wrote [redacted] at 11:13 AM and signed her initials next to the late entry. The ICN stated that there may have been a possible exposure of [redacted] within the [redacted] Unit. The [redacted] RN did not take proper PPE precautions and reportedly did not change his gown between residents who received [redacted] treatments. The ICN further stated that she learned this morning that residents [redacted] and [redacted] tested positive for [redacted] from previously collected swabs. She stated that every resident on the [redacted] Unit should have had signage outside their rooms that informed all who entered of the required PPE to be worn inside all the resident rooms, which required enhanced precautions.

At 12:46 PM, in a later interview with the ICN, she stated that she was new to the position as an Infection Control Nurse. The facility had not yet experienced an outbreak when she began working at the facility on [redacted]. She stated that she was contacted by the Local Health Department (LHD) on [redacted], who informed her that a resident (not sampled) who was now hospitalized previously tested positive for [redacted]. She stated that at that time, she was informed that [redacted] was a life-long infection that was spread by contact. The resident would always be treated on contact precautions (PPE, which included gown and gloves were required to be donned (put on) prior to room entry

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and doffed (removed) prior to exit at the facility. She stated that she did not know when the initial unsampled resident tested positive. She stated that the LHD requested that she swab the entire [redacted] Unit based on the previous [redacted] Infection Outbreak. She stated that on [redacted], the LHD emailed the Licensed Nursing Home Administrator (LNHA), interim DON, and the ICN and requested that we call him to discuss the issue further. The ICN confirmed that she had already left that evening at 4:00 PM. The Interim DON was phoned after 5 PM and was informed that two additional residents tested positive for [redacted]. The ICN further stated that she spoke with the LHD official today and was informed that Resident [redacted] and Resident [redacted] tested positive for [redacted]. She stated that she informed the LHD Official that Resident [redacted] and Resident [redacted] went to the [redacted] Unit. Their positive status was not communicated to the receiving RN prior to their transfer. She stated that the LHD informed her that the entire [redacted] Unit needed to be terminally cleaned (a cleaning method used in healthcare environments to control the spread of infections), including the chairs and [redacted] machinery. The ICN also stated that both residents' rooms should have had proper signage posted outside of their rooms on 10/15/21 when the Interim DON first learned that the residents were positive for [redacted]

On 10/18/21 at 1:10 PM, the DON provided the surveyor with the following email:

On 10/18/21 at 1:50 PM, the email from the "State of New Jersey" to the Administrator provided the complete CDC recommendations and infection control practices and environmental cleaning for [redacted] The email contained

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specific instructions that when transferring a resident with [redacted] to another healthcare facility, they were to notify the receiving facility of the resident's infection or colonization status, including recommended infection control precautions.

At 1:24 PM, the surveyor interviewed the Interim DON, who stated that she received a call from the LHD on 10/15/21 at 4:30 PM and was informed that Resident [redacted] and Resident [redacted] were positive for [redacted]. She stated that she went to the [redacted] Unit and told the nurse, whose name she did not recall, that the residents tested positive for [redacted]. She stated that she informed the nurse that the hospital and receiving units required immediate notice when a resident who tested positive for [redacted] was transferred. She further stated that she informed the nurse that "special precautions" were required to care for the residents, including gowns, gloves, goggles, and a surgical mask. Their status and related interventions should have been documented in their progress notes.

At 1:54 PM, in a later interview with the Interim DON, she stated that when she first learned that Resident [redacted] and Resident [redacted] tested positive for [redacted], she should have provided an in-service to the nursing staff on the [redacted] right away.

At 1:56 PM, the surveyor interviewed the ICN. She stated that an in-service should have been completed on 10/15/21. All nursing staff should have been informed to pass on the information in the shift-to-shift report. She stated that Nursing should have documented on Resident [redacted] and Resident #[redacted] Communication

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Report that the residents tested positive for [redacted] to alert the [redacted] Nursing Staff prior to their treatments.

At 2:07 PM, the ICN contacted the LHD Official via Speakerphone in the presence of the surveyor and Interim DON. He stated that the Outbreak at the facility had been going on for some time and was linked to an acute care hospital from a resident who no longer resided at the facility. He stated that it was not appropriate for the staff not to wear the appropriate PPE when they cared for the residents. He stated that staff should gown and glove and use Alcohol-Based Hand Rub every time they entered the resident's room. He stated that nursing staff should be dedicated if they care for more than one resident at a time or should don and doff their PPE and perform hand hygiene in between residents. He further stated that the resident's environment and all supplies used for the resident were required to be cleaned with cleaning agents specified on the EPA (Environmental Protection Agency) List P.

At 2:30 PM, in a later interview with the Interim DON, she stated that nursing staff were required to call receiving units/facilities and inform them of the resident's diagnosis of [redacted] and need for contact isolation prior to transfer.

On 10/26/21 at 1:19 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated that the Unit Manager (UM), ICN, and nurses on the [redacted] Unit were required to inform oncoming staff of both isolation and PPE needs. He stated that there was an infection control breach and the possible spread of infection to other residents and staff. He further stated that the entire unit should have been

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placed on Contact Isolation. Used when a patient has an infectious disease spread by touching either patient or objects the resident has handled. Staff/visitors were required to wear gowns and gloves to enter [redacted]s room to prevent further infection.

The facility policy dated 7/11/21 and titled "Infection Control Environmental Precautions" for [redacted]. [redacted]. It is a rapidly emerging pathogen and can cause severe infections with high mortality rates. It is frequently misidentified in most clinical laboratories, thus, requiring more identification techniques. This fungus causes outbreaks that [redacted] and is generally resistant to the three available classifications of [redacted]. The policy indicated that the [redacted] can colonize. It is an invasive infection that will spread. It is more resistant to most [redacted] medications. The infection is now creating outbreaks in which were previously well contained. The Centers for Disease Control (CDC) is not sure but are assuming that there are many ways that this [redacted] is being transmitted but has not been identified. The infection typically affects [redacted] and sicker residents but does not seem to affect the public. The policy indicated that the facility would take action to prevent resident care, equipment, and supplies from becoming sources of infection.

The surveyor reviewed the facility policies, "Dialysis Care Guidelines" (Reviewed and Revised 04/09), "Infection Control Environmental Precautions [redacted])" (Dated 07/11/21), and "[redacted]-Control Measures" (Dated 08/26/21), which revealed the following: Purpose: To establish the principles of

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F 880	Continued From page 286 care and documentation for the resident receiving dialysis. The "[redacted] Treatment Summary" may be utilized to enhance the exchange of information regarding the resident's [redacted] treatment and is maintained as a permanent part of the resident's clinical record. Subject: [redacted] is a rapidly emerging pathogen and can cause severe infections with high mortality rates ...It seems to typically affect [redacted] and sicker residents but does not seem to affect the public ...The persistence of this pathogen on environmental services [sic.] presents opportunities to colonize or infect residents and health care workers. There is evidence that C. Auris can persist for weeks to months ...CDC (Centers for Disease Control): Environmental disinfection with daily and terminal cleaning with EPA registered hospital-grade disinfectant. The facility policy dated 8/26/21 and titled "[redacted]-Control Measure." The policy indicated that the facility would implement general control measures to detect, prevent, control infection, and colonize multiple [redacted] organisms. The policy stated the procedure would include the following: Utilize standard precautions for contact with every resident and implement contact, barrier, or droplet as needed. A single room would be the preference of the [redacted]). Prioritize residents at a higher risk of pathogen transmission (uncontained secretions, secretions, and acute diarrhea) however, a shared room is acceptable with the following criteria is met: Cohorting with the same MDRO, maintaining at least 3 feet between beds/roommates, Use privacy curtains to limit direct contact, clean and disinfect surfaces on a more frequent schedule, caregiver changes	F 880		

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PPE and wash hands between residents. The Policy also indicated that continuing education for staff that have direct contact with the resident.

The facility policy with a revised date of 4/09 titled, '[redacted] Care Guidelines indicated that all residents on [redacted] will be checked before and after [redacted] treatment. The policy specified that when a resident attends [redacted], it is important to make sure that the following is documented." Any unusual occurrences or abnormal assessment findings should be documented in the nurse's notes. The policy also contained an attached example of a [redacted] treatment summary, a communication form between the [redacted] center and the facility transferring the resident for [redacted]

Part C

1. The facilities failure to provide a safe environment to prevent the spread of infection after the facility failed to ensure that the facility (Respiratory Therapist (RT) and Certified Nurse Aide (CNA) donned (put on) the appropriate Personal Protective Equipment (PPE) to prevent the possible spread of COVID-19 and [redacted], during an active Outbreak and to ensure cleaning staff adhered to proper precautions for cleaning resident rooms for residents who were on transmission-based precautions for communicable disease [redacted]. Informed the [redacted] Center that two residents who resided on the [redacted] Unit had a contagious disease ([redacted]) prior to transporting the residents to their scheduled treatments resulted in an IJ situation that began on 10/18/21 at 10:36

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AM and the facility was notified on 10/22/21 at 4:40 PM.

The facility provided an acceptable IJ Removal Plan on 10/22/21 at 5:38 PM. The removal plan was verified during an on-site survey on 10/29/21.

On 10/18/21 at 10:50 AM, the surveyor observed the Certified Nursing Assistant (CNA) who wore a surgical mask and gloves and did not wear a gown over her uniform inside of Resident [redacted]s room as she placed the resident's clothing in the closet. When interviewed, the CNA stated that she was employed by an agency and was instructed to adhere to the directions for PPE usage that was detailed on the signage posted outside of the resident rooms. She further stated that there was no signage posted outside of this room to direct her otherwise. The CNA stated that the resident required total assistance and that she had bathed and dressed the resident and emptied the resident's [redacted].

At that time, the surveyor interviewed the Agency LPN who stated that Resident [redacted] was readmitted to the facility from the hospital on [redacted] and was only partially vaccinated for COVID-19. She further stated that the resident was placed on Contact Isolation (used when a patient has an infectious disease that may be spread by touching the patient or objects the resident has handled) for 14 days as a precaution and all staff were required to wear a gown, N-95 Mask (filtering face-piece respirator that filters at least 95% of airborne particles) face shield and gloves. She further stated that the ICN came up to the unit and told the staff that there were two residents who were diagnosed with [redacted] Resident [redacted] and Resident [redacted] and staff

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were required to change their PPE in between residents who were in double rooms. The surveyor confirmed that there was no signage posted outside of Resident [redacted]'s room that cautioned staff to wear PPE as described by the Agency LPN to prevent the further spread of COVID-19 or [redacted]

At 1:36 PM, the surveyor interviewed the ICN, who stated that Resident [redacted] was not fully vaccinated and had only received one COVID-19 Vaccination. She stated that the resident returned to the facility on [redacted] and should have remained on both droplet and contact precautions which required that a surgical mask should have been worn over an N-95 mask, gown, gloves and goggles or face shield should have been worn into the resident's room when care was rendered. She stated that there was no signage on the resident's door to caution staff of the requirement that the resident was on PUI (Person Under Investigation) for COVID-19. She stated that staff who failed to do the appropriate PPE were at risk for transmission of both COVID-19 and [redacted] as the entire unit was on precautions for [redacted] due to an Outbreak at the facility.

At 1:52 PM, in a later interview with the Agency LPN, she stated that she did not inform the Agency CNA that she was required to wear full PPE when she cared for Resident [redacted]. She stated that she assumed that she would have received that information in the report from the outgoing shift.

On 10/22/21 at 10:39 AM, the surveyor observed the Respiratory Therapist (RT) #2 as she donned PPE prior to entry to Resident [redacted]s room. When interviewed, RT #2 stated that she wore

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two-level three surgical masks (three-ply heavyweight fabric masks) and a face shield in addition to the gown and gloves as the resident was on PUI for 14 days. She stated that she knew that she was required to wear an N-95 mask when she entered the resident's room. She stated that she had one on this morning but was unable to tolerate the N-95 mask due to allergies, as the smell of the N-95 mask caused her to cough. She stated that the facility used to have a more dome-shaped N-95 masks that were more comfortable for her to wear, and she did not find that type of N-95 mask on the PPE cart today. She stated that she was more comfortable with two-level three surgical masks with a face shield instead of the N-95 and thought that was fine and offered adequate protection. She stated that she did not report the issue to anyone or attempt to locate an alternate N-95 mask to wear in the resident's room. The surveyor then observed RT #2 enter the resident's room, and she closed the door behind her.

At 11:18 AM, the surveyor interviewed the LNHA, who stated that RT #2 must follow proper protocol and wear an N-95 mask if she wanted to work at the facility.

At 11:43 AM, Surveyor #2 interviewed the Interim DON, who stated that if a staff member could not wear an N-95 mask, they could not go into the [redacted] Unit. She stated that RT #2 should have obtained an alternate N-95 mask that was fit tested (testing to ensure that an N-95 mask fits securely and filters out 95% of particles) for the employee as required. She stated that RT #2 should not have worked with a resident who may have had a potentially communicable disease without an N-95 Mask. She stated that she would

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have thought that someone working with her on the unit would have noticed and told her about it.

On 10/25/21 at 9:49 AM, the surveyor interviewed the Lead Respiratory Therapist (LRT), who stated that RT #2 did not have an N-95 mask last Friday. He stated that she should have gone to the ICN and obtained an alternate N-95 mask. He stated that the risk for COVID-19 transmission was very high because Respiratory Therapists changed the resident's [redacted] (removable liner that fits inside of a [redacted] (an [redacted]) that can be removed to prevent the buildup of [redacted] inside the [redacted]) which placed both Resident [redacted] and RT #2 at high risk of droplet ([redacted]) exposure.

On 10/25/21 at 1:16 PM, the surveyor interviewed the ICN, who stated that RT #2 was not permitted to wear two-level three surgical masks instead of an N-95 mask and had to adhere to the signage that was now posted outside of Resident [redacted]'s room. She stated that RT #2 was more at risk for COVID-19 since the resident was only partially vaccinated against COVID-19 upon admission to the facility. She stated that the facility was scheduled to have a COVID-19 vaccine clinic this week, but it was rescheduled due to survey.

2. On 10/22/21 at 11:00 AM, the surveyor observed two housekeepers inside of Resident [redacted]s room where the following signage was noted outside the resident's door: "Contact Precautions: Hand hygiene, gown, gloves (with corresponding universal symbols displayed) On ALL room entries, regardless of anticipated patient contact. Visitors report to nurses [sic.] desk ..." The surveyor observed that both

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Housekeepers wore surgical masks and gloves and did not wear gowns over their street clothes as they spoke on their cell phones with their gloved hands. Housekeeper #1 stepped out of the room and did not doff (remove) her gloves or perform hand hygiene before she exited the room and spoke on her cell phone in a foreign language. The surveyor attempted to interview Housekeeper #1 and pointed to the sign that hung on the wall. Housekeeper #1 stated, "No English, Portuguese." The surveyor observed Housekeeper #2, who spoke on her cell phone as she mopped the resident's floor with a string mop (cotton or synthetic mop). She exited the resident's room without doffing her gloves or performing hand hygiene. She continued to mop the floor in the corridor that surrounded the elevator doors, and double doors, which led to another nursing unit, and then continued to mop the floor in the hallway of the [redacted] Unit with the same mop used to clean Resident [redacted]s room. Housekeeper #1 held up her cell phone display to the surveyor where the following message was displayed, "Is there a problem?" The surveyor asked the Lead Respiratory Therapist to call the LNHA and DON to report to the [redacted] Unit.

At 11:07 AM, Respiratory Therapist (RT) #3 approached the surveyor and stated that Housekeeper #1 asked her in English if there was a problem with cleaning room [redacted], which bore the following signage: "Keep door closed at all times." Housekeeper #1 denied that she spoke English to RT #3 and stated, "Portuguese." The Housekeeping Director reported to the [redacted] Unit at that time and stated that both Housekeeper #1 and Housekeeper #2 were outsourced workers and should not have been on

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the [redacted] Unit when he was asked if the housekeepers were in-serviced on the appropriate PPE, hand hygiene and cleaning products (EPA List P) required to clean the resident's room. The Infection Control Nurse (ICN) who was present instructed Housekeeper #2 to doff her gloves, and she did not appear to understand the direction. Housekeeper #1 then doffed Housekeeper #2's left glove and discarded both gloves once doffed. Both Housekeepers #1 and #2 spoke on their cell phones without first performing hand hygiene. The Housekeeping Director and ICN attempted to escort the contracted Housekeepers off the [redacted] Unit without first instructing them to perform hand hygiene. When interviewed, the ICN instructed the two Housekeepers in English to perform hand hygiene with hand sanitizer that was readily available on the unit before they entered the elevator and exited the unit. The Housekeepers complied.

At 11:12 AM, the surveyor interviewed the LNHA, who stated that the contracted Housekeepers should not have been on the [redacted] Unit. He further stated that they needed to be removed.

At 11:15 AM, the surveyor interviewed the ICN, who stated that the contracted Housekeepers should have been in-serviced before they began working. She further stated that they also needed to change into scrubs because their clothing was now contaminated.

At 11:16 AM, the surveyor interviewed the Housekeeping Director, who stated that the corridor of the [redacted] Unit was now contaminated after Housekeeper #2 utilized the same string mop and water used to clean

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F 880	Continued From page 294 Resident [redacted] room who was on Contact Precautions for [redacted] At 11:23 AM, in a later interview with the LNHA, he stated that the corridor was contaminated with [redacted], and the floor should be cleaned right away to prevent further contamination. He stated that four contracted housekeeping staff were brought into the building that he needed to follow up with. At 11:43 AM, the surveyor interviewed the Interim DON in the presence of the survey team. She stated that she just got the rundown on the cleaning people who were on the [redacted] Unit. She stated that she knew that they were outsourced and should have been in-serviced prior to working here as there was an outbreak at the facility. She stated that the housekeepers were required to wear a gown, gloves, mask, and goggles on the unit. She stated that if they did not wear a gown, their clothing could become contaminated. She stated that she would expect them to doff their gloves and perform hand hygiene before they exited the resident's room. She stated that the housekeeping staff should have informed the facility staff if they could not read or speak English. She stated that the housekeepers were required to use a clean mop head in each resident room. She stated that if the appropriate disinfectant was not used, it would not kill the [redacted]. There was a potential for all who walked in the area to track the [redacted] into a resident's room may be [redacted] (having an impaired [redacted]). She stated that if the housekeeping staff wore gloves in the hallway and did not perform hand hygiene or follow protocol, they could spread the infection into the	F 880		

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F 880	Continued From page 295 community. On 10/27/21 at 10:56 AM, the LNHA stated that the outsourced housekeepers were brought into the facility without a written contract. He stated that the housekeepers were not in-serviced prior to today and had been in the facility for a week or so. Hand Hygiene: Use alcohol-based hand sanitizer or handwashing with soap and water before and after donning gloves. Policy: The facility will take action to prevent resident care, equipment, and supplies from becoming sources of infection. All used equipment and supplies are contaminated with potentially infectious material and will be cleaned and disinfected as applicable before using with another resident. Each facility will determine and implement an appropriate written schedule for cleaning and method of decontamination. Based upon the location within the facility, type of surface to be cleaned, type of soilage present, and tasks or procedures being performed in the area. Policy: The facility will implement general control measures to detect, prevent and control infections and colonization with multiple [redacted] organisms. Notified the receiving facility and ambulance squad of the resident's colonization or infection history and status prior to treatment or transfer. Assure staff, who may have direct contact with the resident, on enhanced barrier precautions for known colonized [redacted]) appropriate control measures, for cases such as [redacted] [sic.] ...Each employee will don [sic.] PPE gloves and gown's [sic.] while performing high risk activities such as dressing, bathing/showering, transferring, changing linens,	F 880		

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F 880	Continued From page 296 incontinence care or assisting with toileting, device care such as ..[redacted], wound care ... Caregiver changes PPE (if worn) and wash hands between residents ... Present continuing education for staff who have direct resident contact or who are responsible for the decision-making regarding resident care. Washing hands before and after contact. Washing hands before touching other objects ...Instruct visitors regarding control measures, with special emphasis on handwashing. Part D On 10/24/21 at 11:22 AM, Surveyor #11 and Surveyor #12 toured the Pavilion Unit. At approximately 11:35 AM, the surveyor interviewed a CNA who stated that Resident [redacted] had a designated CNA that stayed with the resident at all times. The CNA was unsure why Resident [redacted] was assigned a one-to-one (1 CNA to 1 Resident) observation. At 11:38 AM, the surveyor observed Resident [redacted] in their [redacted] room through the doorway, sitting in a [redacted]. The surveyor observed that the resident had a [redacted] and that a CNA was standing in the resident's room adjusting the bed linens. The surveyor observed that the resident's door was fully open, which limited the visibility of signs posted on the door, including a red sign that read, resident in this room is a PUI (Persons under investigation) for [redacted] and to "please wear appropriate PPE [personal protective equipment] before entering." A green sign with a STOP sign was also posted on the door and asked the	F 880		

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questions, "Do you have on an N95 [respirator mask]? Do you have on your face shield? Do you have on an isolation gown? ... For the safety of residents and staff, please wear the proper PPE when entering this room..."

The surveyor further observed that in addition to the signs that were not clearly visible due to the door being ajar, there was no PPE bin or supplies in the area for donning PPE prior to entering the resident's room. The surveyor glanced inside the room, and next to the resident's dresser, which was inside the resident and beyond the point of his/her footboard of the bed, was a clear PPE bin. The surveyor was able to visualize that there were at least yellow disposable gowns inside the bin. At that time, the surveyor observed the Agency CNA inside the resident's room wearing an improperly donned N-95 respirator mask. The top strap of the mask was strapped to the back of her head, but the bottom strap was not secured around the back of her head/neck and instead was hanging loose below her chin, creating a gap on both lower sides of the mask causing an ill-fit. She was wearing eyeglasses without safety devices and no face shield or other eye protection, and no gown and no gloves. The surveyor observed the resident attempt to stand up from the [redacted], and the Agency CNA immediately assisted the resident back down in the chair, coming into direct contact with the resident's [redacted] s, [redacted], and bed frame without PPE. After the Agency CNA repositioned the resident into the Geri chair, the surveyor interviewed the Agency CNA regarding her assignment. The CNA stated that she was on a one-to-one observation with Resident [redacted] because of the resident's "high [redacted] risk." She stated that the resident was on Transmission

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Based Precautions because the resident was "unvaccinated" and just came back from a hospital admission, so he/she was being monitored as a PUI. The surveyor asked about her use of PPE, including the N95 respirator mask with the strap hanging loose below her chin, and she stated that she had to wear the N95 mask when in the resident's room. The surveyor asked why the bottom strap was below her chin and not properly secured; she stated that it was okay to wear it like that, as long as there were "no gaps" for air to leak through the sides of the mask. The Agency CNA stated that she didn't feel any spaces or gaps in her mask. Therefore it was okay to wear it like that. The surveyor asked if eye protection, a gown, and gloves were needed when in the room as it read on the door, and the Agency CNA stated that she was only required to wear the PPE if she was giving care to the resident, such as providing incontinence care. She stated that sitting with the resident on a one-to-one was not considered care. She stated that she could be in the room with the resident, who was a [redacted] without the face shield, gown, or gloves. The surveyor looked at what was available in the PPE bin, and there were single-use long-sleeve gowns, face shields, and gloves available to the Agency CNA.

On the same day, on 10/24/21 at 11:52 AM, the surveyor observed the same Agency CNA down the opposite end of the hallway with Resident [redacted], who was non-ill, non-exposed to COVID-19. She was propelling Resident [redacted] in their wheelchair to the dining room table. The Agency CNA was wearing the same attire and improperly donned an N95 respirator mask while propelling Resident [redacted] to the dining room table and positioned them with the legs under the table, and

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locked the wheelchair. She then returned to the room of Resident [redacted], who was positioned in a [redacted] at the door frame. She did not don PPE when returning to the room of Resident [redacted] who was identified as a [redacted]. At that time, the surveyor interviewed the Agency CNA, who confirmed that she was on a one-to-one observation for Resident [redacted] but had to take care of Resident [redacted] because she still had to do "multiple things" to help out. She stated that when there are "only so many staff," she had to help with multiple tasks such as transporting residents from their room to the dining room for meals if needed. She stated that she purposely put Resident [redacted] in the door frame of their private room to be visible to staff. She stated that "I deal with [Resident [redacted]] because [he/she] doesn't like a lot of [other] people..." to take care of them. She acknowledged that she went from a resident who was a [redacted] to a resident that was non-ill, non-exposed to [redacted], and did not follow a well-to-ill rounding. The Agency CNA's response was, "I have to do what I have to do." She acknowledged she didn't specifically ask anyone else for assistance.

At approximately 12:00 PM, the surveyor interviewed the resident's assigned LPN, who stated that she also worked for a staffing agency company. She stated that there were 31 residents on the unit today on the [redacted] unit, and one of the CNAs (Agency CNA) had to be pulled from her assignment to do a one-to-one observation for Resident [redacted]. She stated that the resident was on a one-to-one observation because they had a [redacted] and they didn't want the [redacted] to come out. She further stated that Resident #[redacted] was recently readmitted to the facility following a hospitalization. The resident

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was not vaccinated and was therefore currently on Transmission Based Precautions and was quarantined for 14 days as a [redacted]. The surveyor asked what PPE was necessary for Resident [redacted] if they were on transmission-based Precautions. The Agency LPN replied, "We haven't been wearing PPE...the reason for the isolation precautions are to keep [Resident [redacted] from getting into contact with other residents-that's the reason." She went on to explain that "I don't have to wear it." She explained that because she and the other staff didn't have to wear PPE for PUI residents, it didn't really matter where the PPE bin was located. She added that the facility's Infection Preventionist educated her on COVID-19 related infection prevention and control.

At 1:30 PM, the surveyor interviewed the interim Director of Nursing, who acknowledged that the resident was on transmission-based Precautions as a PUI for COVID-19. The surveyor asked about the vaccination status of the resident, and she stated that she did not know and would need to look into it. The DON acknowledged that PPE, including a gown, gloves, eye protection, and an N95 respirator mask, should be worn if entering the room of the [redacted] resident. She stated that the Agency CNA was not on a one-to-one observation and that they had an assignment. The surveyor asked why at least three staff indicated that the Agency CNA was only assigned to Resident [redacted] on a one-to-one basis. The DON could not speak to it. The surveyor asked the DON why the Agency CNA who was assigned the PUI resident (Resident [redacted]) was not wearing the appropriate PPE while in the resident's room. To protect the other residents on her assignment from the potential spread, she claimed the CNA

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F 880	Continued From page 301 had a full assignment and was not on a one-to-one. The DON was unable to answer. The surveyor reviewed the medical record for Resident [redacted]. A review of the Admission Record face sheet (an admission summary) revealed that the resident was admitted to the facility on [redacted] and readmitted to the facility on [redacted]. The surveyor attempted to review the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, but the assessment was not yet completed. A review of the resident's individualized comprehensive care plan initiated on [redacted] reflected that the resident had a potential for [redacted]. It further included that the resident was on [redacted] and had a [redacted] line (a [redacted]). Interventions were non-specific and indicated to monitor the site for infection or changes and "observe infection control." There were no interventions regarding instituting transmission-based precautions. It did not address the one-to-one observation. A review of the resident's physician Order Summary Report for [redacted] did not reflect evidence of physician orders for Transmission-Based Precautions or address the one-to-one observation. A review of the electronic Progress Notes (ePN) dated [redacted] and [redacted] reflected that the resident was hospitalized with a diagnosis of	F 880		

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F 880	Continued From page 302 [redacted] and readmitted to the facility on [redacted]. A review of a Physician's Progress Note dated [redacted] did not address transmission-based Precautions. Further review of subsequent ePN did not address that transmission-based Precautions were being implemented for Resident [redacted] or evidence of a [redacted] observation being implemented. A review of the electronic immunization records for Resident [redacted] did not reveal a history of a [redacted] vaccine report. A review of the Admission Record face sheet for Resident [redacted] reflected that the electronic immunization record revealed that Resident [redacted] had received their second dose of the [redacted] vaccination on [redacted]. On the same day, on 10/24/21, at approximately 1:45 PM, the LNHA stated that he tried to get in touch with the Infection Preventionist but was unable to get in touch with them. The surveyor requested evidence of in-service training/competencies on infection prevention and control related to [redacted] the vaccination status of Resident [redacted] and evidence of [redacted] testing or vaccination status of the Agency CNA that was assigned to Resident [redacted] The LNHA stated that he would have to get back to the surveyor. At 3:45 PM, the LNHA informed the surveyor that he didn't have the information yet to provide to the survey team, but as far as he knew, Resident	F 880		

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F 880	Continued From page 303 [redacted] was not vaccinated and was on transmission-based precautions as a [redacted] due to a recent hospitalization less than 14 days ago. The DON confirmed that she did not have additional information yet either and that they probably would not have it until the next day, [redacted] when the Infection Preventionist returned to work. No additional documentation, infection prevention and control in-service records, an assignment sheet for the [redacted] Unit, or vaccination records were provided to the surveyors. At 4:00 PM, the two surveyors notified the Interim DON and the LNHA that the facility's failure to ensure all staff were appropriately implementing the use of necessary PPE in accordance with the CDC guidelines, and their failure to ensure a well-to-ill rounding strategy to prevent transmission of [redacted] in accordance with their Outbreak Response Plan, posed a serious and immediate threat to the safety and wellbeing of the residents on the [redacted] Unit. This resulted in an Immediate Jeopardy (IJ) situation that began on 10/21/21 when Resident [redacted] was readmitted to the facility, and according to staff interviews, the resident was placed on Transmission Based Precautions as a [redacted] due to not being vaccinated. The IJ continued until 10/25/21 when the facility alleged complete implementation of the elements of their removal plan was accepted on 10/27/21. The facility administration was notified of the Immediate Jeopardy situation on 10/24/21 at 4:00 PM. On 10/25/21 at approximately 12:30 PM, the LNHA provided the survey team evidence that Resident [redacted] received a second dose of a	F 880		

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[redacted] vaccine on [redacted]. He acknowledged that while staff were not aware of the resident's vaccination status, they were not implementing the necessary PPE if they had not been vaccinated. The practices implemented were contrary to guidance issued by the U.S. CDC to prevent the spread of [redacted] in nursing homes.

On 10/25/21 at 8:56 AM, Surveyor #4 observed Resident [redacted] at the doorway of their room, sitting in a [redacted]. There was a trash can next to the resident outside the room with the top open, an isolation bin containing disposable yellow personal protective equipment (PPE) gowns, and N95 respirator masks with a box of gloves sitting on top. The signage on the wall started, "observation area: residents on this unit are placed under observation to complete a 14 day isolation. A red sign which included, residents on this unit are person under investigation (PUI) for [redacted]. Please wear appropriate personal protective equipment (PPE) before entering." There was a green sign on the door which included, "are you wearing an N95 mask, face shield and isolation gown?"

A review of Resident [redacted]'s Transfer/Discharge Report revealed the resident was recently admitted with diagnoses that included but were not limited to other [redacted] as the cause of diseases classified elsewhere [redacted]. A physician's order dated [redacted] revealed [redacted] hours for 14 days for [redacted].

On 10/25/21 at 8:58 AM, Surveyor #4 observed

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the LPN enter the isolation room of Resident [redacted] without donning (putting on) a PPE gown or eye protection and only wearing a pair of gloves and a surgical mask. The LPN moved the resident sitting in the [redacted] back a little further from the entry of the doorway and then exited the room. At that time, surveyor #4 interviewed the LPN, who stated Resident [redacted] was placed on precautions on [redacted]. He further stated to his understanding the resident was on contact precautions. The LPN stated the required PPE for this resident on contact precautions was a pair of gloves and a surgical mask. He stated he was not fully sure why the resident was on contact precautions but assumes it's because they were readmitted from the hospital with a diagnosis of [redacted]. An infection that is difficult to treat because of [redacted]). The LPN acknowledged the isolation bin and green signs on the door regarding isolation gowns and eye protection outside the resident's door. The LPN stated the Infection Preventionist (IP) was going to clarify the signage on the door and will have an "official" contact precaution sign starting today. The LPN removed his gloves and acknowledged he should have performed hand hygiene but realized there was no alcohol-based hand rub (ABHR) dispensers close to him.

On 10/25/21 at 9:05 AM, the IP stated Resident [redacted] was placed on contact precautions due to [redacted] in his/her [redacted]. She confirmed the resident was fully vaccinated and was not a PUI for [redacted]

On 10/25/21 at 9:06 AM, Surveyor #4 observed a Speech Therapist (ST) donned a yellow

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F 880	Continued From page 306 disposable PPE gown, an N95 respirator mask with a surgical mask over it, eye protection, and a pair of gloves prior to entering the room of Resident [redacted]. The ST entered the room to assist with feeding the resident. She brought the resident all the way to the resident's bed from the position the LPN had placed the resident. On 10/25/21 at 11:37 AM, the IP stated for Resident [redacted] on contact precautions for [redacted]. The required PPE was a gown, surgical mask, and a pair of gloves. She stated she had done several in-services with staff regarding taking precautions. The IP acknowledged it was "not good practice" to go into a resident's room on contact precautions with [redacted] wearing only gloves and masks. She further stated there was an isolation bin with PPE and signage on the door on what should be worn prior to entering the room. The IP concluded the signage had been changed because Resident [redacted] vaccination status was confirmed, and was on isolation precautions for [redacted] and not COVID-19. On 10/25/21 at 11:44 AM, Surveyor #4 observed the updated signage of a red stop sign and checked with the nurse before entering. An orange contact precautions sign was put on the door to perform hand hygiene, gloves, and a gown prior to entering. On 10/26/21 at 1:33 PM, the IP provided an In-service for contact precautions/[redacted] that was conducted on [redacted]. The LPN was in attendance. The In-service included ...."hand hygiene, gloves, and gown .... applies whether or not contact with the patient or the patient's environment is anticipated ...."	F 880		

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F 880	Continued From page 307 On 10/27/21 at 10:27 AM, the IP stated she was unable to find any more infection control in-services for the LPN. She acknowledged the only in-service she had was the contact precautions/[redacted] in-service she provided the day prior. A review of the facility's policy Isolation Precautions for [redacted], undated, included, ..."Proper handwashing technique with antibacterial soap and the use of PPE is required. Staff will comply with contact and standard precautions." According to the U.S. Centers for Disease Control and Prevention (CDC) guidelines updated September 10, 2021, for the Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 (COVID-19) Spread in Nursing Homes included that, "In general, all unvaccinated residents who are new admissions and readmissions should be placed in a 14-day quarantine, even if they have a negative test upon admission. Facilities located in counties with low community transmission might elect to use a risk-based approach for determining which unvaccinated residents require quarantine upon admission. Decisions should be based on whether the resident had close contact with someone with SARS-CoV-2 infection while outside the facility and if there was consistent adherence to IPC [Infection Prevention and Control] practices in healthcare settings, during transportation, or in the community prior to admission. Guidance addressing recommended PPE when caring for residents in quarantine is described in Section: Manage Residents who had Close Contact with Someone with SARS-CoV-2 Infection..." Under that section, it included	F 880		

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guidelines that specifically addressed that "Unvaccinated residents who have had close contact with someone with SARS-CoV-2 infection should be placed in quarantine for 14 days after their exposure, even if viral testing is negative. HCP [Healthcare Personnel] caring for them should use full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator)."

F880 continued at a lower scope and severity of an "F" as evidenced by the following:

Based on observation, interview, record review, and other pertinent facility documentation, it was determined that the facility failed to:

1.) ensure that privacy curtains, wheelchairs, furniture, and environment were maintained in a sanitary manner to prevent the spread of infection for 5 of 5 units.

2.) failed to maintain proper infection control practices during resident meal service on 1 of 5 units ([redacted]).

3.) follow their facility policy for contact isolation related to a suspected [redacted] diagnosis for 2 of 2 (Resident [redacted] and Resident [redacted]).

4.) annually update the facilities Infection Control Policy and Procedure Manual.

5.) ensure vital sign monitoring was completed for signs and symptoms of [redacted] as indicated during a [redacted] outbreak for 5 of 5 residents (Resident # [redacted], and [redacted]) reviewed for [redacted] monitoring,

6.) ensure proper infection control measures

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were followed during a meal observation when staff used bare hands to cut up a food item prior to a resident's consumption for 1 of 5 nursing units ([redacted] Unit).
Part 1

Based on observation interview and review of pertinent documentation, the facility failed to ensure that the resident care equipment and environment were maintained in a sanitary environment. The following observations were made during the tour:

On 10/18/21 at 8:28 AM, Surveyor #3 toured [redacted] Unit and observed the following:

On the [redacted] unit in room #[redacted], the surveyor observed feces in the toilet, on the toilet seat, and on clothes that were located on the floor.

At 9:09 AM, observation of room [redacted] revealed debris on the floor. The floor was very sticky.

At 9:11 AM, an observation of room [redacted] revealed that the floor was dirty and stained underneath the bed and by the door.

At 9:12 AM, observation of room [redacted] revealed that the floor was stained, and debris was observed on the floor.

At 9:13 AM, observation of room [redacted] revealed a torn mattress, and the toilet was dirty.

At 9:14 AM, observation of room [redacted] revealed debris on the floor.

At 9:15 AM, an observation of room #[redacted] revealed that the floor was visibly soiled.

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F 880	Continued From page 310 At 9:17 AM, observation of room # [redacted] revealed that the toilet was soiled with feces. At 9:18 AM, observation of room # [redacted] revealed that the toilet was stained. On 10/18/21, Surveyor #4 observed the following environmental concerns on the [redacted] Unit: At 9:19 AM, observation of room # [redacted] revealed stains on the toilet. At 10:05 AM, observation of room [redacted] revealed a dirty sink with brown stains. At 12:10 PM, observations of flies on an unsampled resident's hands, shoulder, and arms while sitting in a reclining chair in the [redacted] side 2 dayroom. Another fly was observed on an unsampled resident's elbow while sitting in a wheelchair in the dayroom. At 12:12 PM, the surveyor observed an ambulatory unsampled resident sitting in a chair on the [redacted] side [redacted] dayroom. The resident was barefoot, and the floor was wet where the resident was sitting. At 12:32 PM, observed in room [redacted] had broken furniture, mattress on the floor and the toilet was full of [redacted], and the toilet seat was stained. At 12:34 PM, observed in room [redacted] had a stained floor, urine odor, toilet running, flies were in the room, and [redacted] was in [redacted] hanging on the side of the bed. At 12:26 PM, observed in room [redacted] that there	F 880		

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was a torn floor mat, floor dirty, and flies were in the room.

At 12:40 PM, observed in room [redacted] that the floor was stained, feces was on the bathroom floor and on the toilet.

At 12:42 PM, observed that room [redacted]'s floor was dirty and there was a dirty floor mat laying on the floor. There was trash on the floor and flies in the room.

At 12:43 PM, observed in room [redacted] strong [redacted] odor, and the floor was sticky.

At 12:44 PM, observed the floor in room [redacted] was sticky.

At 12:46 PM, observed in the sunroom on [redacted] side [redacted] an unsampled resident sitting in a broken chair with flies on [redacted].

At 12:51 PM, observed a strong [redacted] odor in room #[redacted]

At 12:52 PM, the surveyor observed an unsampled resident sitting in the sunroom on the [redacted] side [redacted] in a dirty red recliner chair with flies on [redacted] and a cup with [redacted] was on the window still in the corner by the window.

At 12:52 PM, observed flies in room [redacted]

At 12:53 PM, the floor in room [redacted] was sticky.

At 12:53 PM, the floor in room [redacted] was sticky.

At 12:54 PM, both dayrooms and sunrooms on the [redacted] Unit had sticky, stained floors.

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The facility policy dated March 2016 and titled "Bathroom Cleaning" indicated that housekeeping was to be provided with a complete outline of the equipment and supplies necessary to perform daily routine cleaning of the bathrooms. The policy specified that daily cleaning would be done to ensure optimum levels of cleanliness and sanitation, prohibit the spread of infection and bacteria and maintain the outward appearance of the facility.

The job description titled "Facility Administrator" with a date of May 2020 indicated that the primary purpose of the position is to direct the day-to-day functions in the facility in accordance with current federal, state, local standards, guidelines, and regulations that govern long-term care facilities to assure that the highest degree of quality of care can be provided to residents at all times. The duties and responsibilities include the following:

Review the policies and procedures that govern the operations of the facility.

Review job descriptions and performances evaluations of each staff position.

Create and maintain an atmosphere of warmth, personal interest, positive emphasis, as well as a calm environment throughout the facility.

Make routine inspections of the facility to assure that established policies and procedures are being implemented and followed.

Consult with department directors on the operation of their departments and assist in eliminating/correcting problem areas and/or

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improvement of services.

Assure that the building and grounds are in good repair.

Assist the Maintenance Director in developing and implementing waste disposal policy and procedures.

Assure that the facility is maintained in a clean and safe manner for resident comfort and convenience.

Assure that all residents receive care in a manner and in an environment that maintains or enhances their quality of life without abridging the safety and right of other residents.

The job description titled "Maintenance Director" and dated May 2020 indicated that the primary purpose of this position is to maintain the orderly functioning of all equipment in the facility, including the kitchen, laundry, heating, air conditioning, and elevators, as well as purchase the necessary supplies for repair, maintenance, and emergencies within the budgetary guidelines. The main duties include the following:

Assure the proper maintenance and running of all electricity and plumbing in the entire building.

Assure the proper maintenance and running condition of all equipment in the building.

Perform all repairs that do not fall under the purview of housekeeping.

Supervise repairs and routine maintenance of the building and all departmental equipment.

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The job description titled "Director of Housekeeping" with an of May 2020 indicated that the Director of Housekeeping was responsible for planning, organizing, staffing, directing, coordinating, reporting, budgeting, and physical management of the housekeeping departments employees and equipment in a way that maximum cleanliness and order throughout the building and laundry services for both resident clothing and facility linen are maintained. The HD must:

Be physically and mentally capable of performing job duties.

Must have compassion, tolerance, and understanding for the elderly.

Update and correct personnel policies pertaining to the housekeeping and laundry staff and submit them to the Administrator for approval. To staff and residents (at a ratio of 3:1).

Supervise the laundry staff to ensure proper handling of isolation linen and clothing, laundering, and drying of all delivered linen and clothing, proper distribution of clean clothing to residents, and proper distribution of bed linen and towels on all wings to ensure continuous service to residents.

Implement any plan of corrections as required by state and federal surveys in the housekeeping department.

Provide monthly, quarterly, and annual reports, including recommendations for changes in center

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practice for the Quality Assurance and Performance Improvement Committee.

The updated "Maintenance and Repair" policy provided to the surveyor on 10/12/21 at 3:46 PM indicated the following:

Existing structures should be replaced or repaired as needed.

The facility policy titled "Cleaning Methods-Housekeeping," updated on 05/17/21, indicated that the facility will develop a cleaning schedule utilizing the same procedure for rooms on isolation precautions. Clean the room thoroughly once the resident had been discharged. Terminal cleaningof the walls, blinds, curtains are not recommended unless they are visibly soiled. High-touch cleaning surfaces will be cleaned and disinfected on a more frequent schedule compared to minimal-touch housekeeping surfaces. High touch surfaces include, but are not limited to:
-bed rails
-call bells
-doorknobs
-faucet handles
-light switches
-surfaces in and around toilets in resident rooms
Cleaning of resident rooms will be performed daily to include:
-high dusting
-spot-cleaning the walls
-windows
-doors
-light fixtures
-ledges
-tables
-chairs

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-beds
-call bells
-floors
-vacuuming carpets
The policy also indicated that curtains were to be cleaned on a routine basis and, when visible soiled, bathrooms daily and that equipment was to be maintained in good repair.

The job description titled "Maintenance Director" and dated May 2020 indicated that the primary purpose of this position is to maintain the orderly functioning of all equipment in the facility. Including the kitchen, laundry, heating, air conditioning, and elevators and purchasing the necessary supplies for repair, maintenance, and emergencies within the budgetary guidelines. The primary duties include the following:

Assure the proper maintenance and running of all electricity and plumbing in the entire building.

Assure the proper maintenance and running condition of all equipment in the building.

Perform all repairs that do not fall under the purview of housekeeping.

Supervise repairs and routine maintenance of the building and all departmental equipment.

The updated "Maintenance and Repair" policy provided to the surveyor on 10/12/21 at 3:46 PM indicated the following:

Existing structures should be replaced or repaired as needed.

The job description titled "Director of

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Housekeeping" updated on May 2020, indicated that the Director of Housekeeping was responsible for the following: Planning, organizing, staffing, directing, coordinating, reporting, budgeting, and physical management of the housekeeping departments employees and equipment in a way that maximum cleanliness and order throughout the building and laundry services for both resident clothing and facility linen are maintained. The HD must

Be physically and mentally capable of performing job duties.

Must have compassion, tolerance, and understanding for the elderly.

Update and correct personnel policies pertaining to the housekeeping and laundry staff and submit them to the Administrator for approval.

To staff and residents (at a ratio of 3:1).

Supervise the laundry staff to ensure: proper handling of isolation linen and clothing, laundering, and drying of all delivered linen and clothing, proper distribution of clean clothing to residents, and proper distribution of bed linen and towels on all wings to ensure continuous service to residents.

Implement any plan of corrections as required by state and federal surveys in the housekeeping department.

Provide monthly, quarterly, and annual reports, including recommendations for changes in center practice for the Quality Assurance and Performance Improvement Committee.

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The facility policy, "Cleaning Methods-Housekeeping," updated on 05/17/21, indicated that the facility will develop a cleaning schedule utilizing the same procedure for rooms on isolation precautions. Clean the room thoroughly once the resident had been discharged. Terminal cleaning of the walls, blinds, curtains are not recommended unless they are visibly soiled. High-touch cleaning surfaces will be cleaned and disinfected on a more frequent schedule compared to minimal-touch housekeeping surfaces. High touch surfaces include, but are not limited to:

bed rails
call bells
doorknobs
faucet handles
light switches
surfaces in and around toilets in resident rooms

The cleaning of resident rooms to be performed daily includes:

high dusting
spot-cleaning the walls
windows
doors
light fixtures
ledges
tables
chairs
beds
call bells

Part 2

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F 880	Continued From page 319 On 10/22/21 at 8:58 AM, the surveyor, in the presence of the LPN/UM, observed the CNA on the [redacted] unit used his bare hands to tear apart a pancake for an unsampled resident to eat. The CNA placed the plate of pancakes in front of the resident for the resident to eat. The surveyor intervened before the resident ate the pancakes. At 9:15 AM, the surveyor interviewed the LPN/UM, who confirmed the above findings and stated that it was unacceptable, and he reported the CNA to Human Resources for education. During an interview with the CNA at 11:30 AM, he admitted that he had used his bare hands to tear apart the resident's pancake because he was rushing. The CNA stated that he should have worn gloves to prevent cross-contamination. The CNA further stated, "I should have my gloves on for infection control." At 12:15 PM, the surveyor interviewed the Human Resource Manager, who confirmed that she also observed the CNA shred the pancake with his bare hands before giving the food to the resident. She stated that she could not comment on why she or the LPN/UM did not intervene immediately before the resident was given the plate of food. The Human Resource Manager stated that using bare hands to cut a resident's food was not the expectation at the facility, and the CNA would be in-serviced regarding appropriate infection control practices. At that time, the surveyor requested the CNA's employee file for review. A review of the CNA's employee file indicated that on [redacted], the CNA received disciplinary action	F 880		

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for not following infection control practices.

On 10/22/2021 at 1:15 PM, Surveyor #3 interviewed the Infection Control Preventionist regarding the flies observed on the Unit during the breakfast meal and other meals throughout the survey. The IP informed the surveyor that she was aware of the flies in [redacted] and reported the same to the former administrator. She informed the surveyor that the Unit Manager for the [redacted] Unit reported the same. The IP went on to state," Since I started here, that was a major concern that was discussed with the administrator. The facility needs to get an exterminator. Nothing is being done. It is not acceptable to have staff swatting flies while assisting residents with their meals. Flies can lay eggs that can cause "maggots".

On 10/25/2021 at 8:40 AM, Surveyor #3 went to the [redacted] Unit and observed that room [redacted] was still not cleaned, and the toilet bowl was observed with feces. The surveyor observed Resident [redacted] (unsampled resident) eating breakfast in the dayroom and observed flies on the tray, on the spoon, and on the coffee mug's lid. The CNA was at the table assisting another resident with the breakfast meal. The CNA was swatting the flies as multiple flies were noted on the table, on the chair, and on Resident #[redacted]

An interview with the CNA who cared for Resident #60 revealed that Resident [redacted] received a shower this morning.

The facility policy dated 01/05 and titled " Hand Washing" indicated that hand washing is considered the most important single procedure for preventing nosocomial infections. The policy

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also indicated handwashing was taught as an important component of the personal hygiene of all nursing home personnel. In addition, personnel is reminded to wash their hands after using the toilet, before preparing food, before smoking, and before going home for the rest of the day.
Part 3

1.) According to the Resident Face Sheet, Resident [redacted] was admitted to the facility with medical diagnoses that included [redacted], and [redacted] disease.

Review of the Quarterly Minimum Data Set (MDS), an assessment tool, dated [redacted], revealed Resident [redacted] was identified with [redacted], needed limited assistance from staff for Activities of Daily Living (ADLs), and identified with impairment of [redacted] on one side.

On 10/22/21 at 9:30 AM, the CNA stated to the surveyor, Resident [redacted] had cream for [redacted] applied last night that needed to be washed off this morning. The surveyor did not observe contact isolation precautions on or around Resident [redacted]'s room. The CNA said Resident [redacted] self-propelled herself/himself around the unit prior to the cream being applied. The surveyor observed the CNA taking the resident to the shower room. The surveyor reviewed Resident [redacted]s progress notes and observed on [redacted], the Nurse Practitioner (NP) wrote an order for [redacted] cream to be applied at night and

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washed off 8 hours later, with a diagnosis of scabies. No isolation precautions were ordered by the NP at that time.

During an interview with the Infection Preventionist (IP) on 10/22/21 at 1:53 PM, the IP stated she received a text message from the DON on 10/22/21 at 9:52 am about a resident in the facility with possible [redacted]. The surveyor observed the text exchange between the DON and the IP on the IP's cell phone. The DON responded via text: "OK. [redacted] do we keep him/her isolated after treatment?" The IP responded via text, "No, cream would be applied HS and showered off 8-10 hours after per CDC guidelines, gloves would be needed to avoid direct skin to skin contact for 8 hours after the cream is applied.

On 10/22/21 at 2:35 PM, the surveyor interviewed the NP by phone about Resident [redacted] diagnosis. The NP stated no test was done for [redacted], but it looked like a '[redacted] and the diagnosis was her "best guess" based on her evaluation of the resident. The NP stated the resident would have to be sent to [redacted] for [redacted] for a "definitive" diagnosis, which could take months. The NP stated she was told that she could just treat the resident without a [redacted]. The NP did not order contact precautions for the resident at the time of the diagnosis. The NP did not notify the IP or DON, nor did she report it to the local health department or Department of Health (DOH) because "that wasn't her responsibility." The NP ordered '[redacted] - apply to all body parts, use down to the [redacted] xx 1 dose leave on for 8 hrs at bedtime, wash off in the AM." The NP discussed the treatment and order with

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the day shift LPN #1 and left the facility.

On 10/22/21 at 2:50 PM, the surveyor interviewed LPN, who stated the NP told her that "it looks like it's [redacted] and we will order the cream to treat her/him." LPN stated she faxed the order to the pharmacy, put the order in the treatment book, flagged it, and passed it on to the next shift before she left the floor. LPN stated, "We did not put [redacted] on isolation. We don't have a UM, and I didn't talk to the DON about it. I documented it in the record." LPN also stated the resident was treated with [redacted] cream last evening at 9 PM. When the surveyor observed the Treatment Administration Record (TAR), the evening LPN didn't sign the TAR. LPN stated that LPN said she did do the treatment but didn't sign the TAR. LPN didn't know why LPN didn't sign the TAR. LPN stated, "I didn't inform the IP or DON because I was very busy on the floor, and I gave the order to the 3-11 shift to pass it on. The resident was all over the unit on 10/20/21 and 10/21/21 before they received treatment. I tried to keep them in their room, but it was very hard, and I was busy."

The LPN further stated," I did not know it was a reportable condition. I do not know who the resident came in contact with, but we tried to keep him/her in the room. Resident [redacted]'s clothes were not washed because the resident was wearing a hospital gown. I was supposed to let the IP know, but she could see the notes in my report I should've let the IP know when the NP told me it was [redacted]

On 10/25/21 at 12:34 PM, the surveyor interviewed the Interim DON on what to do if a resident had suspected [redacted] diagnosis. The

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DON stated, "I would be expected to be notified, and for the resident to be treated by the physician. I would expect the nursing staff to have bagged up all the resident's laundry and washed it separately. I would have expected the nursing staff to have the resident moved out of the room and have it exterminated." The DON stated, "I don't know anything that happened with the resident's treatment or isolation precautions."

According to the facility policy, "Isolation - Categories of Transmission-Based Precautions," revised 1/2019, under section "Policy Statement - Standard Precautions shall be used when caring for residents at all times regardless of their suspected or confirmed infection status. Transmission-Based Precautions shall be used when caring for residents who are documented or suspected to have a communicable diseases or infections that can be transmitted to others." Also, in the policy under section "Contact Precautions, implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the residents or indirect contact with environmental surfaces or resident-care items in the resident's environment with the example of #9 Scabies."

2. During the tour of the facility on 10/18/2021 at 09:30 AM, Surveyor #3 observed Resident [redacted] sitting in a [redacted] in the dayroom. The resident was screaming and continuously [redacted] ratching the skin. On 10/19/2021, the surveyor toured the unit again. The surveyor observed Resident #[redacted] in bed. Resident [redacted] was again screaming and scratching all over.

On 10/202021 at 08:45 AM, Surveyor #3 went to

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the unit. The door was closed. From the double door leading to the resident's room, the surveyor could hear the resident screaming. The surveyor knocked at the door and entered the room. Resident [redacted] was covered with flies. The surveyor went to the nursing station and asked the nurse to call the Director of Nursing (DON). The surveyor accompanied the DON to the room, and we both observed the flies on the bed and on the resident [redacted]. The DON stated, "I never see something like that."

Surveyor #3 reviewed Resident [redacted]'s clinical record on 10/20/2021, which reflected that Resident [redacted] had diagnoses which included [redacted]

The Quarterly Minimum Data Set dated [redacted] MDS-- an assessment tool developed by the facility to identify resident's needs and implement care interventions, revealed that Resident [redacted] was totally dependent on staff for all activities of daily living (ADL's) and required extensive assistance of staff for bed mobility and transfer.

On 10/20/2021 at 10:30 AM, Surveyor #3 interviewed the Unit Manager (UM) regarding Resident #[redacted]. The UM informed the surveyor that Resident [redacted] had a treatment ordered for the [redacted] Surveyor #3 then inquired if Resident [redacted] had been seen/ evaluated by a [redacted] for the [redacted]. The UM indicated that the [redacted] had not been in the facility since the pandemic.

Surveyor #3 further reviewed the clinical record and noted that Resident [redacted] was treated with

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F 880	Continued From page 326 [redacted] cream in [redacted] for a [redacted] and again in [redacted]. According to the physician order, the cream was to be applied aftercare. The surveyor reviewed the clinical record with the UM and could not find any [redacted] consult. On 10/20/2021 at 12:30 PM, during a second interview with the UM, he stated that the physician was notified of the [redacted] again today. The physician wrote an order for Resident [redacted] to be treated with [redacted] cream followed by a [redacted] consult. The following entries were entered in the medical record, " Note Text: pt [referring to patient]seen By MD this shift for f/u on [redacted] with [redacted]-mainly on [redacted] [redacted]c infection-will treat with [redacted] cream-1 time treatment and [redacted] 2 weeks if no improvement. Cont [redacted] cream bid [twice a day] for 14 days will f/u [redacted] eval". On 10/25/2021 at 12:46 PM, Surveyor #3 interviewed the physician regarding the treatment ordered for Resident #[redacted]. The physician informed the surveyor that the facility was aware of the protocol to follow. She did not elaborate further. On 10/26/2021 at 09:57 AM, during a telephone interview with the UM, he confirmed that Resident [redacted] was being treated for a presumptive case of [redacted] The treatment was applied on [redacted] on the 03:00 -11:00 PM shift. Resident [redacted] was showered on the morning of [redacted]. Surveyor #3 reviewed the Treatment Administration Record (TAR) and confirmed that the treatment was applied.	F 880		

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F 880	Continued From page 327 Surveyor #3 asked the UM if he was aware of the protocol to follow. The UM told the surveyor the treatment was applied, and Resident [redacted] was showered the next day. No directive was provided to the staff who applied the treatment. He stated clearly that he was not aware of any protocol to follow. On 10/26/2021 at 11:45 AM, Surveyor #3 interviewed the Infection Preventionist (IP), who indicated that she was not aware of any presumptive cases of [redacted] on the [redacted] Unit. he went on to state she had the policy and the protocol for [redacted] to follow. On 10/26/2021 at 02:07 PM, the IP provided an undated policy titled" [redacted] Policy" The following were noted: [redacted] Treatment X 1, [redacted] / [redacted] apply on the entire [redacted] from [redacted] at HS after a shower. Shower prior to tx[treatment] is to remove body lotion applied. Shower 8 hours after. Wear gloves and gowns during close contact with residents, clothing or bed linens, and during the treatment period. All personal clothing linens and privacy curtains will be laundered by outsource only during the treatment period. Non-washable items can be sealed in plastic bags for a period of 7-14 days to suffocate the [redacted].	F 880		

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[redacted] treatment to a suspicious resident will include his/her roommate (s) and environmental cleaning of treated residents. Unit nurses will assist the social worker in notifying the resident's families/ responsible parties to explain the treatment and environmental cleaning, including the laundry of personal clothing. Infection Control Nurse will inform ancillary departments on the start date and end date of quarantine. The protocol was not followed as the staff was not aware of how to proceed with the treatment. The IP was made aware only after the treatment had been applied.

A review of the policy, "Procedure to be followed with suspected [redacted]," sections 1-6 in the policy were not followed by the facility for Resident [redacted]

Part 4

On 10/27/21 at 10:33 AM, the surveyor, in the presence of the Licensed Practical Nurse Infection Preventionist (LPN/IP), reviewed the facility's Infection Control Policies and Procedures located in the ICPP binder. The surveyor observed the ICPPP binder revealed no signature page to indicate that the information or policies and procedures had been updated since 2019.

At that time, the LPN/IP stated the IPCP binder had not been reviewed since she had been IP and that she was unaware of how often the IPCP binder should be reviewed. The LPN/IP stated the ICPP binder had just been located that morning. The LPN/IP stated that she had been asking the Director of Nursing (DON) for any information

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regarding infection control since the facility did not have an IPCP binder. The LPN/IP further stated that it was important to be up to date on the most recent policies and procedures to ensure the facility was doing the right things.

On 10/27/21 at 11:05 AM, the Licensed Nursing Home Administrator (LNHA) stated the ICPP binder was located that morning. The LNHA reviewed the binder and stated there was no signed signature page, so he was unable to determine when the ICPP binder was last reviewed or updated. The LNHA stated the IPCP binder should be reviewed and updated annually.

The DON was not available for an interview.

The facility failed to provide a policy.

Part 5

Based on interview, and review of facility documentation, it was determined that the facility failed to monitor all residents for signs and symptoms of [redacted] by monitoring Vital Signs during a [redacted] Outbreak.

This deficient practice was identified for 5 of 5 residents (Resident # [redacted], and [redacted] reviewed for [redacted] monitoring as evidenced by the following:

On 10/18/21 at 9:09 AM, the Infection Preventionist (IP) provided the Line listing for the most recent [redacted] outbreak, which revealed the [redacted] Outbreak started on [redacted] and the last staff member who tested positive for [redacted] was on [redacted] and recovered on [redacted]

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During an interview with Surveyor #7 on 10/22/21 at 12:26 PM, the IP stated that the facility was currently in a [redacted] Outbreak until [redacted] 1 as long as the facility did not have any more positive [redacted] cases. The IP further stated that during a [redacted] Outbreak, all residents were monitored for signs and symptoms of [redacted] each shift which included taking Vital Signs (VS) and documenting the results in the Electronic Medical Record (EMR). The IP further stated that if VS were not obtained as per their Outbreak plan, the residents would be at risk of getting [redacted] or other infections. The IP confirmed that the facility was in Phase 0 of the [redacted] Outbreak phases.

The surveyor reviewed the progress notes and Vital Signs (Temperature, Blood Pressure, Pulse, Respirations and Oxygen level (POX)) documentation from [redacted] until 1[redacted] which reflected the following:

Resident [redacted]
From [redacted], VS were not documented on every shift.

Resident [redacted]
On [redacted]
VS were not documented on each shift.
On [redacted], VS were not documented on night or day shift
On [redacted], VS were not documented on night or evening shift
On [redacted], and [redacted], VS was not documented on each shift

Resident # [redacted]
On [redacted]

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F 880	Continued From page 331 VS were not documented on each shift. On [redacted] VS were not documented on night or day shift On [redacted], VS were not documented on night or day shift On [redacted], VS were not documented on night or day shift On [redacted], VS were not documented on night or day shift Resident # [redacted] On [redacted]-VS were not documented on any shifts. Resident # [redacted] On [redacted] VS were not documented on each shift On 1[redacted], VS not documented on each shift (Only POX obtained on night shift) On [redacted], VS not documented on each shift (Only POX obtained on night shift) On [redacted], VS were not documented on night or evening shift On [redacted], VS were not documented on each shift (POX only on night shift) On [redacted], VS not documented on each shift (POX only on night shift) On [redacted], VS not documented night and day shift On [redacted], VS were not documented on the night of the day shift On [redacted] and [redacted], VS were not documented on each shift On [redacted], VS was not documented on each shift (POX only documented on evening shift) On [redacted], VS not documented on night or day shift During an interview with Surveyor #7 on [redacted]	F 880		

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F 880	Continued From page 332 at 9:36 AM, the Licensed Practical Nurse (LPN) stated that during a [redacted] Outbreak, only residents who are [redacted] positive or under quarantine would have vital signs checked each shift. Those residents not on quarantine, their vital signs would only be checked as ordered, such as monthly or weekly. The LPN further stated," I know we are still in an outbreak until [redacted] as long as there are no new positive [redacted] cases." During an interview with Surveyor #7 on 10/25/21 at 10:18 AM, a Staff Registered Nurse (RN) stated that when in a [redacted] outbreak, the staff would monitor the residents by taking their vital signs and assessing for signs and symptoms of [redacted] such as SOB, coughing, fever or change in status every shift and document them in the EMR. During an interview with Surveyor #7 on 10/26/21 at 11:27 AM, the Director of Nursing (DON) stated that during a [redacted] Outbreak, each resident was to be assessed for signs and symptoms of [redacted] which included obtaining vital signs every shift and documenting them in the EMR. A review of the facility's Outbreak Plan titled "Pandemic Influenza/[redacted] Preparedness and Readiness Plan", revised on September 1, 2021, reflected that in Phase 0 of a [redacted] Phases, screen all residents for signs and symptoms of [redacted] by monitoring vital signs. N.J.A.C 8:39-4.1 (11), 5.1(a); 19.1(a), 19.4(f), 19.4 (a) (g), 19.7 (b), 31.2 (a-i), 31.3, 31.4 (a) (b) (c) (f), 31.5 (a)	F 880		
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F 886	Continued From page 333 CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and	F 886		

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F 886	Continued From page 334 (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to test unvaccinated staff for Coronavirus Disease 2019 (COVID-19) at a frequency based on the Reports of County COVID-19 Level of Community Transmission. This deficient practice was identified for 3 of 5 staff members reviewed for COVID-19 testing and was evidenced by the following: On 10/18/2021 at 9:09 AM, the Infection Preventionist (IP) provided the Line listing for the most recent COVID-19 outbreak which revealed the last staff member who tested positive for	F 886	F886 Element One – Corrective Actions • COVID19 antigen testing of all residents and staff was immediately completed on 10/24/21 and 10/25/21 to ensure no new positive asymptomatic or symptomatic conversions had occurred since the last round of testing. Twice weekly testing was completed until the facility received notification that the active outbreak was resolved. • The IC clinical consultant met with the IC Preventionist and reviewed the NJDOH COVID19 testing requirements based on	

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F 886	Continued From page 335 Covid was on 9/30/2021 and recovered on 10/12/2021. During an interview with Surveyor #10 on 10/21/2021 at 9:43 AM, the IP stated that during the COVID-19 Outbreak, all staff and residents were tested for Covid by an outside company twice a week until 10/18/21. The IP further stated that after 10/18/2021, only unvaccinated staff were tested. The IP told Surveyor #10 that the previous Administrator had informed her that after 10/18/2021 only unvaccinated staff needed to be tested for COVID-19 weekly. The IP stated that the facility was not currently using an outside company to test staff and that she and the supervisors at the facility were the staff members responsible for conducting the COVID-19 testing. During an interview with Surveyor #7 on 10/22/2021 at 12:26 PM, the IP stated that the facility was currently in a COVID-19 Outbreak and they were testing per their Outbreak Plan which included all residents and staff biweekly until 14 days passed without any positive results. The IP stated that this was completed on 10/14/2021. The facility would be out of an Outbreak on 10/28/2021 as long no staff or residents tested positive for Covid by that date. The IP further stated that as of this date, the facility was testing vaccinated staff monthly and unvaccinated staff weekly. The residents would only be tested for Covid by a rapid Covid test if they showed any signs or symptoms of Covid. The IP stated, "the previous administrator told me that after 10/14/2021, the facility would test vaccinated staff monthly and unvaccinated staff weekly. I am going by what the old LNHA told me do. The testing and all additional testing would be done per the COVID-19 Activity Level Index (CALI)	F 886	the county CALI score. Weekly antigen testing of unvaccinated staff was completed based on the county CALI index score. Element Two – Identification of at Risk Residents All residents have the potential to be affected by this practice. Element Three – Systemic Changes • The facility IC Preventionist was a no call no show 11/18 – 11/20/21 and did not respond to calls texts or emails. The ICP was replaced by an interim IC preventionist on 11/20/21. Antigen testing was resumed by the IC preventionist based on the facility outbreak status and the county CALI score. The active outbreak was officially resolved per NJDOH and Camden County DOH on 11/3/21. • Due to three new COVID 19 positive staff members, the facility is back in active outbreak status as of 12/2/21 when the county HD issued a new E number. Biweekly testing of all Residents and staff was completed on 11/29/21 and 12/2/21 and will be conducted twice weekly per protocol until no new positive cases are identified for two weeks. Testing will continue per protocol for another two week period following NJDOH guidance until the facility outbreak is resolved. • The facility interim IC preventionist is completing the daily line list and survey and submitting information to NJDOH and the county HD as required. The COVID 19 outbreak assessment was also	

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F 886	Continued From page 336 score." The IP further stated that the CALI score was based on the region positivity rate not the county positivity rate. The IP stated that she did not know the CALI score because she had not checked it yet. The IP further stated, "I was supposed to test staff today, but I had not had time to do it today." Review of the outside testing completed for all residents and staff revealed all residents and staff tested negative for Covid on 10/4/2021, 10/7/2021, and 10/11/2021. During an interview with Surveyor #7 on 10/25/2021 at 8:42 AM, the IP stated that she did not know the CALI score today because she had not checked it yet. The IP further stated that she was unaware of the revised Centers for Medicare and Medicaid Services (CMS) regulation for routine testing of unvaccinated staff according to the county transmission rate. At this time, the IP stated again that all unvaccinated staff would be tested for Covid weekly. During an interview with Surveyor #7 on 10/25/2021 at 1:29 PM , the present administrator (LNHA) stated that he was not involved in the testing of staff and would refer all testing questions to the IP. The LNHA further stated "All I was told was that we didn't have any Covid positive cases in the building. I know we complete all Covid testing based on CMS, NJDOH and CDC guidelines." During a follow up interview with Surveyor#7 on 10/26/2021 at 1:33 PM, the IP stated that the facility was currently in Phase 0 of the Covid Outbreak Plan and that the facility testing had not been completed per the county transmission rate.	F 886	completed as required and submitted. • Staff received re-enforcement regarding proper use of PPE, hand hygiene, and reporting exposure to positive cases outside the facility and s/s of COVID before reporting to work. • Staff received additional training regarding completion of the COVID assessment in PCC every shift. • The IC clinical consultant communicates daily with the facility interim IC preventionist and is providing assistance as needed. • The facility interim IC preventionist and the IC clinical consultant make rounds throughout the facility to observe use of PPE and Hand Hygiene and provide on the spot education when needed based on these observations. • Nursing managers and supervisors have been trained and are also monitoring staff compliance with IC practices throughout the day on assigned units. Element Four – Quality Assurance Weekly the IC Preventionist will report the results of required COVID testing results at the morning operations meeting and provide results to the Core Team to assure COVID testing policies are followed per facility protocols and NJDOH guidance as appropriate. Findings from these reports will be reported to the DON who will provide results statistics in aggregate quarterly at the QAPI committee meeting for action and further guidance as appropriate.	

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F 886	Continued From page 337	F 886		

The IP provided a copy of the CDC Covid Tracker form from the CDC Website that indicated that the facility was in a county with a high transmission rate. The IP then stated that because the facility was still in a Covid Outbreak, they were supposed to test all residents and staff twice a week until the Outbreak was over. The IP stated that the facility would test only the unvaccinated staff per the community transmission rate. The IP confirmed that Covid testing was not completed per the county transmission rate or Outbreak plan since 10/14/2021.

Review of 3 of the 5 unvaccinated staff members Rapid Covid testing results revealed the following:

1. A CNA tested negative by rapid Covid test on 10/16/2021 and 10/23/2021. A review of the CNA's time sheet revealed the CNA had worked on 10/19/2021, 10/20/2021 and 10/22/2021.
2. A Laundry Aide tested negative by rapid Covid test on 10/16/2021 and 10/24/2021. A review the Laundry Aides time sheet revealed the staff member worked on 10/21/2021 and 10/22/2021.
3. A Human Resource (HR) Staff member tested negative by Rapid Covid test on 10/16/2021 and 10/24/2021. A review of the HR's time sheet revealed the staff member worked on 10/20/2021, 10/21/2021 and 10/22/2021.

Review of the CMS Interim Final Rule (IFC) CMS-3401-IFC , revised 04/27/2021, revealed for outbreak testing, all staff and residents should be tested, regardless of vaccination status, and all staff and residents that tested negative should be retested every 3 days to 7 days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least

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F 886	Continued From page 338 14 days since the most recent positive result. Routine Testing of Staff : Routine testing of unvaccinated staff should be based on the extent of the virus in the community. Fully vaccinated staff do not have to be routinely tested. Facilities should use their county positivity rate in the prior week as the trigger for staff testing frequency. Reports of COVID-19 county-level positivity rates are available on the following website (see section titled, "COVID19 Testing"). The facility should test all unvaccinated staff at the frequency prescribed in the Routine Testing table based on the county positivity rate reported in the past week. Facilities should monitor their county positivity rate every other week (e.g., first and third Monday of every month) and adjust the frequency of performing staff testing. NJAC 8:39-5.1(a); 19.1(a)	F 886		
F 908 SS=L	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, and review of facility documentation, it was determined that the facility failed to ensure that clothes dryers located inside the laundry department were maintained in safe operating conditions. On 10/19/2021 at 11:45 AM, the life safety code (LSC) surveyor and Surveyor #5 toured the laundry area and observed 3 of 4 large commercial grade clothes dryers that were operational. The interior of the	F 908	F 908 Element One □ Corrective Actions " On 10/19/21 immediately in response to a gas smell, [redacted] was called, the gas was shut to the commercial grade dryer, [redacted] checked all other gas lines, and all were in safe working order without any leaks. The dryer with the gas valve leak was immediately taken out of use on	12/28/21

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F 908	Continued From page 339 clothes dryer drums had large areas located in the dryer drums of embedded potentially combustible debris. The surveyor observed various colors of brown and white potentially combustible debris that was embedded and blocking the airflow pockets of the drum. The LSC surveyor also smelled a gas-like odor, the gas company [name redacted] was notified upon surveyor identification, and it was determined by the gas company representative the interior gas line attached to the dryer was positive for an active gas leak due to a gas valve that was in disrepair. The gas company representative issued a violation. The violation reflected the following: "This appliance or section of gas piping has been SHUT OFF due to an unsafe condition. DO NOT operate until the noted condition(s) have been corrected and RE-INSPECTED by [Gas Company name redacted]or your local building code official." REMARKS: Replace the flex connection on the dryer At that time, the life safety code surveyor interviewed the maintenance director regarding a procedure to maintain the integrity of the interior of the dryer drums. The Director of Maintenance (DM) stated there was no policy, procedure, or process to ensure the dryer drums were regularly maintained or monitored for condition. On 10/21/2021 at 2:01 PM, the DM provided Surveyor #5 with a copy of a [redacted] Dryers, Installation/Operation/Maintenance Manual dated April 2019. The Maintenance Section of the	F 908	10/19/21. " The inside of all the dryer drums were cleaned on 10/20/21 to remove loose debris to ensure proper air flow within the drums. A call was placed to the contractor who services the dryers on 10/20/21 when notified of the additional surveyor concern about the integrity of the drums and an inspection completed on 10/21/21. Due to the inability to properly clean the dryers all four were taken out of use and all laundry was outsourced on 10/28/21 pending replacement of the dryers. " [redacted] units were inspected on 10/20/21 and were cleaned and/or filters replaced. Additional contracted Housekeeping and maintenance staff were hired to assist with this process. Element Two □ Identification of at Risk Residents All residents have the potential to be affected by this practice. Element Three □ Systemic Changes " Four new dryers were ordered and received the week of 11/14/21. They have been hooked up but have not been put back into use. Laundry currently continues to be outsourced. " A procedure for daily cleaning of drums and removal of all lint and debris was implemented on 10/24/21 to maintain the integrity of the interior of the drums and laundry staff received education for completing the log daily. " Laundry staff received re-education about properly cleaning debris and lint	

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F 908	Continued From page 340 manual revealed, "Daily", "1. Inspect the area surrounding tumble dryers, remove all combustible materials, including lint, before operating the machines", "Bi-Annually" "2. Check gas connections for leakage". On 10/22/2021 at 9:25 AM, Surveyor #5 interviewed the contracted maintenance technician (MT) in the presence of the Housekeeping Director (HD) in the laundry department. The surveyor inquired to the MT regarding the state of the dryer drums. The MT stated "cleaning is a nightmare". He referred to the imbedded debris on the dryer drums and stated that it is "hours and hours of debris" and it was plastic at one point, "now melted on there". The MT stated he would not recommend to use the dryers, "they are past the point of being cleaned." The MT stated he has not cleaned the drums in the state they were in and recommended to replace the drums on the dryers or replace the dryers because the debris blocked the heat source. The MT stated he could not clean the drums when they were in the condition they were in. Surveyor #5 reviewed a Laundry Report (LR), dated 10/22/2021 which was completed by the MT. The LR revealed "the dryer baskets were covered with melted plastic," we will give an estimate to replace baskets or replace drums. The facility's failure to maintain the commercial-grade clothes dryers (dryers), located inside the laundry department, in safe operating condition by ensuring the dryer drum air vents remained free of embedded potentially combustible debris that blocked the airflow for 3 of 4 operational dryers. This deficient practice	F 908	between each dryer load to ensure safe and proper functioning and lint log established to be used once the in-house laundry resumes services. " A cleaning schedule has been established for all PTAC units that includes changing filters on a routine basis. The housekeeping director and Maintenance are responsible to ensure the schedule is followed. " A schedule to check cleanliness of PTAC units and changing of filters was established by maintenance. " The facility has a contract with an outside provider to assist with oversight and guidance to both housekeeping and laundry departments. Element Four □ Quality Assurance " The dryers are checked during random rounds daily by facility administration in addition to the environmental services director inspections until taken out of use on 10/28/21. Currently laundry is outsourced. " PTAC units will be checked according to established schedule weekly by the Maintenance Director for three months then monthly thereafter to ensure the units are clean and the filters are changed per the schedule. The Maintenance Director will report findings weekly to the Administrator and Quarterly on an ongoing basis at the QAPI committee meeting.	

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F 908	Continued From page 341	F 908		

posed a serious and immediate threat to the safety and wellbeing of all residents who resided in the facility.

This situation resulted in an Immediate Jeopardy (IJ) that began on 10/19/2021. The facility was notified of the IJ situation on 10/20/2021.

The facility submitted an acceptable removal plan via electronic mail (e-mail) on 10/22/2021.

The IJ removal plan was confirmed prior to receiving the facility's written removal plan and verified onsite by the survey team on 10/20/2021.

The non-compliance remained on 10/21/2021 at a lower scope and severity, with no actual harm but the potential for more than minimal harm that was not immediate jeopardy.

The evidence was as follows:

Based on observation, interview, and record review from 10/18/2021 to 10/19/2021, in the presence of facility management, it was determined that the facility failed to maintain their Packaged Terminal Air Conditioner (PTAC) units in a safe and optimal condition for 90 of 100 units observed. This deficient practice was evidenced by the following:

While touring the facility from 10/18/2021 to 10/19/2021, the surveyor observed that PTAC units had clogged and dirty filters. The Maintenance Director indicated that the PTAC unit filters were not cleaned and that he needed help. He was asked if he had a filter cleaning log or a policy and procedure on the maintenance of PTAC units but did not provide any documents at

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F 908	Continued From page 342 that time. NJAC 8:39-31.2(e) NJAC 8:39-31.4(b)	F 908		
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Complaint # NJ149075 Based on observation, interview, and record review it was determined that the facility failed to a.) maintain a functioning call-bell system and provide residents with an alternate means of a call bell (i.e tap bell) when the system was only functioning intermittently which was identified on 2 of 5 resident care units ([redacted]), and for 1 of 1 residents (Resident [redacted] reviewed for call bells b.) have a preventive maintenance program in place to monitor failures in the call bell system and to make necessary corrections for 2 of 5 care units. This deficient was evidenced by the following: 1. On 10/18/2021 at 12:31 PM, Surveyor #1 and Surveyor #5 toured [redacted] and observed the call bell system was not functioning in residents' rooms and bathrooms. The rooms the call bells	F 919	F919 Element One – Corrective Actions Residents in rooms [redacted], and [redacted] were all provided with tap bells. The maintenance staff were informed about the call bell and the vendor was contacted to immediately come in to repair the call bells. Resident [redacted] was immediately provided with a tap bell to communicate with staff. The tap bell was placed within easy reach of the resident. Residents [redacted] and their roommate were immediately provided with a tap bell. The maintenance staff were informed about the call bell in need of repair and the vendor was contacted to immediately come in to repair the call bells.	12/28/21

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F 919	Continued From page 343 were not functioning in were rooms [redacted], and [redacted]. The surveyors observed that there were residents residing in the rooms the call bells were not functioning in. At 12:55 PM, Surveyor #5 interviewed an unsampled alert and oriented resident in his/her room who stated that the call bell hadn't worked in over a year. At 1:00 PM, Surveyor #5 interviewed the Registered Nurse (RN) who worked on [redacted] who confirmed that the residents call bells did not work. The RN stated that the unit was shut down during COVID and then re-opened back up about one or two months ago. The RN stated that on other units where the call bells weren't working the residents had tap bells, but she had not seen any tap bells on the unit. At 1:57 PM, Surveyor #1 interviewed the Maintenance Director (MD) who stated that the call bell system was down in [redacted] and had been broken for about a month due to faulty wiring in the walls. The MD further stated that the Administration knew that the call bell system was not working on the unit and they were supposed to supply the residents with tap bells, but never did, and doesn't know why. 2. On 10/21/2021 at 11:01 AM, during a tour of the [redacted] Unit, Surveyor #2 observed Resident [redacted] who was lying in bed and was unable to [redacted] due to a [redacted] and [redacted] (an appliance for [redacted]) and utilized a [redacted] board ([redacted] with [redacted]) to	F 919	Element Two – Identification of at Risk Residents All residents have the potential to be affected by this practice. Call bell audits were conducted on all units throughout the facility to identify any in need of repair and a proposal for repair requested. PTAC units were audited for function to identify any in need of repair, cleaning, or replacement. Element Three – Systemic Changes The vendor evaluated the call bell functioning and provided a proposal for repair and/or replacement of call bells. All resident call bells on all units where residents reside were inspected and are working. Tap bells were placed in the Nursing Supervisors office for easy access by staff in the event of any malfunctions. The Atrium unit was closed and all Residents on the [redacted] unit were moved to [redacted] of [redacted] as appropriate. Estimates to replace the call bell system on the Atrium are being obtained. Call bells in all unoccupied units were audited and a contract for repair is pending. These areas are not in use. Staff were provided with re-education about the process for notifying maintenance of work orders to assure	

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F 919	Continued From page 344 communicate. The resident [redacted] and informed the surveyor that he/she needed a call bell and had not had one since he/she returned from the hospital. The resident demonstrated that he/she banged loudly on the table with the television remote to alert staff when needed. Review of the Transfer/Discharge Report revealed that Resident [redacted] was readmitted to the facility on [redacted] with diagnoses which included but were not limited to: [redacted] Review of the admission Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that Resident [redacted] had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated that the resident was [redacted] and was totally dependent on two staff members for bed mobility and transfers. Review of Resident [redacted]'s Care Plan revealed an entry that was dated [redacted] 1, which focused on adequate [redacted] and [redacted] delivery) r/t (related to) [redacted] (both sides) through the next review date. Interventions included but were not limited to: Keep call bell within easy reach (initiated [redacted]) and monitor/document for [redacted]). At 11:04 AM, the surveyor interviewed the	F 919	timely response. Element Four – Quality Assurance Call bell inspections are monitored during environmental rounds by maintenance staff and the Administrator. Work orders are checked daily by the maintenance staff and immediately responded to. Weekly the Maintenance Director/designee provides the Administrator with the results of repairs and response time. Findings from the work order audits are presented at the quarterly QAPI committee meeting by the maintenance director on an ongoing basis for further direction and action as appropriate. Monthly the Maintenance Director inspects PTAC units for cleanliness and functional status. Filters are replaced based manufacturers recommendations or more often if needed. Quarterly reports are provided by the Maintenance Director on an ongoing basis at the quarterly QAPI meeting for further direction and action as appropriate.	

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Registered Nurse (RN) who stated that Resident [redacted] had a tap bell for [redacted] before he/she went to the hospital and it must have been misplaced. She immediately went to the nurse's station and obtained a metallic, manual, non-wired tap bell and placed it within reach of the resident on the resident's nightstand. The RN stated that the resident's wired call bell (a call bell that when pressed caused a light to go on outside of the resident's room and alarmed through a call system box located at the central nurse's station) had been broken for a while, so we used this type instead.

At 2:35 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) and requested a copy of the work orders that were placed for the [redacted] Unit. He stated that the RN should have reported the broken call bell right away once identified and stated that he would speak with [redacted]. The LNHA failed to provide documented evidence that a work order was placed to alert the Maintenance Department of a need to repair Resident #[redacted]2's call bell system.
3. On 10/24/2021 at approximately 11:02 AM, two surveyors walked to the end of the small corner hallway on the [redacted] unit. In the same hallway as the housekeeping closet. At that time, there was no evidence of a call light alarm sounding or lit up in the hallway. The surveyors randomly selected the two residents in the room to interview. The surveyors knocked and were invited to enter the room. The surveyor observed Resident [redacted] sitting in a wheelchair adjacent to the bed. The resident immediately stated to the two surveyors that they had pressed the call bell and wanted to go back to bed because they had been out of bed since 8:30 AM that morning. The resident stated that he/she had pressed the call

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light and that it was lit up in [redacted] r room. The surveyor observed that there was a small red light activated where the call light cord connects to the wall, indicating that the call bell had been pressed. The surveyors looked again outside the room where there was a light panel on the ceiling outside the resident's room, but it was not lit up and there was no alarm sound audible outside of the room to indicate that the resident was requesting assistance.

The surveyors also noted that both Resident [redacted] and his/her roommate did not have tap bells. Resident #[redacted] and his/her roommate confirmed that they did not have a tap bell to alert staff that they needed assistance but believed that the call bell had been working because they had seen the small red light on in the room on the wall.

The surveyor asked how long ago he/she had pressed the call light, and Resident #[redacted] replied "maybe two minutes" before the surveyors had entered. The resident stated that call bell response time varies. The surveyors exited the room to find the resident's assigned CNA after interviewing the resident.

At 11:06 AM, the CNA and the LNHA were outside the resident's room, and the surveyor observed the CNA walk into the room of Resident [redacted]. At that time, the surveyor asked the LNHA about how residents communicate their needs if the call bell system was not functioning, and stated in the presence of the two surveyors that he was not aware that the call bell system was not functioning. The LNHA and surveyors then tested a nearby resident room which was vacant in the same hallway, and the light did not turn on.

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He indicated this may be why it was a vacant room. The surveyor then observed the CNA enter the resident room and went to turn off the call bell light. The surveyor asked the CNA before he turned it off to test the functioning of the call bell. The surveyors observed with the CNA that there was no light and no audible sound to alert staff that a call bell light had been activated for the room belonging to Resident [redacted] and his/her roommate. The surveyor interviewed the CNA at that time who stated that he doesn't know why the call light doesn't work and that he believed it, "was a ghost."

Both the CNA and the LNHA confirmed that there was no light and audible sound coming from the room belonging to Resident [redacted], and that both residents did not have tap bells or a means to summon staff.

At approximately 11:15 AM, another CNA tested the call bell system in room [redacted] in the presence of two surveyors and the LNHA. The call bell system lit up and had an audible alarm, indicating that room was functioning properly. The CNA confirmed that the call bell system was old and that some rooms don't always work. The surveyor asked if residents on the unit get tap bells if the bells do not work, and she indicated that, "No one has tap bells here."

On 10/22/2021 at 9:29 AM, the surveyor interviewed the Lead Maintenance (LM) staff member, who stated that the facility had used TELLS (a computerized system to report building maintenance issues) for the past three months and utilized a logbook prior to that. The surveyor requested to view the TELLS logs that were available. The facility failed to provide the

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F 919	Continued From page 348 surveyor with documented evidence that the call bell system failure was reported or noted. At 10:50 AM, the surveyor observed Resident [redacted] who was asleep in his/her bed. The resident had both a tap bell on his/her nightstand and a wired call bell within his/her reach. The surveyor pressed the wired call bell which triggered an audible bell tone sound, and a light was illuminated in the hallway above the doorway outside of the resident's room simultaneously. The RN responded immediately to assess the resident's needs and did not turn the alarm off which caused the alarm to continue to sound. At 10:56 AM, the Respiratory Therapist responded to Resident [redacted]s room to assess the resident's needs and disarmed the alarm which caused the ringing sound to arrest and the light that was lit outside of the resident's room to go out. On 10/26/2021 at 1:13 PM, in a later interview the LNHA stated that staff were expected to report all maintenance issues and they were required to be logged into the TELLS System. He further stated that he did not rely on that. The surveyors requested policies on the call bell system from the MD and they were not provided. No additional documentation was provided to the survey team during the survey to refute the surveyor's findings.	F 919		
F 925 SS=F	NJAC 8:39-31.8 (c) 9 Maintains Effective Pest Control Program CFR(s): 483.90(i)(4)	F 925		12/28/21

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F 925	Continued From page 349 §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation it was identified that the facility failed to provide an effective pest control program. This deficient practice was identified on 3 of 5 nursing units, ([redacted] Unit, and [redacted] and was evidenced by the following: On 10/18/2021 at 10:29 AM, during the initial tour, Surveyor #4 observed Resident [redacted] in bed resting. The resident's meal tray was still on the bedside table with an unopened container of milk and vanilla shake. The resident's [redacted] wheelchair had cracks in both arm rests. At that same time, Surveyor #4 observed flies on the resident while he/she was lying in bed. On 10/18/2021 at 12:16 PM, Surveyor #2 observed Resident [redacted] with flies on his/her pillow while the resident was lying in bed. Resident # [redacted] also had a [redacted], and [redacted], which is the [redacted] after the procedure. A [redacted] may be inserted into the opening for support and is [redacted]). On 10/21/2021 at 8:50 AM, Surveyor #9 observed Resident [redacted] sitting up in his/her wheelchair eating breakfast. The resident complained that the toilet in the room was clogged. At that time, Surveyor #9 observed the toilet in the resident's room was clogged with a [redacted] and	F 925	F925 Element One – Corrective Actions • [redacted] Pest control was immediately called to treat again for flies. Treatments continued daily until the flies were eradicated. [redacted] assisted the facility to identify possible causes of the flies and recommended the use of fly lights and provided a plan that identified the placement locations for the fly lights which were ordered on 10/24/21, received on 11/21/21, and installed on 11/28/21. As of 12/1/21 no flies have been observed in the facility. Element Two – Identification of at Risk Residents All residents have the potential to be affected by this practice. Element Three – Systemic Changes • Root cause analysis was used to identify the possible sources of the flies. Trash pickup and soiled linen removal from the units were increased to minimize these as possible breeding areas for flies. • Cleaning schedules for resident rooms and bathrooms and common space areas were reviewed and modified with assistance from [redacted], the vendor engaged to assist with housekeeping and dietary issues. • The kitchen grease traps were	

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F 925	Continued From page 350 there were multiple flies flying around the toilet. Resident [redacted] further stated that every time the toilet is fixed, it breaks again. The resident also stated the toilet has been currently broken for the last one to two days and that the resident will just use the toilet even if it is clogged with [redacted]. The surveyor further observed there were multiple flies flying around the resident while he/she was eating breakfast and a fly landed on his/her Styrofoam water cup. The resident stated that the flies have been in the room for about a month and that it is worse when the toilet is broken. The resident further stated that sometimes the flies land on his/her food. On 10/21/2021 at 8:55 AM, Surveyor #9 observed Resident [redacted] sitting up in bed. The resident stated every time the toilet is fixed, it works for a day or two before clogging again. The resident further stated the odor in the bathroom was "terrible." Surveyor #9 then observed a fly land on the resident's forehead and the resident stated the flies have been "bad all summer." On 10/21/2021 at 9:00 AM, Surveyor #9 observed Resident [redacted] sitting on the side of bed. The resident stated he/she can't use the toilet in the room because it is broken and that he/she has to use the bathroom "across the hall" which is "very inconvenient." The resident further stated the flies are, "a pain." On 10/21/2021 at 10:30 AM, Surveyor #6 interviewed five alert and oriented resident's during the Resident Council Meeting. Five of five (5 of 5) residents complained that there were flies and gnats everywhere throughout the facility. On 10/21/2021 at 11:11 AM, Surveyor #9	F 925	cleaned the week of [redacted] and put on a preventive maintenance schedule. • New trash cans and additional liners were purchased and the kitchen was terminally cleaned with daily cleaning schedules revised by [redacted] the contract service providing dietary support to eliminate possible sources of flies. • Daily rounds were initiated in [redacted] to monitor the situation with the flies and the pest control company was contacted to come daily if needed to treat for flies. Element Four – Quality Assurance Weekly the Administrator and Housekeeping Director conduct walking rounds to monitor for compliance with cleaning schedules, trash, and linen removal are followed to ensure possible sources for flies are eliminated. Results of the rounds are discussed at morning operation meetings and reported at the weekly QAPI compliance committee meeting by the housekeeping director. Monthly the pest control company routinely treats the facility to prevent infestations with pests and provides a report to the facility administrator. The reports are reviewed and acted upon and results reported at the QAPI committee meeting quarterly for action as appropriate.	

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observed Resident [redacted] lying in bed and a fly landed on the resident's [redacted].

On 10/22/2021 at 9:08 AM, Surveyor #9 observed Resident [redacted] sitting up in his/her wheelchair next to the bed which had two flies on the pillows and one fly on the privacy curtain.

On 10/21/21 at 9:05 AM, during an interview with Surveyor #9, the Certified Nursing Assistant (CNA) stated she reported the broken toilet to maintenance this morning and that they should be coming down shortly to fix it. The CNA further stated the toilet gets clogged "every so often." The CNA also stated that if the toilet is clogged, they take residents into an empty resident room to use the toilet. She further stated the shower room toilet was broken so residents can't use it. The CNA also acknowledged that the unit has had an issue with flies within the last few weeks and that pest control was on the unit a couple weeks ago.

Review of the Pest Management log obtained from [redacted] revealed pest control was on the unit [redacted] and [redacted] with "No Reports" documented.

On 10/22/2021 at 9:08 AM, Surveyor #3 and #4 observed Resident [redacted] sitting in dayroom [redacted] eating breakfast. Both surveyors observed flies on his/her coffee cup, on the spoon that was inside of the oatmeal as well as on top of the oatmeal. In addition, there were flies on the resident's shoulder and chair he/she was sitting in.

On 10/22/2021 at 9:20 AM, Surveyor #3 observed an unsampled resident on the [redacted] Unit with

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multiple flies on the resident's [redacted], [redacted], plate with food on it, and on the table the resident was seated at. Surveyor #3 observed the CNA waving her hands to swat the flies away from the resident.

On 10/22/2021 at 9:25 AM, Surveyor #3 interviewed the CNA who confirmed that she had been swatting flies away from the resident. She stated, "All we can do was swatting them away. There is nothing else we can do."

On 10/22/2021 at 10:51 AM, Surveyor #4 interviewed the Director of Nursing (DON) who stated in the presence of the survey team that it was unacceptable for flies to be on resident's food because it was not hygienic.

On 10/22/2021 at 1:15 PM, Surveyor #3 interviewed the Infection Preventionist (IP) regarding the flies on the [redacted] Unit who stated that she was aware of flies in [redacted] and had reported it to the Administrator. The IP further stated that since she had started working at the facility the flies were a, "major concern" and the facility needed to get an exterminator, but nothing was getting done. The IP stated that it was unacceptable for staff to be swatting away flies while feeding the residents and flies could also lead to maggots.

On 10/25/2021 at 9:03 AM, Surveyor #3 and #4 observed Resident [redacted] sitting at the table in dayroom [redacted] eating his/her breakfast. While the resident was eating there were flies on the utensils and flying around the resident.

On 10/25/2021 at 1:26 PM, Surveyor #4 interviewed the facility's Administrator who stated

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that since he started working at the facility, the flies were a big issue. The Administrator further stated that the facility hired a cleaning company to come in and take care of the problem which he felt was a result of trash and linen being left in the soiled utility rooms. The Administrator stated that there was currently no cleaning schedule in place, but he was working with the Housekeeping Director to come up with one to keep the facility clean and eliminate the fly issue.

On 10/26/2021 at 1:02 PM, Surveyor #14 observed Resident [redacted] on the [redacted] Unit scrunched up in the [redacted] with his/her head resting on a pillow, eyes closed, seated in his/her reclining in the sunroom on the [redacted] unit. Surveyor #14 observed flies buzzing around the resident's [redacted]. One of the flies was observed landing on the resident's closed eye and remained there for approximately 30 seconds. Surveyor #14 notified the recreation aide on the unit who swatted the fly off the resident. At that time, the surveyor observed two more flies, flying around the resident's lunch tray. Surveyor #14 conducted an interview with the recreation aide at that time who stated that the flies on the unit were a new thing and maybe started a week ago.

On 10/26/2021 at 1:08 PM, Surveyor #14 interviewed Resident [redacted] Licensed Practical Nurse (LPN) on the [redacted] unit who stated that he noticed the flies about a month ago. The LPN stated that the facility's former Administration who included the Administrator, Maintenance Director, Housekeeping Director, and Exterminator were fully aware of the concern regarding the flies but did nothing to resolve the issue. The LPN stated that the Exterminator was at the facility that

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morning, but he didn't think he did anything. The LPN further stated that the Exterminator told him that the flies were coming from the soiled linen room on the [redacted] unit. The LPN further stated that he did not know how frequently the soiled linen room was cleaned.

On 10/27/2021 at 9:20 AM, Surveyor #14 interviewed the CNA on the [redacted] unit who stated that there were flies throughout the unit and the flies had been there for the past few months and it, "was really ridiculous." The CNA stated that he has seen them landing on the residents throughout the unit and some of the residents couldn't move to swat them off. The CNA further stated that the day before, he saw three flies in a resident's [redacted]. The CNA stated that everyone working at the facility knew they were there, and the Exterminator was at the facility a few days ago. The CNA explained that on the [redacted] unit there were more flies on the [redacted] side, so the staff would bring the residents to the [redacted] side to prevent as many flies as possible from landing on them.

On 10/27/2021 at 9:24 AM, Surveyor #14 interviewed the Licensed Practical Nurse/Unit Manger (LPN/UM) on the [redacted] unit who stated that he had worked at the facility since the end of [redacted]t and had noticed flies throughout the unit for the about a month or so and the flies have, "been really bad the past couple of weeks." The LPN/UM further stated that he saw the flies land on the residents and their meal trays, and the flies were more prevalent by the soiled utility room. The LPN/UM stated that he had told the Administration and Housekeeping Department almost every day about the fly infestation and he thought the Exterminator came out recently and

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	315280	A. BUILDING _____ B. WING _____	C 11/01/2021

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SILVER HEALTHCARE CENTER	1417 BRACE ROAD CHERRY HILL, NJ 08034

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referred the surveyor to the Pest Control Binder where the problems would be documented. The LPN/UM stated that regardless of the Exterminator coming to the facility, the problem had not been resolved and the facility sent out overnight crews the past couple of nights to clean the place up, but the flies were still present.

Surveyor #14 reviewed the Pest Control Binder for the [redacted] Unit. There was no documentation that indicated the Pest Control Company was made aware of flies being present on the unit. Staff observations revealed, "no reports" on the following dates: 06/08/21, 06/15/21, 06/22/21, 06/29/21, 07/906/21, 07/14/21, 07/20/21, 07/27/21, 08/03/21, 08/10/2108/17/21, 08/24/21, 08/31/21, 09/05/21, 09/14/21, 09/19/21, 09/26/21, 10/05/21, and 10/12/21.

On 10/27/2021 at 9:44 AM, Surveyor #14 interviewed a Housekeeping/Laundry (HK/L) staff member who stated that she had seen flies on the Pavilion unit here and there and thought they were coming from the soiled utility room because the nursing staff put dirty adult briefs covered in feces in the garbage area in no bags. The HK/L staff member stated that when she did the laundry, she also had seen the dirty adult briefs commingled with the linens and she would have to weed out the dirty adult briefs from the bed linens before she put the bed linens in the washing machine to be washed. The HK/L staff member stated that the housekeeping staff would remove the garbage and the linens throughout the day whenever the garbage and laundry became full. The HK/L staff member further stated that the staff has been telling upper management about the problem and they did

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nothing about it. The HK/L staff member stated that the housekeeping staff took it upon themselves to try and educate the nursing staff not to throw soiled adult briefs in with linens. The HK/L staff member stated, "I would go to clean the bedsheets in laundry, shake it and a diaper full of poop fell out. Like I said, they don't care." At that time the surveyor asked to speak with the Director of Housekeeping and was told that he/she was not in the facility and unavailable for an interview.

On 10/27/2021 at 9:59 AM, Surveyor #14 interviewed the Maintenance Lead (ML) who stated that the Maintenance Director recently left the facility and he just became in charge. The ML stated that he had noticed flies throughout the building and the facility had hired an Exterminator to take care of the issue.

On 10/27/2021 at 10:08 AM, Surveyor #14 entered the soiled utility room on the [redacted] unit with the LPN and observed [redacted] caked on discolorations throughout the floor. Surveyor #14 was wearing a surgical mask and smelled a foul odor. The LPN stated that the discoloration on the floor were, "stains" and he didn't smell anything but garbage. Surveyor #14 further observed several flies buzzing around the area.

On 10/27/2021 at 10:24 AM, Surveyor #14 reviewed the Pest Control Binder in the presence of the LPN/UM and the LPN/UM could not speak as to why there was no reported problem with flies documented in the binder because the flies had been an ongoing issue. The LPN/UM stated that the Administration called the Exterminator and that was as much as he knew, because he

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never wrote in the book, the Exterminator was supposed to.

Surveyor #14 asked to speak with the Exterminator and was given the phone number for the new Pest Company that was just hired.

On 10/27/2021 at 10:57 AM, Surveyor #14 spoke with a representative of the new pest control company who stated that the process was for the Exterminator to check with the Administration, Maintenance, Kitchen, and House Keeping personnel, make rounds throughout the facility, check the Pest Control Binders on the unit, and treat the facility preventatively for ants, roaches, mice, and flies. The representative from the Past Control Company stated that the Exterminator would check all common areas throughout the facility including the soiled utility rooms for pests because the soiled utility rooms were considered a common area.

On 10/27/2021 at 1:28 PM, Surveyor #14 spoke with the account manager from the Pest Control Company who stated that he was in the process of establishing a contract with the facility and "literally just took over the contract last night." The account manager further stated that he was there to correct any issues identified.

Review of the Pest Control Company Service Inspection Report dated [redacted] indicated that the [redacted] soiled utility room was treated for fruit flies and flies. A further review of the Pest Control Company Service Inspection Report dated [redacted] revealed that the Director of Nursing verbally reported fruit flies in [redacted]-wing and gnats. The Pest Control Company Service Inspection Report dated [redacted] indicated, "Better

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F 925	Continued From page 358 sanitation needed in [redacted] and soiled rooms needed. Better sanitation needed in both courts and atriums, recommended proper cleaning." A further review of the Pest Control Company Service Inspection Report dated [redacted], indicated that better sanitation was needed in the [redacted] soiled utility room, personnel was spoke to regarding the issue, and heavy fruit fly activity was observed in the dining room and pantry walls. The Pest Control Company Service Inspection Report dated [redacted] indicated that the [redacted] both [redacted] both [redacted] were inspected and treated, logbooks were checked with no reports. NJAC 8:39-31.5(a)	F 925		

New Jersey Department of Health

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint # NJ149176 Based on observation and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General	S 560	S560 Element One □ Corrective Actions " Resident [redacted] □s room, including all floors, was immediately cleaned. " The [redacted] for the [redacted] and the [redacted] for the [redacted] were placed on Resident [redacted]. Nursing staff who failed to put the required [redacted] and [redacted] on Resident [redacted] were counseled and received re-education about using ordered [redacted], and [redacted] as ordered by the physician to prevent [redacted]. Instructions for the use of the [redacted] was added to the	12/28/21

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

Electronically Signed | 12/06/21

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S 560	Continued From page 1 Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher.	S 560	CNA POC in the EHR. The care plan was reviewed and updated to reflect the use of these adaptive devices and nursing staff re-educated by therapy. On 12/2/21 the use of the [redacted] was discontinued by the PCP as recommended by therapy. " All units were audited beginning on October 25, 2021, by Administration and Housekeeping for cleanliness. Cleaning, carbolization and stripping and waxing schedules were implemented to address environmental concerns. Additional housekeeping staff were hired and a contract entered into with [redacted] to provide housekeeping management. " A direct care staffing analysis was completed to identify by shift the amount of direct care staff and licensed nursing staff required to meet the care needs of the residents based on the daily census in compliance with regulations. The staffing schedule was reviewed by the Director of Nursing (DON) with the staffing coordinator to identify by shift the required numbers of staff. " Additional Agencies were contacted to fill vacant direct care certified nurse aide and licensed nurse positions while the facility advertised for new staff. As a result of these additional contracts the facility has been able to meet requirements and on some days of the week overstaff with direct care staff until permanent positions can be filled. " When there are additional direct care staff these individuals are assigned to provide residents with additional bathing, grooming, and hygiene. The additional staff also are assigned to organizing resident rooms, clean high touch surfaces	

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S 560	Continued From page 2 (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... On 10/18/21, 10/19/21, 10/20/21, 10/21/21, 10/22/21, 10/25/21, 10/26/21, and 10/27/21, the surveyors observed one to six Certified Nursing Aides (CNA)s working on the Court 1, Court 2, Atrium, Vent, and Pavilion units throughout the facility. These CNAs provided direct care to the residents who resided at the facility. Review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report for the weeks of 09/12/21 and 09/19/21 revealed the facility was deficient in CNA staffing for 14 of 14-day shifts, deficient for total staff to residents on 1 of 14 evening shifts, and deficient in total staff to residents for 1 of 14 overnight shifts as follows: 09/12/21 had 11 CNAs for 152 residents on the day shift, required 19 CNAs. 09/13/21 had 11 CNAs for 152 residents on the day shift, required 19 CNAs. 09/14/21 had 12 CNAs for 152 residents on the day shift, required 19 CNAs. 09/15/21 had 15 CNAs for 151 residents on the day shift, required 19 CNAs. 09/16/21 had 15 CNAs for 151 residents on the day shift, required 19 CNAs. 09/17/21 had 16 CNAs for 151 residents on the	S 560	in resident rooms and spend time meeting the psychosocial needs of residents. " The facility hired a new permanent Director of Nursing (DON) who began at the facility on [redacted] The interim DON was retained to assist with Infection Control and staff education. " The facility hired two Unit Managers to fill vacant positions. Advertising, use of digital media and recruiters is ongoing to fill all vacancies " Assignments were reviewed to assure residents requiring total assistance were not all on one assignment to assure resident grooming, hygiene, and personal care needs are met. " Performance evaluations are being completed so targeted education can be provided to staff to improve the care provided to residents. Element Two □ Identification of at Risk Residents All residents have the potential to be affected by this practice. Element Three □ Systemic Changes " Administration has formed a staffing committee and has conducted salary analyses and implemented creative strategies for attracting new employees to minimize the use of agency personnel. " Bonuses and incentive programs have been implemented to attract and to retain current staff. " An employee recognition committee comprised of front line workers was implemented to plan events to improve the morale of staff and recognize the exemplary services provided by staff.	

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S 560	Continued From page 3 day shift, required 19 CNAs. 09/18/21 had 13 CNAs for 151 residents on the day shift, required 19 CNAs. 09/18/21 had 8 CNAs to 17 total staff on the evening shift, required 9 CNAs. 09/19/21 had 11 CNAs for 155 residents on the day shift, required 20 CNAs. 09/19/21 had 11 total staff for 155 residents on the overnight shift, required 12 total staff. 09/20/21 had 8 CNAs for 153 residents on the day shift, required 20 CNAs. 09/21/21 had 13 CNAs for 153 residents on the day shift, required 20 CNAs. 09/22/21 had 14 CNAs for 153 residents on the day shift, required 20 CNAs. 09/23/21 had 17 CNAs for 153 residents on the day shift, required 20 CNAs. 09/24/21 had 16 CNAs for 153 residents on the day shift, required 20 CNAs. 09/25/21 had 15 CNAs for 153 residents on the day shift, required 20 CNAs. 09/25/21 had 14 total staff for 153 residents on the evening shift, required 16 total staff. Review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report for the weeks of 09/26/21, 10/03/21, and 10/10/21 revealed the facility was deficient for CNA staffing on 19 of 21 day shifts and were deficient for total staff for residents on 3 of 21 overnight shifts as follows: 09/26/21 had 16 CNAs for 155 residents on the day shift, required 20 CNAs. 09/26/21 had 10 total staff for 155 residents on the overnight shift, required 12 total staff. 09/27/21 had 18 CNAs for 153 residents on the day shift, required 20 CNAs. 09/27/21 had 10 total staff for 153 residents on the overnight shift, required 11 total staff.	S 560	" Improvements in the environment and working conditions has helped attract new staff. Element Three □ Systemic Changes " The facility is utilizing all types of digital media as well as recruiters to identify and hire new staff. " Facility management team is working with the union to promote cooperation and minimize call outs. " Therapy conducted evaluations of all residents in need of adaptive devices, instructed direct care staff about proper use, established a back up system when devices are being laundered to assure a replacement was readily available for use by direct care staff, and re-enforced contacting therapy if any replacement devices are needed. Element Four □ Quality Assurance " Daily staffing levels are reported to the core team and management company and additional incentives are provided for working an extra shift if needed. The success of bonuses and incentives is analyzed by the facility Administrator and Director of Nursing who make recommendations weekly to the QAPI compliance committee at the weekly meetings and to the management company regarding what incentives or bonuses are working. " Staffing is discussed at daily morning operations meetings and recommendations solicited from the management team about ways to attract new hires to fill vacant positions. " Staffing levels of direct care staff and	

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S 560	Continued From page 4 09/28/21 had 14 CNAs for 149 residents on the day shift, required 19 CNAs. 09/29/21 had 16 CNAs for 149 residents on the day shift, required 19 CNAs. 10/01/21 had 15 CNAs for 149 residents on the day shift, required 19 CNAs. 10/02/21 had 12 CNAs for 149 residents on the day shift, required 19 CNAs. 10/02/21 had 10 total staff for 149 residents on the overnight shift, required 11 total staff. 10/03/21 had 10 CNAs for 144 residents on the day shift, required 18 CNAs. 10/04/21 had 14 CNAs for 142 residents on the day shift, required 18 CNAs. 10/05/21 had 15 CNAs for 142 residents on the day shift, required 18 CNAs. 10/06/21 had 16 CNAs for 141 residents on the day shift, required 18 CNAs. 10/07/21 had 15 CNAs for 141 residents on the day shift, required 18 CNAs. 10/08/21 had 13 CNAs for 141 residents on the day shift, required 18 CNAs. 10/09/21 had 14 CNAs for 141 residents on the day shift, required 18 CNAs. 10/10/21 had 14 CNAs for 141 residents on the day shift, required 18 CNAs. 10/11/21 had 14 CNAs for 141 residents on the day shift, required 18 CNAs. 10/12/21 had 15 CNAs for 143 residents on the day shift, required 18 CNAs. 10/14/21 had 16 CNAs for 142 residents on the day shift, required 18 CNAs. 10/15/21 had 16 CNAs for 142 residents on the day shift, required 18 CNAs. 10/16/21 had 15 CNAs for 142 residents on the day shift, required 18 CNAs. The surveyor reviewed the staffing during the re-certification survey from 10/18/21 through 10/27/21 which revealed the following:	S 560	recruitment efforts are discussed daily by nursing management and the administrator, are reported daily to the management company, and are reviewed at the weekly QAPI compliance meetings. Vacancy rates are reviewed weekly by the Director of Nursing and discussed with the Administrator. The effectiveness of strategies to attract and retain staff are discussed and strategies modified as needed. Findings are also discussed weekly with the management company that provides direct assistance with recruitment efforts..	

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S 560	Continued From page 5 Monday, October 18, 2021. Census (number of residents who resided in the facility) was 142. 7:00 AM - 3:00 PM, 14 CNAs worked.142 (census) / 14 (divided by the number of CNAs working = 10.1 (number of resident's the CNAs had on their direct care assignments). 3:00 PM - 11:00 PM, 8 CNAs worked. 142/8 = 17.75 Tuesday, October 19, 2021. Census was 141. 7:00AM - 3:00 PM, 15 CNAs worked. 141/15 = 9.4 Wednesday, October 20, 2021. Census was 141. 11:00 PM - 7:00 AM, 10 CNAs worked. 141/10 = 14.1 Thursday, October 21, 2021. Census was 142. 7:00AM - 3:00 PM, 17 CNAs worked. 142/17 = 8.3 11:00 PM - 7:00 AM, 13 CNAs worked. 142/13 = 14.1 Sunday, October 24, 2021. Census was 140. 7:00AM - 3:00 PM, 15 CNAs worked. 140/15 = 9.3	S 560		
S1350	8:39-19.4(d) Mandatory Infection Control and Sanitation (d) The infection control coordinator shall provide continuous collection and analysis of data, including determination of nosocomial infections, epidemics, clusters of infections, infections due to unusual pathogens or multiple antibiotic resistant bacteria, and any occurrence of nosocomial infection that exceeds the usual baseline levels.	S1350		12/28/21

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S1350	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of pertinent facility documentation, it was identified that the facility failed to adhere to the Executive Directive No. 20-0261 issued by the New Jersey Commissioner in response to the COVID-19 Pandemic by failing to hire a qualified Infection Control Preventionist for the facility. This deficient practice was evidenced by the following: On 10/8/21 at 10:13 AM, Surveyor #2 interviewed the Infection Control Nurse (ICN) who stated that she was a Licensed Practical Nurse (LPN) and did not have any prior experience with infection control before she had begun working at the facility on [redacted]. She stated that she consulted with friends who worked outside of the facility, the former Director of Nursing (DON), the current Interim DON (IDON), Corporate and the Department of Health if she required assistance. She stated that the former DON was supposed to provide her with course information for infection control certification but failed to do so. She further stated that the IDON who came to the facility on [redacted], agreed to get the information for her. On 10/12/21 at 8:19 AM, Surveyor #2 interviewed the Licensed Nursing Home Administrator (LNHA) who stated that both the former DON and the IDON were certified in infection control. He stated that the former DON was supposed to ensure that the ICN obtained the required infection control certification and failed to do so before she resigned from her position without prior notice. He stated that he was unsure if the Medical Director was certified in infection control or if the facility was contracted with an Infection	S1350	S1350 Infection Control Element One – Corrective Actions • A contract for Infection Control consulting per the DPOC of [redacted]0/22/21 was signed with an Infection Control Preventionist consultant and copies of the required certificates submitted to NJDOH. Weekly reports have been submitted to NJDOH as required in the DPOC of 10/22/21 and includes corrective actions and progress updates on a weekly basis. • The IC Preventionist completed the CDC IC Preventionist training on 10/12/21 but then resigned A contract for Infection Control consulting per the DPOC of [redacted] was signed with an Infection Control Preventionist consultant and copies of the required certificates submitted to NJDOH. Weekly reports have been submitted to NJDOH as required in the DPOC of 10/22/21 and includes corrective actions and progress updates on a weekly basis with no notice on 11/18/21. • The facility hired an interim DON with infection control preventionist credentials. • The new permanent DON who began at the facility on [redacted] who completed a 24 IC Preventionist program approved by NJDOH. • A job offer was made and accepted to fill the fulltime position of the Infection Control Preventionist nurse who is due to start within 30 days. In the meantime, the prior interim DON was temporarily retained to assist with Infection Control and staff education.	

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 11/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S1350	Continued From page 7 Preventionist. He stated that the ICN completed 22 training modules via the Centers for Disease Control (CDC) over the weekend and he agreed to furnish proof of completion. He further stated that the ICN previously worked under the former DON who was certified in infection control. On 10/12/21 at 2:35 PM, the LNHA provided Surveyor #2 with the former DON's training certificates which did not meet the minimum qualificiation for the state and federal regulations for infection control certification. In a later interview with the LNHA at 3:47 PM, he stated that the facility secured a contract with an Infection Preventionist which would not become effective until [redacted]. The surveyor reviewed the Job Description for the Infection Control Preventionist which revealed the following: Job Summary: The purpose of this position is to plan, organize, develop, implement, and interpret the programs, goals, objectives, policies, procedures, etc. of the Infection Control Committee and to coordinate the systemic monitoring of causes, spread of infection, prevention, policies pertaining to isolation techniques, documentation of incidents, and corrective action related to infection and staff education. Qualifications: Must be a graduate of an accredited school of nursing and hold a current Registered Nurse's license in the State of New Jersey. Must have Training in Infection Control as minimum CDC 19 hours training. Must be qualified to assume the position by training and/or previous experience...Based on interview, record	S1350	Element Two – Identification of at Risk Residents All residents have the potential to be affected by this practice. Element Three – Systemic Changes • The facility hired a new permanent DON who began at the facility on [redacted] who completed the CDC IC Preventionist program. A job offer was made and accepted to fill the fulltime position of the Infection Control Preventionist nurse who is due to start within 30 days. In the meantime, the prior interim DON was temporarily retained to assist with Infection Control and staff education. • The clinical consultants engaged to address the DPOC are also CDC and AHCA certified IC preventionists with extensive experience in LTC and are providing direction and oversight onsite and remotely daily and are reviewing IC practices in the facility. • The DPOC clinical consultants have completed the ICAR assessment, the OSHA ETS hazard assessment, implemented the required Respiratory Protection Program plan, provided train the trainer fit test education for facility staff, and conducted onsite fit testing with the new trainers to verify competency. • The clinical consultants are currently evaluating the entire IC program focusing first on COVID19 testing, protocols, and outbreak assessment and the active outbreak of Candida Auris and work directly with the interim IC preventionist to assure a consistent approach to IC is implemented.	

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S1350	Continued From page 8 review, and review of pertinent facility documentation, it was identified that the facility failed to adhere to the Executive Directive No. 20-0261 issued by the New Jersey Commissioner in response to the COVID-19 Pandemic by failing to hire a qualified Infection Control Preventionist for the facility.	S1350	• Required swabbing of all facility residents was completed per NJDOH CDS requirements and all PCR test results are negative. Culture results are still pending. Correct precautions are in place to prevent spread. Element Four – Quality Assurance • The clinical consultants have prioritized changes to the facility IC plan based on survey findings, current outbreaks of COVID19 and Candida Auris and revised CDC, CMS, and NJDOH guidance related to COVID19 visitation and testing and initial and booster vaccination of residents and staff. Policies and protocols continue to be reviewed and modified and staff education provided S1350 Element Four – Quality Assurance as changes are implemented. Compliance with use of PPE and Hand Hygiene are monitored weekly through random observations throughout the facility. Findings are discussed at morning operations meetings and weekly QAPI compliance committee meetings for action as appropriate.	