STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060411	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint NJ #: 157789; 158780 Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. This was evident for 27 out of 28 day shifts and 2 out of 28 overnight shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey	S 560	I. Corrective action(s) accomplished for resident(s)affected: Resident #87 remains a long-term care resident in this facility. Resident #87 was assessed by a Registered Nurse for any physical, mental, and psychological adverse effects related to the facility not meeting New Jersey Statutes Annotated new minimum staffing requirements for nursing homes for Certified Nursing Assistant and use of Agency staff. This resident has had no negative outcomes as a result of this practice. Resident #118 remains a long-term care resident in this facility. Resident #118 was	5/23/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 05/05/23

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S 560	Continued From page 1 Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. On 4/5/23 at 11:03 AM, the surveyor requested the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) complete the "Nursing Staff Report" for the weeks of 3/19/23 to 3/25/23 and 3/26/23 to 4/1/23. At this time, the DON stated that staffing was good and had improved; that the facility utilized Agency staff for coverage. As per the "Nurse Staffing Report" completed by the facility for the weeks of 3/19/23 to 3/25/23 and 3/26/23 to 4/1/23, which revealed the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift and total staff for residents of 1 to 14 on the overnight shift as documented below: 3/19/23 had 26 CNAs for 283 residents on the day shift, required 35 CNAs.	S 560	assessed by a Registered Nurse for any physical, mental, and psychological adverse effects related to the facility not meeting New Jersey Statutes Annotated new minimum staffing requirements for nursing homes for Certified Nursing Assistant and use of Agency staff. This resident has had no negative outcomes as a result of this practice. Resident #135 remains a long-term care resident in this facility. Resident #135 was assessed by a Registered Nurse for any physical, mental, and psychological adverse effects related to the facility not meeting New Jersey Statutes Annotated new minimum staffing requirements for nursing homes for Certified Nursing Assistant and use of Agency staff. This resident has had no negative outcomes as a result of this practice. Resident #208 remains a long-term care resident in this facility. Resident #208 was assessed by a Registered Nurse for any physical, mental, and psychological adverse effects related to the facility not meeting New Jersey Statutes Annotated new minimum staffing requirements for nursing homes for Certified Nursing Assistant and use of Agency staff. This resident has had no negative outcomes as a result of this practice. Resident #212 remains a long-term care resident in this facility. Resident #212 was assessed by a Registered Nurse for any physical, mental, and psychological adverse effects related to the facility not meeting New Jersey Statutes Annotated	

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S 560	Continued From page 2 3/20/23 had 29 CNAs for 283 residents on the day shift, required 35 CNAs. 3/21/23 had 32 CNAs for 283 residents on the day shift, required 35 CNAs. 3/23/23 had 34 CNAs for 289 residents on the day shift, required 36 CNAs. 3/24/23 had 28 CNAs for 289 residents on the day shift, required 36 CNAs. 3/25/23 had 31 CNAs for 289 residents on the day shift, required 36 CNAs. 3/25/23 had 19 total staff for 289 residents on the overnight shift, required 21 total staff. 3/26/23 had 29 CNAs for 289 residents on the day shift, required 36 CNAs. 3/27/23 had 29 CNAs for 296 residents on the day shift, required 37 CNAs. 3/28/23 had 23 CNAs for 296 residents on the day shift, required 37 CNAs. 3/29/23 had 31 CNAs for 296 residents on the day shift, required 37 CNAs. 3/30/23 had 32 CNAs for 298 residents on the day shift, required 37 CNAs. 3/31/23 had 32 CNAs for 291 residents on the day shift, required 36 CNAs. 4/1/23 had 26 CNAs for 289 residents on the day shift, required 36 CNAs. During a Resident Council meeting on 4/10/23 at 10:14 AM, all six residents (Resident #87, #118, #135, #208, #212, and #260) who were in attendance, informed the surveyor that the facility was short of staff and used a lot of Agency staff. The surveyor requested additional "Nursing Staff Reports" for the weeks of 9/4/22 to 9/10/22 and 10/16/22 to 10/22/22. As per the "Nursing Staff Report" completed by the facility for the week of 9/4/22 to 9/10/22, which revealed the staffing to resident ratios that	S 560	new minimum staffing requirements for nursing homes for Certified Nursing Assistant and use of Agency staff. This resident has had no negative outcomes as a result of this practice. Resident #260 remains a long-term care resident in this facility. Resident #260 was assessed by a Registered Nurse for any physical, mental, and psychological adverse effects related to the facility not meeting New Jersey Statutes Annotated new minimum staffing requirements for nursing homes for Certified Nursing Assistant and use of Agency staff. This resident has had no negative outcomes as a result of this practice. II. Residents identified having the potential to be affected and corrective action taken: All resident residing in this facility had the potential to be affected. III. Measures will be put into place to ensure the deficient practice will not recur: The Call Out policy was reviewed by facility administration and staff have been re-educated by the Facility Educator on the policy. The facility currently sponsors staff through the Angels of Mercy School after the Certified Nurse Aide skills test is complete. The facility currently utilizes four contracted nursing agencies for both Licensed and Certified Nursing staff.	

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S 560	Continued From page 3 did not meet the minimum requirement of 1 CNA to 8 residents for the day shift and total staff for residents of 1 to 14 on the overnight shift as documented below: 9/4/22 had 18 CNAs for 280 residents on the day shift, required 35 CNAs. 9/5/22 had 26 CNAs for 280 residents on the day shift, required 35 CNAs. 9/6/22 had 19 CNAs for 280 residents on the day shift, required 35 CNAs. 9/7/22 had 19 CNAs for 280 residents on the day shift, required 35 CNAs. 9/8/22 had 24 CNAs for 280 residents on the day shift, required 35 CNAs. 9/8/22 had 16 total staff for 280 residents on the overnight shift, required 20 total staff. 9/9/22 had 23 CNAs for 280 residents on the day shift, required 35 CNAs. 9/10/22 had 19 CNAs for 285 residents on the day shift, required 35 CNAs. As per the "Nursing Staff Report" completed by the facility for the week of 10/16/22 to 10/22/22, which revealed the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as documented below: 10/16/22 had 24 CNAs for 284 residents on the day shift, required 35 CNAs. 10/17/22 had 28 CNAs for 283 residents on the day shift, required 35 CNAs. 10/18/22 had 31 CNAs for 283 residents on the day shift, required 35 CNAs. 10/19/22 had 29 CNAs for 283 residents on the day shift, required 35 CNAs. 10/20/22 had 32 CNAs for 283 residents on the day shift, required 35 CNAs. 10/21/22 had 32 CNAs for 285 residents on the	S 560	Daily bonuses for agency and in-house staff are offered for double shifts, extra shifts, weekends, and for staff recognition. Referral and sign-on bonuses are offered for both Licensed and Certified Nursing staff. Advertisement lawn signs are placed in the front of the building for staff recruitment. The facility is recruiting on multiple employment search engines and multiple social media platforms. Staffing needs for the day are assessed daily and it is evaluated if Nursing Management (Unit Managers, ADON, Facility Educator) needs to assist with resident care. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The Director of Nursing (DON)/designee will conduct daily Certified Nursing Assistant (CNA) staffing schedule audits for the next six months. The DON/designee will report audit findings to the Administrator for analysis, tracking, and trending. The Administrator will report the findings of the Certified Nursing Assistant staffing audits to the Quality Assessment and Assurance (QAA) Committee for the next two quarters. The QAA Committee will determine the need for any additional monitoring of Certified Nursing Assistant	

New Jersey Department of Health

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S 560	Continued From page 4 day shift, required 35 CNAs. 10/22/22 had 22 CNAs for 280 residents on the day shift, required 35 CNAs. On 4/18/23 at 11:38 AM, the surveyor interviewed the Staffing Coordinator who stated she was responsible for making the schedules for all nursing staff which included CNAs, Registered Nurses (RN), and Licensed Practical Nurses (LPN). The Staffing Coordinator stated she utilized a computer application to determine the number of staff needed per shift which was based on the resident census for the day. The Staffing Coordinator continued that she thought the minimum required staff for the day shift was one CNA to every eight residents, and if the facility did not meet the minimum requirements, they used Agency staff for those shifts. NJAC 8:39-5.1(a)	S 560	staffing after the 2nd quarterly meeting. V. Date of Compliance: 05/23/2023	

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F 000	INITIAL COMMENTS Complaint NJ #: 155891; 157789; 157938; 158780; 159807 Survey Date: 4/19/23 Census: 286 Sample: 35 +3 +7 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	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		5/23/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 05/05/2023

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

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F 550	Continued From page 1 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 observations, interviews, and review of pertinent facility documents, it was determined that the facility failed a.) to ensure residents on transmission-based precautions (TBP) were treated in a dignified and respectful manner for their toileting needs and b.) ensuring the privacy curtain was closed during personal care. This deficient practice was identified for 2 of 35 residents (Residents #19 and #213) reviewed for dignity, and was evidenced by the following: 1. On 4/14/23 at 9:30 AM, during the initial tour of the facility, the surveyor observed cautionary signage and a personal protective equipment (PPE; clothing or equipment worn to protect the body from harm or infection) bin outside of Resident #19's room. A "Stop Sign" cautioned that TBP (precautions intended to prevent	F 550	I. Corrective action(s) accomplished for resident(s) affected: Resident #19 was reassessed for the need to use the toilet. A therapy screen was completed, and resident was able to transfer with assistance to use the toilet as requested. Resident #19 remained in the room and was able to use the bathroom as needed. Resident□s urine was retested for EX. Order 26 infection and Resident #19 was cleared from isolation precautions due to a negative result of her urine that was resulted on EX. Order 26.(4) B1. The facility Social Worker and nursing met with Resident #19 on EX. Order 26.(4) B1 3 as a follow-up visit to offer comfort and reassurance. Resident #19 appears to have no negative psychosocial effects	

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transmission of infectious agents) were in effect and directed to perform hand hygiene and don (put on) gloves and gown before entering the room. The surveyor observed Resident #19 who self-propelled themselves in a wheelchair within the room. When interviewed, the resident stated that he/she had a EX. Order 26.(4) B1), and was not permitted to use the bathroom because their roommate used it. The resident further stated staff instructed the resident to both defecate and urinate in their EX. Order 26.(4) B1 brief because there was a chance that their roommate could become infected if they used the bathroom. The resident stated that their roommate went to the hospital about a week ago and he/she was not happy about it, and preferred to use the bathroom; at least while the roommate was hospitalized. The resident confirmed that their skin was not affected. The resident reported occasional EX. Order 26.(4) B1 and stated that he/she was able to call for help to use the bathroom and knew when he/she had to go. The resident further stated that neither a bedside commode nor bed pan were offered in lieu of going to the bathroom in their brief.

On 4/11/23 at 10:15 AM, the surveyor interviewed the Certified Nursing Assistant (CNA #1) who stated that Resident #19 required total assistance for activities of daily living (ADLs), and used to go into the bathroom. CNA #1 explained that the resident no longer used the toilet because the resident could not stand for a long period of time. CNA #1 stated that the resident wore an incontinent brief and was able to tell her when they had to go to the bathroom or when they needed to be changed. CNA #1 stated that a gown, gloves, mask, and goggles were required to enter the resident's room due to the presence

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related to allegedly being told by the staff to use her brief for incontinent management because there was a chance the roommate could be infected if she used the bathroom.
Resident #213 was evaluated by the Social Worker on EX. Order 26.(4) B1 and found to have no negative psychosocial effects related to the privacy curtain not being pulled by the assigned aide during care as observed. Certified Nurse Aide #2 received 1:1 re-education immediately by the Director of Nursing/designee on privacy, dignity, and resident rights.

II. Residents identified having the potential to be affected and corrective action taken:
All residents have the potential to be affected by this deficient practice. The Infection Preventionist Nurse conducted an audit of all residents on isolation precautions. No other residents were identified as affected by this practice.
All residents have the potential to be affected by this deficient practice. Walking rounds during am care were conducted by the Assistant Director of Nursing and Unit Managers on all units and found no other residents affected by this practice.
III. Measures will be put into place to ensure the deficient practice will not recur:
Unit Manager/Licensed Practical Nurse #1 received 1:1 re-education by the Director of Nursing/designee on resident rights, dignity, documentation of room changes, and cohorting of residents on precautions.
Certified Nurse Aide #2 received 1:1 re-education by the Director of

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

PRINTED: 09/12/2023
FORM APPROVED
OMB NO. 0938-0391

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of EX. Order 26 in the resident's EX. Order 26

The surveyor reviewed the medical record for Resident #19.

A review of the Admission Record face sheet (an admission summary) revealed that the resident was re-admitted to the facility in EX. Order 26.(4) B1 with diagnosis which included EX. Order 26.(4) B1).

A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated EX. Order 26.(4), reflected the resident had a brief interview for mental status (BIMS) score of EX. O out of EX. which indicated a EX. Order 26.(4) B1. Further review of the MDS revealed that the resident required extensive assistance of one-person for bed mobility, transfers, toilet use, and personal hygiene. Further review of the MDS revealed that the resident was frequently incontinent of urine and frequently EX. Order 26.(4) B1 of EX. Order 26. and a EX. Order 26.(4) B1 was not being used to manage the resident's EX. Order 26.(4) B1 EX. Order 26.(4) B1.

On 4/12/23 at 11:13 AM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN #1) who stated that Resident #19 did not currently have a roommate. UM/LPN #1 stated that Resident #19 informed her that the resident did not use the bathroom, as he/she was EX. Order 26.(4) B1 and the aides provided EX. Order 26.(4) B1 care in the resident's bed. The UM/LPN #1 further

Nursing/designee on privacy, dignity, and resident rights.
All Licensed and certified nursing staff received re-education by the facility educator/designee on maintaining privacy, dignity, and resident rights.
All Licensed and certified nursing staff received re-education by the facility educator/designee on toileting residents based on their functional capabilities and personal preference along with cohorting of residents on isolation precautions.
An audit tool for maintaining cohorts was updated to include any impact on roommates when precautions are implemented, room changes, and any additional equipment implemented to maintain care needs.
An audit tool for conducting unit rounds was updated to ensure resident rights, dignity, and privacy are being maintained during care.
IV. Corrective actions will be monitored to ensure the deficient practice will not recur:

The Infection Prevention Nurse/designee will conduct one audit per week on all residents on isolation precautions for four weeks and monthly thereafter for five months to assure residents on transmission-based precautions are maintained appropriately for their toileting needs and report the results to the Director of Nursing/designee.

The Assistant Director of Nursing/designee will conduct one unit round audit per week on all units for four weeks and monthly thereafter for five

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F 550	Continued From page 4 stated that Resident #19 requested to use the bathroom after they had spoken with the surveyor, and that Physical Therapy (PT) had since evaluated the resident, who was deemed able to use the toilet with assistance. UM/LPN #1 stated that the resident must be the only one who used the toilet due to their history of EX. Order 26, and since the resident's prior roommate did not have EX. Order 26, the resident's roommate was the only one who could use the bathroom. UM/LPN #1 further explained that Resident #19 declined to have their room changed when they tested EX. Order 26.(4) for EX. Order 26, and did not voice a desire to use the toilet. At that time, the surveyor asked UM/LPN #1 if she documented that Resident #19 was offered a room change and declined? UM/LPN #1 stated that she did not believe that she needed to document the conversation as the resident was incontinent at that time. UM/LPN #1 explained that the resident's EX. Order 26 tested EX. Order 26.(4) B1 on EX. Order 26.(4), and was not treated with an antibiotic because the resident was determined to have been EX. Order 26.(4) B1). UM/LPN #1 stated that she did not see it as a dignity issue. UM/LPN #1 further stated that if the resident's roommate returned from the hospital, she would change the resident's room or check with the family. On 4/12/23 at 12:17 PM, the surveyor interviewed the Infection Preventionist/Registered Nurse (IP/RN) who stated that if a resident were to test positive for EX. Order 26. and both residents used the same bathroom, then one of the residents must be moved to a different room. IP/RN stated, "She would never tell a resident that they were not permitted to use the bathroom because it was a	F 550	months to assure that staff are following proper procedure regarding pulling privacy curtain while providing care and resident rights, privacy, and dignity are maintained during care and report the results to the Director of Nursing/designee. The Director of Nursing/designee will report the results of the weekly audits for residents on transmission- based precautions to the Quality Assessment and Assurance (QAA) Committee for the next two quarters. The QAA Committee will determine the need for any additional monitoring of residents on precautions after the 2nd quarterly meeting. The Director of Nursing/designee will trend the audit findings and report outcomes to the Quality Assessment and Assurance (QAA) Committee for the next two quarters with follow-up recommendations as necessary. The QAA Committee will determine the need for any additional monitoring of rounding after the 2nd quarter. V. Date of Compliance: 5/23/2023	

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	315159	A. BUILDING ______ B. WING ______	C 04/19/2023

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F 550	Continued From page 5 dignity issue to tell them to use the [EX. Order 26.(4) B1 brief] all the time for EX. Order 26.(4) B1 On 4/12/23 at 1:30 PM, the surveyor interviewed the Director of Rehab (DOR) who stated that as of EX. Order 26.(4) B1, Resident #19 was currently receiving Occupational Therapy (OT, rehabilitation through performance of ADLs) for safety and transfer levels. The DOR confirmed that the resident previously received OT from EX. Order 26.(4) B1 and was determined to have required moderate assistance overall at that time. The DOR stated that the resident was presently at baseline and was able to use the toilet with one-person moderate assistance. A review of a Certified Nursing Assistant (CNA) Assignment Sheets dated 4/3/23, 4/5/23, 4/7/23, 4/8/23, 4/9/23, 4/10/23, and 4/13/23, revealed that Resident #19 required complete care, transferred with EX. Order 26.(4) B1 technique, and was EX. Order 26.(4) B1 and EX. Order 26.(4) B1. On 4/13/23 at 11:13 AM, the surveyor observed that Resident #19's roommate returned from the hospital and shared a room with Resident #19 once more. On 4/13/23 at 12:02 PM, the surveyor interviewed LPN #1 who stated that Resident #19's roommate returned to the facility last evening, and did not use the bathroom at this time. On 4/13/23 at 12:17 PM, the surveyor interviewed the Medical Director (MD) in the presence of the survey team via speaker phone with permission. The MD stated that when a resident was colonized with EX. Order 26.(4) B1 produced by EX. Order 26.(4) B1	F 550		

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F 550	Continued From page 6	F 550		

that are EX. Order 26.(4) B1ics) and required TBP, the facility had to come up with a safe scenario for bathroom use which may include not letting one of the residents use the bathroom. The MD stated they may offer an alternative such as a bedside commode or bedpan. The MD further stated that an EX. Order 26.(4) B1 brief was not always the best choice, but would be better than using the same toilet or commode. The MD stated it was hard to say if telling the resident to go in their brief was a dignity issue; that you had to be thoughtful of the safety of the negative resident.

On 4/17/23 at 12:40 PM, the surveyor interviewed the Director of Nursing (DON) who stated that when a resident testedEX. Order 26.(4) B1 and their roommate was negative, the facility determined whether the resident was EX. Order 26.(4) B1 and wore an EX. Order 26.(4) B1 brief, otherwise, a room change was implemented. The DON stated that UM/LPN #1 could have documented that Resident #19 had a EX. Order 26.(4) B1 and was offered a room change and declined. The DON stated that she was surprised that Resident #19 did not communicate a desire to go to the bathroom, instead of in their EX. Order 26.(4) B1 brief.

On 4/18/23 at 10:45 AM, the surveyor observed Resident #19 seated their wheelchair at the bedside. When interviewed, the resident stated that he/she was now able to use the bathroom and wore an EX. Order 26.(4) B1 brief just in case.

2. On 4/13/23 at 9:20 AM, the surveyor heard screaming coming from a resident's room with a closed door. The surveyor proceeded to knock on the door, announced themselves, and began

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F 550	Continued From page 7 to open the door. The surveyor was informed by CNA #2 that she was providing care for Resident #213. The surveyor observed Resident #213 lying in bed with an EX. Order 26.(4) B1 brief on with exposed legs, torso, and arms with the privacy curtain not closed as CNA #2 provided care with a washcloth to their torso. The resident's unsampled roommate was sitting in their bed facing Resident #213 and CNA #2 with their privacy curtain opened as well. At this time, CNA #2 immediately started closing the privacy curtain for Resident #213 to provide privacy for the resident. On 4/13/23 at 9:26 AM, CNA #2 exited Resident #213's room and the surveyor interviewed the aide who confirmed she was rendering care to Resident #213. The surveyor asked if the privacy curtain should be opened or closed when rendering care, and CNA #2 stated the curtain should be closed for the resident's privacy. CNA #2 confirmed she had not closed Resident #213's privacy curtain while rendering care which exposed the resident, she continued that the resident's unsampled roommate preferred the privacy curtain opened. The surveyor stated you were rendering care to Resident #213 and not their roommate, which CNA #2 acknowledged the curtain should have been closed. On 4/13/23 at 9:35 AM, the surveyor interviewed UM/LPN #2 who stated when staff was providing care to a resident, they were expected to pull the privacy curtain closed prior to rendering care to ensure resident privacy and dignity, as well as make sure the room door was closed. At this time, the surveyor informed UM/LPN #2 of their observation with CNA #2, and she confirmed that CNA #2 should not have rendered care on	F 550		

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F 550	Continued From page 8 Resident #213 until their privacy curtain was closed. On 4/13/23 at 10:09 AM, the surveyor interviewed the DON who stated CNA #2 was an Agency staff aide who was oriented on facility policy and procedure prior to attending to the residents. The DON continued that staff was expected to close the privacy curtain prior to rendering resident care for privacy, which was a standard of practice. The surveyor reviewed the medical record for Resident #213. A review of the Admission Record face sheet reflected that the resident was admitted to the facility in EX. Order 26.(4) B1 021 with diagnoses which included EX. Order 26.(4) B1 and EX. Order 26.(4) B1. A review of the most recent quarterly MDS dated EX. Order 26.(4 reflected the resident had a BIMS score undetermined, with EX. Order 26.(4) B1 EX. Order 26.(4) B1 and a EX. Order 26.(4) B1 . On 4/19/23 at 10:46 AM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA) and survey team, acknowledged CNA #2 had not closed the resident's privacy curtain, and she stated that CNA #2 acknowledged she was aware that she should have closed Resident #213's privacy curtain prior to rendering care. A review of the facility's "Resident Rights" policy dated January 2023, included to be treated with courtesy, consideration, and respect for your dignity and individuality...	F 550		

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F 550	Continued From page 9 A review of the facility's undated "Nursing Assistant Skills Review Checklist" included Interpersonal Skills/Communication...pulls curtains, drapes when giving care... A review of the facility's "Isolation Precautions/COVID-19" policy dated revised January 2023, included isolation precautions...the resident will be placed in a private room, if possible. When a private room is not available, the resident will be placed with another resident who is colonized or infected with the same organism and isolation type (contact versus droplet) but does not have any other infection (cohorting)... NJAC 8:39-4.1(a)(12)	F 550		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(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	F 609		6/5/23

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F 609	Continued From page 10 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: NJ Complaint #157789 Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to report to the New Jersey State Department of Health (NJDOH) a.) an injury of unknown origin for an incident on EX. Order 26.(4) B1; b.) an allegation of staff to resident abuse for an incident on EX. Order 26.(4); and c.) and allegation of staff to resident mistreatment on EX. Order 26.(4) B1. This deficient practice was identified for 3 of 3 residents (Resident #15, #152, and #440) reviewed for abuse, and the evidence was as follows: 1. On 4/6/23 at 9:37 AM, the surveyor observed Resident #15 sitting in their wheelchair in their room asleep. The surveyor reviewed the medical record for Resident #15. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in EX. Order 26.(4) B1 with diagnoses which included EX. Order 26.(4) B1	F 609	I. Corrective action(s) accomplished for resident(s) affected: Resident #15 remains in the facility for long-term care placement. Resident #15 does not appear to have any negative effects from the EX. Order 26.(4) B1 area observed to the EX. Order 26.(4) B1 ye. The area healed without issue. A recent EX. Order 26.(4) B1 consult was conducted on EX. Order 26.(4) B1 without any negative effects noted related to this previous finding. A care plan for EX. Order 26.(4) B1 has been updated and remains active. The Director of Nursing was re-educated by the Administrator on the facility Abuse Policy which included reporting abuse in accordance with State law. The Department of Health was notified 06-05-2023. Resident #152 remains in the facility for long-term care placement. Resident #152 does not appear to have any negative effects from the alleged interaction with a staff member that occurred on EX. Order 26.(4) B1. Resident #152 is routinely followed by EX. Order 26.(4) B1 and had a recent	

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F 609	Continued From page 11 EX. Order 26.(4) B1 . A review of the most recent quarterly Minimum Data Set (MDS), and assessment tool dated EX. Order 26.(4), reflected the resident had a brief interview for mental status (BIMS) score of EX out of EX. Or which indicated a EX. Order 26.(4) B1 paired EX. Order 26.(4) B1. A review of the Progress Notes included a Nurses Note dated EXEX. Order 26. at 3:25 PM, that during morning medication administration, the resident was noted with EX. Order 26.(4) B1 around [his/her] EX. Order EX. Ord. The resident was unable to explain the EX. Order 26.(4) B1 On 4/11/23 at 9:00 AM, the surveyor requested from the Director of Nursing (DON) all incident and accident investigations for Resident #15. On 4/11/23 at 11:06 AM, the surveyor observed Resident #15 sitting in their wheelchair in the dayroom. The resident was sitting at the table having a snack repeating the word EX. Order 26.(4) B1 and was unable to be interviewed. On 4/11/23 at 11:47 AM, the surveyor received the requested investigations from the DON. A review of an incident report dated EX. Order 26.(4) at 3:06 PM, included during medication administration, the resident was observed with EX. Order 26.(4) B1 . (Nurse Note indicated EX. Order 26.(4) B1 around the EX. Order Resident was unable to explain the EX. Order 26.(4) B1 was noted on the EX. Order 26.(4) B1	F 609	EX. Order 26.(4) B1 consult on EXEX. Order 26.(4) B1. Resident #152 denied any complaints/concerns during this last consult. The Department of Health was notified on 06-05-2023. Resident #440 was discharged from the facility on EX. Order 26.(4) B1 prior to this survey. The Department of Health was notified on 06-05-2023. II. Residents identified having the potential to be affected and corrective action taken: All residents residing in this facility had the potential to be affected. A review of the last quarter of grievances was conducted by the Administrator. No other residents were identified as affected by this practice. III. Measures will be put into place to ensure the deficient practice will not recur: The facility Abuse Policy was reviewed by the Administrator. No updates were required to the policy. The Director of Nursing was re-educated by the Administrator on the facility Abuse Policy which included reporting abuse in accordance with State law. Facility staff were re-educated by the facility educator/designee on the Abuse policy which included a review of what constitutes abuse and the response to allegations of abuse, neglect, exploitation, and mistreatment. A new measure has been implemented utilizing an Abuse Investigation Checklist form. The Director of Nursing (DON)/designee will confirm that all abuse allegations have been fully investigated and reported to the Department of Health	

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F 609	Continued From page 12 EX. Order and slightly EX. Order 26.(4) B1. The resident was unable to explain what happened. The resident's mental status was EX. Order 26.(4) B1. Staff was interviewed and surveillance video was watched. On 4/12/23 at 9:50 AM, the surveyor interviewed the DON regarding the facility's process for investigations who stated the facility investigates falls, skin tears, bruises, any event out of the normal for the resident, resident to resident abuse, any allegations of abuse, neglect, sexual abuse, misappropriation of funds, injuries of unknown origin. The DON continued that the facility reported to the NJDOH any allegations of abuse, neglect, misappropriation of funds. During a follow-up interview on 4/13/23 at 9:14 AM, the DON confirmed the facility had two hours to report to the NJDOH anything that involved abuse including allegations, and twenty-four hours to report anything non-abuse related. On 4/14/23 at 9:08 AM, the surveyor asked the DON if she reported the injury of unknown origin for Resident #15 to the NJDOH, and the DON responded no because after an "extensive investigation" and went through hours of video surveillance, it was determined that the incident was not caused from abuse so it did not have to be reported. The surveyor asked if the facility had to report the injury of unknown origin prior to the conclusion of the investigation, and the DON responded no because she immediately investigated the situation spending hours reviewing surveillance videos. The surveyor asked if discoloration of the eye was considered a suspicious area, and the DON responded not in this case because "I completed a full investigation."	F 609	and Office of the Ombudsman as appliable by utilizing the Abuse Investigation Checklist Form. The DON will report any concerns to the Administrator with follow up actions as necessary. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The Director of Quality Assurance Performance Improvement (QAPI) will conduct one audit per week for four weeks then monthly audits for five months on the completion of the Abuse Investigation Checklist form. Results of the audits will be reviewed with the Administrator for analysis, tracking, and trending. Any corrective actions required as a result of these audits will be addressed by the Director of QAPI with the Director of Nursing. The Administrator will report the results of the Abuse Investigation Checklist and Abuse reporting audits to the Quality Assessment and Assurance (QAA) Committee for the next two quarters. The QAA Committee will determine the need for any additional monitoring of abuse reporting after the 2nd quarterly meeting. V. Date of Compliance:06/05/2023	

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F 609	Continued From page 13	F 609		

The surveyor continued to review the medical record.

A review of the Progress Notes revealed a Physician's Progress Note dated EXEX. Order 26.(4) at 11:44 PM, which included the resident was being seen for a EX. Order 26.(4) B1) and EX. Order 26.(4) B1 EX. Order 26.(4) B. Resident was unable to provide information regarding injury to EX. Order 26.(4) B1 or EX. Order 26 no witnessed falls or injuries noted by staff.

On 4/14/23 at 1:03 PM, the DON informed the surveyor that based on the EX. Order 26.(4) B1 was not EX. Order 26.(she did not suspect abuse. The DON confirmed when the EX. Order 26.(4) B1 of the EX. Ord was reported, it was unwitnessed.

On 4/19/23 at 10:46 AM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA) and survey team confirmed this incident was noted reported to the NJDOH.

2. On 4/3/23 at 11:18 AM, the surveyor observed Resident #152 laying on the bed requesting assistance from the nursing staff.

The surveyor reviewed the medical record for Resident #152.

A review of the Admission Record face sheet reflected the resident was re-admitted to the facility in EX. Order 26.(4) B1 with diagnosis which included EX. Order 26.(4) B1 EX. Order 26.(4) B1 following EX. Order 26.(4) B1 affecting EX. Order

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F 609	Continued From page 14 EX. Order 26.(4) B1 A review of the most recent quarterly MDS dated EX. Order 26., had a BIMS score of EX. Order 26.(4) B1 which indicated a EX. Order 26.(4) B1. Further review of the MDS indicated the resident was dependent on staff for all activities of daily living (ADLs). On 4/12/23 at 10:20 AM, the surveyor was informed by Resident#152 of a situation involving a Certified Nursing Assistant (CNA #1). With Resident #152's permission, this conversation was held in the presence of their roommate (Resident #113). Resident #152 advised that CNA #1 EX. Order 26.(4) B1 [...] EX. Order 2 EX. Order 26. Resident #152 further stated that CNA #1 "EX. Order 26.(4) B1 [to cover me up] because I had a EX. Order 26.(4) B1. I told her I got a EX. Order and she said you don't have EX. Order 26.(4) B1 hanging out like that." Resident #113 confirmed the entire event and stated that Resident #152 was EX. Order 26 after the event. When asked if CNA #1 had been assigned to Resident #152 or Resident #113, they both confirmed that they have not seen CNA #1 since that time. On 4/13/23 at 2:15 PM, the surveyor reviewed the facility's "Grievance Form" dated EX. Order 26.(4), which included it was reported that the Social Worker (SW) met with Resident #152 on EX. Order 26.(4 Resident #152 reported that on EX. Order 26.(4), the resident's CNA #1 attended to the resident for care. Resident #152 stated that CNA #1 "started EX. Order 26.(4) B1 EX. Order 26.(4) I told her that you don't have to touch me [...] she kept EX. Order 26.(4) B1 [...] EX. Order 26.(4) B1 and so shocked." Under the section identified as "Actions Taken", the following was handwritten, "Allegation is unfounded". A review of CNA #1's	F 609		

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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 609	Continued From page 15 written statement dated EX. K. Order 3, revealed that CNA #1 entered the room and asked Resident #152 if he/she could fix the resident's gown to "protect [his/her] dignity". CNA #1 reported that he/she "would never grab someone's EX. Order I always ask the residents first before I help them." On 4/14/23 at 1:02 PM, the surveyor reviewed Resident #152's grievance with the DON. The surveyor asked the DON if the incident was reported to the NJDOH, and the DON responded that based on their investigation, this did not rise to the level of reporting. The surveyor inquired that if their investigation took two days to complete, was that longer than the two hour reporting requirement? The DON responded, "of course". 3. The surveyor reviewed the closed medical record for Resident #440. A review of the Admission Record face sheet reflected the resident was admitted to the facility in EX. Order 26.(4) B1, and had diagnoses which included EX. Order 26.(4) B1 Attack EX. (EX. O a EX. Order 26.(4) B1 similar to a EX. Order 26.(4) A review of the admission MDS dated EX. Order 26.(4) B1 indicated the resident had a BIMS score of EX. O out of EX. O which indicated that the resident's cognition was EX. Order 26 A review of the facility's "Grievance Form" dated EX. Order 26.(4), revealed that the SW met with Resident #440 on EX. Order 26.(4) B Resident #440 reported that on EX. Order 26.(4) B the resident's [CNA #2] attended to the resident for care. The resident was thirsty and	F 609		

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	315159	A. BUILDING ______ B. WING ______	C 04/19/2023

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F 609	Continued From page 16 had called for CNA #2 again at 1:00 PM and 2:00 AM. CNA #2 stated to the resident, "why do you have your [profanity] lights on again, I am changing other people, you have been changed." Resident #440 reported that CNA #2 should not have spoken that way to the resident. Further review of the Grievance Form dated and signed by the DON on EX. Order 26.(4) revealed that an investigation was initiated, and the DON interviewed Resident #440. Resident #440 confirmed that CNA #2 used profanity when speaking to the resident. CNA #2 was "held off work" and CNA #2 denied using profanity toward the resident. A review of CNA #2's written statement dated EX. Order 26.(4), revealed that CNA #2 changed Resident #440 at 2:30 AM, and two hours later the resident had their light on to be changed. CNA #2 explained to the resident that she just changed the resident and had begun changing other residents and would be back soon. Resident #440 "demanded to be change now" and was told by CNA #2 that when she was finished with the other resident, she would be back. Further review of CNA #2's statement revealed that CNA #2 was frustrated at the time, but denied threatening or using profanity toward the resident. On 4/14/23 at 12:55 PM, the surveyor reviewed Resident #440's grievance with the DON. The DON stated that CNA #2 used an inappropriate comment, and that CNA #2 was not using profanity directly to the resident. The surveyor re-read the DON's written interview to the DON. The surveyor asked the DON if the incident was reported to the NJDOH. The DON stated that based on their (the facility's) assessment, it was not a reportable event.	F 609		

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F 609	Continued From page 17 A review of the facility's "Abuse and Neglect Policy and Procedure" dated November 2022, included the purpose was to ensure prevention, protection, prompt reporting and intervention in response to alleged, suspected or witnessed abuse, neglect, mistreatment, misappropriation of property, or exploitation of any facility resident...Investigative and Reporting Procedure...The Department of Health and Senior Services, and the Office of the Ombudsman if the resident is over 60, will be notified immediately (as soon as possible but not to exceed two hours) of the incident, followed by a written report within five days of the incident and if the alleged violation is verified, the facility shall take all appropriate action... NJAC 8:39-9.4(e)	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	F 610		5/23/23

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F 610	Continued From page 18 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, interviews, and review of pertinent facility documents, it was determined that the facility failed to thoroughly investigate an allegation of abuse for 1 of 3 residents (Resident #152) reviewed for abuse. This deficient practice was evidenced by the following: On 4/3/23 at 11:18 AM, the surveyor observed Resident #152 laying on the bed requesting assistance from the nursing staff. On 4/12/23 at 10:20 AM, the surveyor was informed by Resident#152 of a situation involving a Certified Nursing Assistant (CNA). With Resident #152's permission, this conversation was held in the presence of their roommate (Resident #113). Resident #152 advised that the CNA 'EX. Order 26.(4) B1 [...] EX. Order 26.(4) B1 [...] EX. Order 26 EX. Order 26" Resident #152 further stated that the CNA EX. Order 26.(4) B1 [to cover me up] because I had a EX. Order 26.(4) B1. I told her i got a EX. Order 26 and she said you don't have EX. Order 26.(4) B1 hanging out like that". Resident #113 confirmed the entire event and stated that Resident #152 was EX. Order 26 after the event. When asked if the CNA has been assigned to Resident #152 or Resident #113, they both confirmed that they have not seen the CNA since that time. A review of the Admission Record face sheet (an admission summary) reflected the resident was re-admitted to the facility in EX. Order 26.(4) B1 with diagnosis which included EX. Order 26.(4) B1 of EX. Order 26.(4) B1) and EX. Order 26.(4) B1	F 610	I. Corrective action(s) accomplished for resident(s) affected: Resident #152 remains in the facility for long-term care placement. A thorough investigation was completed for the resident including re interview of resident and chart review. Resident stated that the certified nursing assistant stopped attempting to cover EX. Order when EX. Order asked her to and supervisor had another staff member take care of EX. Order Outcome of investigation reviewed with resident and resident was satisfied. II. Residents identified having the potential to be affected and corrective action taken: All residents residing in this facility had the potential to be affected. A review of the last quarter of grievances was conducted by the Administrator. No other residents were identified as affected by this practice. All facility staff was re-educated regarding the abuse policy by the facility educator/designee. III. Measures will be put into place to ensure the deficient practice will not recur: The facility Abuse Policy was reviewed by the Administrator. No updates were required to the policy. The Resident Grievances Policy and Grievance Report form was reviewed by the Administrator. No updates were required to the policy or reporting form.	

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F 610	Continued From page 19 EX. Order 26.(4) B1 following EX. Order 26.(4) B1 . A review of Resident #152's most recent quarterly Minimum Data Set (MDS), an assessment tool dated EX. Order 26.(4), the resident had a brief interview for mental status (BIMS) score of EX. Order 26.(4) B1, which indicated a EX. Order 26.(4) B1 . Further review of the MDS indicated the resident was dependent on staff for all activities of daily living (ADLs). A review of Resident #113's the most recent quarterly MDS dated EX. Order 26.(4), the resident had a BIMS score of EX. Order 26.(4) B1, which indicated that the resident is EX. Order 26.(4) B1. The surveyor reviewed the facility provided Grievance Packet, for EX. Order 26.(4) B included the following: A review of the "Grievance Form" dated 1/30/23, which it was reported that the Social Worker (SW) met with Resident #152 on EX. Order 26.(. Resident #152 reported that on EX. Order 26.(4), the resident's CNA attended to the resident to provide care. Resident #152 stated that the CNA "started EX. Order 26.(4) B1 EX. Orde [...] I told her that you don't have to touch me [...] she kept EX. Order 26.(4) B1 y arm [...] EX. Order 26.(4) B1 and so shocked". A review of the Staff Statement form by the Nursing Supervisor, that identified the incident date of EX. Order 26.(4) at 2:10 PM. The reported allegation occurred on EX. Order 26.(4). The description of the incident identified that a call was received from [Resident #113] at about 6:30 PM. The documented statement did not address the	F 610	The Director of Nursing was re-educated by the Administrator on thoroughly investigating and reporting allegations of abuse in accordance with State law. The Director of Nursing was re-educated by the Administrator on thorough completion of Grievance Report form responses which included gathering statements of those involved, providing names of all parties involved, and documentation of a final response for the grievance. The Director of Social Services/Grievance Officer was educated by the Administrator that the Grievance Report form must be complete before determining the grievance report as resolved. A new measure has been implemented utilizing an Abuse Investigation Checklist form. The Director of Nursing (DON)/designee will confirm that all abuse allegations have been fully investigated and reported to the Department of Health and Office of the Ombudsman as applicable by utilizing the Abuse Investigation Checklist Form. The DON will report any concerns to the Administrator with follow up actions as necessary. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The Director of Quality Assurance Performance Improvement (QAPI) will conduct one audit per week for four weeks then monthly audits for five months on the completion of the Abuse Investigation Checklist forms for compliance. Results of these audits will	

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Continued From page 20

concerns that were identified with the grievance including the remarks EX. Order 26.(4) B1 and so shocked I asked [Resident # 113] to call my EX. Order and tell them". The documented statement identified actions that were taken and did not confirm the identity of the alleged CNA.

A review of the section titled, "Actions taken", included "All appropriate departments made aware. Allegation is unfounded."

A review of the section titled, "Final Response", was blank.

On 4/12/23 at 9:50 AM, the Director of Nursing (DON) was interviewed by the survey team. During the interview, the DON confirmed that a roommate could be identified as a witness and they would "write or have phone interview with them". The DON further explained that upon conclusion of the investigation, the resident's care plan was updated with interventions.

On 4/19/23 at 9:52 AM, the DON was interviewed by the survey team. When asked if the investigation was completed, the DON stated, "There wasn't abuse". The DON was questioned why there was no statement from Resident #113 regarding the grievance. The DON responded that Resident #113 had his/her privacy curtain closed. When asked if the Nursing Supervisor followed-up with the claims that Resident #152 was crying or if the resident's family was contacted, the DON responded, "I will have to double check". When asked if the resident was questioned if he/she would like the CNA to continue to care for the resident, the DON responded, that the [residents] preferred men. The DON confirmed that this was not

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be reviewed with the Administrator for analysis, tracking, and trending. Any corrective actions required as a result of these audits will be addressed by the Administrator with the Director of Nursing.

The Director of Social Services will conduct one audit per week for four weeks then monthly audits for five months on the completion of Grievance Report forms for compliance. Results of these audits will be reviewed with the Administrator for analysis, tracking and trending. Any corrective actions required as a result of these audits will be addressed by the Administrator with the Director of Nursing.

The Administrator will report the results of the Abuse Investigation Checklist and Grievance Report form audits to the Quality Assessment and Assurance (QAA) Committee for the next two quarters. The QAA Committee will determine the need for any additional monitoring of abuse reporting and Grievance Report form completion after the 2nd quarterly meeting.

V. Date of Compliance: 05/23/2023

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F 610	Continued From page 21	F 610		

documented on the grievance form. When the surveyor inquired if the care plan was updated to identify any interventions, the DON stated, "I can double check". The survey team asked if there should be a summary or response on the second page of the grievance form? The DON acknowledged that there should be some type of summary completed.

A review the facility's "Abuse and Neglect Policy and Procedure", dated November 2022, included the definition of alleged violation: a situation nor occurrence that is observed or reported by staff, another health care provider, resident, relative, visitor, or others but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse including injuries of unknown source, and misappropriation of resident property...Investigative and Reporting...the following steps will be taken: Incident report will be completed; Interviews will be conducted- an statements obtained from all staff members, residents, family, volunteers and others that may have witnessed or have knowledge with the respect to the alleged events; All such statements will be in writing and place in the investigatory file related to the alleged incident; The employee file of any accused staff will be reviewed. All findings from such a review will be memorialized in writing and placed in the investigatory file related to the alleged incident; [...] A written report, which among other things, provides an overview of the incident, pertinent medical data, and a summary of statements take, investigative findings, follow-up actions and a conclusion will be prepared; [...] based on investigative findings may implement corrective action to prevent further potential abuse that may

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F 610	Continued From page 22 include, but are not limited to, staffing changes, etc... A review the facility's "Social Services Policy and Procedure for Resident Grievances", dated November 2022, included...Grievance Officer responsibilities: ensuring that all written grievances decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's grievance, a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance and the date the written decision was issued...Process...After reviewing the information and facts fathered during the investigation, the employee responsible for answering the grievance will put a report in writing and submit it to the Administrator/Grievance Officer (GO). The report is to include: the date the grievance was received; a summary of the grievance; record of who was interviewed; record of information/facts gathered; any conclusions/recommendations made regarding the grievance; the date the written decision was issued... NJAC 8:39-4.1(a)(5)	F 610		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		5/23/23

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F 656	Continued From page 23 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 656		

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F 656	Continued From page 24 (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: NJ Complaint #157789 Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to a.) implement care plan interventions of a EX. Order 26.(4) B1 for a resident with a history of EX. Order; and b.) develop and implement a care plan for a resident with EX. Order 26.(4) which included daily EX. Order 26.(4) B1 and a EX. Order 26.(4) B1. This deficient practice was identified for 2 of 35 residents (Resident #15 and #152) reviewed for comprehensive care plans and the evidence was as follows: 1. On 4/6/23 at 9:37 AM, the surveyor observed Resident #15 sitting in their wheelchair in their room asleep. The resident was wearing non-skid socks. The surveyor reviewed the medical record for Resident #15. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in EX. Order 26.(4) B1 with diagnoses which included EX. Order 26.(4) B1 . A review of the most recent quarterly Minimum Data Set (MDS), and assessment tool dated EX. Order 26.(4), reflected the resident had a brief interview for mental status (BIMS) score of EX. out	F 656	I. Corrective action(s) accomplished for resident(s)affected: Resident #15 remains in the facility for long-term care placement. The care plan for this resident was reviewed and updated as needed. The current care plan includes the EX. Order 26.(4) B1 and to check the placement and function every shift. The silent bed alarm was added to the Certified Nurse Aide Kardex. This resident has not had any EX. ls reported since the conclusion of this survey. Resident #152 remains in the facility for long-term care placement. The care plan for this resident was reviewed and updated. The current care plan includes applying the EX. Order 26.(4) B1 t daily and to remove it at bedtime as tolerated with skin checks. The care plan includes offering a EX. Order 26 under the resident□s EX. Order 26.(4) l EX. Order 26.(4) B1 s when in bed. These interventions were added to the Certified Nurse Aide Kardex. Resident #152 was evaluated by Physical and Occupational therapies and remains on program for both entities at this time. II. Residents identified having the potential to be affected and corrective action taken: All residents with orders for a silent bed alarm had the potential to be affected. An audit of residents with EX. Order 26.(4) B1 was conducted and found that no other residents were affected by this practice. All residents with EX. Order 2 s and orders for EX. Order 26.(4) for positioning had the potential to	

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F 656	Continued From page 25 EX. Order 26 which indicated a EX. Order 26.(4) B1 EX. Order 26.(4) B1 A further review in "Section J. Heath Conditions", included the resident had two EX. Orde with no injury and one EX. O with injury (except major) which included EX. Order 26.(4) B1 ince admission to the facility. A review of the Progress Notes included a Nurses Note dated 10/22/22 at 8:02 AM, that the resident was observed [EX. Order 26.(4) B] on [his/her] EX. Order 26.(4) in the hallway around 7:10 AM. The resident was assessed with no injury or complaint of pain and was unable to state how he/she got to the floor. The resident's bed was noted on the lowest position, wheelchair was at bedside, and the resident wore non-skid socks. A further review of the Progress Notes included a Nurses Note written by Licensed Practical Nurse (LPN #1) dated EX. Order 26.(4) B1 at 8:09 AM, that the resident was received in bed asleep upon my arrival on shift. The resident was redirected several times and assisted back to bed during the shift. Around 7:00 AM, staff noticed the resident on the floor at the entrance of his/her room and the Supervisor was made aware. Upon assessment, no injury was noted or pain. A review of the resident's comprehensive person-centered care plan included a focus area initiated on EX. Order 26.(4) B1, for the resident was at risk for EX. Orde with regards to EX. Order 26.(4) B1, EX. Order 26.(4) B1 EX. Order 26.(4) B1, history of EX. Order diagnosis of EX. Order 26.(4) B1 EX. Orde, use of high-risk medications, EX. Order 26.(4) B1, EX. Order 26.(4) B1, and EX. Order 26.(4) B1. Interventions	F 656	be affected. Audits of residents with EX. Order 26. and additional EX. Order 26.(4) for positioning were reviewed and found no other residents affected by this practice. III. Measures will be put into place to ensure the deficient practice will not recur: The facility Care Plan policy that was updated January 2023 was reviewed by Administration with no new updates required. The facility Functioning Maintenance Nursing policy was reviewed by Administration and updated 05/2023. LPN #1 and CNA #1 were re-educated by the facility Staff Educator to ensure care plan interventions are in place for residents at risk for EX. Orde and that active interventions are included in statements as applicable when submitting for an investigation. The Director of Nursing was re-educated by the Administrator to include a review of the resident□s current interventions listed on their plan of care for EX. O investigative summaries and to assure all applicable interventions were in place at the time of an incident. If an intervention was not present, additional follow-up with staff, up to and including disciplinary action, will result to decrease/prevent additional events from occurring. The Functioning Maintenance Program EX. Order 26.(4) B1 Communication form was reviewed and updated by the interdisciplinary team on 04/28/2023. This form is completed by rehab when a resident is discontinued from therapy and referred to the nursing functional maintenance program.	

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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 656

Continued From page 26

included to [EX. Order 26.(4) B1] to bed, check placement/function every shift; bed against side of wall; and encourage to use call bell for assistance.

A review of the Order Summary Report dated active orders as of [EX. Order 26.(4) B1], included a physician's order (PO) dated [EX. Order 26.(4) B1] for [EX. Order 2] [EX. Order 26.(4) B1] connected to call bell; check placement and function every shift.

On 4/11/23 at 9:00 AM, the surveyor requested from the Director of Nursing (DON) all incident and accident investigations for Resident #15.

On 4/11/23 at 11:06 AM, the surveyor observed Resident #15 sitting in their wheelchair in the dayroom. The resident was sitting at the table having a snack repeating the word [EX. Order 26.(4) B], and was unable to be interviewed.

On 4/11/23 at 11:47 AM, the surveyor received the requested investigations from the DON and the surveyor reviewed the unwitnessed incident report dated [EXEX. Order 26.(4) B] The report included the resident was observed [EX. Order 26.(4)]ing" on their [EX. Order 26.(4) B] in the hallway outside his/her room and was unable to give description; the resident was [EX. Order 26.(4) B1] The bed was noted in the lowest position, wheelchair was noted beside his/her bed, and he/she wore nonskid socks. Witness statements included from LPN #1 that the resident was received in bed and redirected several times back to bed. Around 7:00 AM, he/she was noticed on the floor by the entrance of their room and the Supervisor was made aware. An additional witness statement from Certified Nursing Aide (CNA #1) included I was about to walk down the hallway when I noticed

F 656

The Rehab Referral form was reviewed and updated by the interdisciplinary team on 04/28/2023. This form is generated by nursing and completed by therapy for all therapy disciplines.
All Licensed and Certified Nursing staff were re-educated by the facility Staff Educator/Designee to ensure fall prevention interventions are in place per the resident□s plan of care and that applicable interventions are identified on statement summaries for [EX. Or] investigations.
All Licensed and Certified Nursing staff were re-educated by the facility Staff Educator/Designee to ensure interventions for positioning are in place per the resident□s plan of care to maintain optimal physical, mental, and psychosocial functioning of our residents.
All Nursing and Therapy staff were educated by the Rehab Director/Designee on the updates to the Rehab Referral form.
All Nursing and Therapy staff were educated by the Rehab Director/Designee on the updates to the Functioning Maintenance Program Walking/Splint/Brace Communication form.
IV. Corrective actions will be monitored to ensure the deficient practice will not recur:

The Director of Quality Assurance Performance Improvement (QAPI) will conduct one audit per week for four weeks then monthly audits for five months on the completion of incident report forms to assure compliance with determining the

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F 656	Continued From page 27 Resident #15's feet out of the doorway on the floor; notified nurse and the resident's wheelchair was next to bed. Prior to the fall, CNA #1 indicated the resident was in bed asleep. The EX. Or conclusion indicated probable causes of the EX. O unknown, EX. Ord interventions in place prior to fall were call light within reach, proper footwear, and bed against wall. Staff were at the Nurse's Station when they observed resident in the hallway EX. Order 26.(4) B1 on their EX. Order 26.(4) B. Resident's bed was observed in lowest position, non-skid socks were on their feet, and wheelchair was noted next to bed. The investigation did not include the intervention of EX. Order 26.(4) B1. On 4/12/23 at 9:50 AM, the surveyor interviewed the DON regarding the facility's investigation process. The DON stated that for a EX. Ord, staff interviewed and collected statements from any witnesses or staff that cared for the resident. The team reviewed all statements, any video surveillance footage, reviewed interventions put in place at the time to determine the cause of the incident and if new interventions should be implemented. The care plan was reviewed and updated as necessary. On 4/17/23 at 10:50 AM, the surveyor interviewed CNA #1 who stated that Resident #15 had behaviors of EX. Order 26.(4) B1, and they were EX. Order 26.(4) B1 with asking for assistance from staff. CNA #1 stated on the day of the incident on EX. Order 26.(4) B1 she was standing at the Nurse's Station, and she recalled hearing the resident's EX. Order 26.(4) B1 which sounded closer. She continued that she observed the resident EX. Order 26.(4) B themselves down the hallway on their EX. Order 26.(4). CNA #1 stated the resident had a EX. Order 26.(4) B1 currently, but did not recall if at the time the	F 656	disposition of EX. O l prevention interventions at the time of incidents. Results of these audits will be reviewed by the Administrator for analysis, tracking, and trending. Any corrective actions required as a result of these audits will be addressed by the Administrator with the Director of Nursing. The Director of Quality Assurance Performance Improvement (QAPI)/designee will conduct one audit per week for four weeks then monthly audits for five months on residents with EX. Order 26.(4) B1 devices to ensure compliance. Results of these audits will be reviewed by the Administrator for analysis, tracking, and trending. Any corrective actions required as a result of these audits will be addressed by the Administrator with the Director of Nursing. The Administrator will report the results of the EX. Ord incident report audits to the Quality Assessment and Assurance (QAA) Committee for the next two quarters. The QAA Committee will determine the need for any additional monitoring of fall incident reports after the 2nd quarterly meeting. The Administrator will report the results of the EX. Order 26.(4) B1 device audits to the Quality Assessment and Assurance (QAA) Committee for the next two quarters. The QAA Committee will determine the need for any additional monitoring of splints and devices after the 2nd quarterly meeting.	

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F 656	Continued From page 28 resident had the EX. Order 26.(4) B1. CNA #1 continued that the EX. Order 26.(4) B1 rang only at the Nurse's Station and the resident's light outside their door turned on when triggered. CNA #1 stated she did not recall hearing a EX. Order 26.(4) B1 ring; she only heard the resident's EX. Order 26.(4) B1 On 4/17/23 at 11:50 AM, the surveyor interviewed LPN #1 who stated the resident did not sleep at night and spent most of the night self-propelling in their wheelchair down the hallway EX. Order 26.(4) B1. LPN #1 continued that the resident had medication to manage their behaviors, but he/she refused their medication at night. LPN #1 continued that the resident had a history of EX. Order 26 because he/she tried to get out of bed without assistance. She continued that the resident had a EX. Order 26.(4) B1 that she had to check the placement and function during her shift that rang at the Nurse's Station, but she could not recall when the EX. Order 26 was ordered. LPN #1 stated she recalled on EX. Order 26.(4) B1, seeing the resident's EX. Order or feet in the hallway as the resident EX. Order 26.(4) B1 themselves out of the room. The surveyor asked if the resident had a EX. Order 26.(4) B1 at this time, and LPN #1 stated she did not recall hearing an EX. Order 26 and "staff would have run into the room and she would not have been able to EX. Order [him/herself] on [his/her] EX. Order 26.(4) s into the hallway; staff would have made it to EX.EX. room by then." On 4/17/23 at 12:36 PM, the surveyor interviewed the Unit Manager/LPN (UM/LPN) who stated Resident #15 was a EX. Order 26.(4) B1 alls. The UM/LPN continued that the resident's had a EX. Order 26 EX. Order 26.(4) B1 that rang at the Nurse's Station if the resident got out of bed without assistance. The UM/LPN stated the resident's had the EX. Order 26.(4) B1	F 656	V. Date of Compliance: 5/23/2023	

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F 656	Continued From page 29 alarm she thought since EX. Order 26.(4) B1, and the nurses checked for placement and function every shift. The UM/LPN stated she was not in the facility at the time the resident's EX. Ord on EX. Order 26.(4) B1 so she was unable to speak to it. On 4/17/23 at 12:46 PM, the surveyor accompanied by the UM/LPN went into Resident #15's room, and the UM/LPN checked the function of the resident's EX. Order 26.(4) B1. The surveyor observed the light outside the resident's room illuminate and observed the call system activate at the Nurse's Station and the EX. Order 26 sound. On 4/19/23 at 10:46 AM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA) and survey team acknowledged that the resident had a EX. Order 26.(4) B1 EX. Order 26 at the time of the fall, but she could not speak to if the EX. Order 26 was activated that morning. 2. On 4/3/23 at 11:18 AM, the surveyor observed Resident #152 lying on the bed requesting assistance from the nursing staff. A review of the Admission Record face sheet reflected the resident was re-admitted to the facility in EX. Order 26.(4) B1 with diagnosis which included EX. Order 26.(4) B1 EX. Order 26.(4) B1 A review of the most recent quarterly MDS dated EX. Order 26., had a BIMS score of EX. Order 26.(4) B1, which indicated a EX. Order 26.(4) B1.	F 656		

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F 656	Continued From page 30	F 656		

Further review of the MDS indicated the resident was dependent on staff for all activities of daily living (ADLs).

A review of the Ordered Summary Report dated EX. Order EX. Or, included a physician's order (PO) dated EX. Order 26.(4) B to apply EX. Order 26.(4) B1 apply in AM and remove at EX. Order 26.(4) B1 everyday and evening shift; worn EX. Order 26.(4) B1 hours and perform skin checks after removal. An additional PO dated EX. Order 26.(4) B to apply EX. Order 26.(4) B1 when in bed every shift.

A review of the comprehensive care plan did not include the resident's need for EX. Order 26.(4) B1 or EX. Order 26. under EX. Order 26.(4) B1.

On 4/12/23 at 10:58 AM, the surveyor observed Resident #152 lying in bed without a EX. Order 2 applied to the EX. Order 26.(4) B1. The resident was covered in a blanket and the surveyor was unable to observe if the EX. Order 26. was placed under their EX. Order 26.(at this time.

On 4/13/23 at 1:30 PM, the surveyor observed Resident #152 lying in bed without a EX. Order 2 applied to the EX. Order and without a EX. Order 26 under EX. Order 26.(4) ees.

On 4/14/23 at 11:26 AM, the surveyor observed Resident #152 lying in bed without a EX. Order applied to the EX. Order 2 and without a EX. Order 26. under EX. Order 26.(4) EX. Order

On 4/14/23 at 11:26 AM, the surveyor observed Resident #152 lying in bed without a EX. Order 2 applied to the EX. Order 26 and without a EX. Order 26 under EX. Order 26.(4) B1.

On 4/17/23 at 10:08 AM, the surveyor observed Resident #152 lying in bed without a EX. Order 2 applied to the EX. Order and without a EX. Order 26. under EX. Order 26.(4) B1.

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F 656	Continued From page 31 On 4/17/23 at 11:30 AM, the surveyor interviewed LPN #2 regarding Resident #152 physician's orders. LPN #2 advised that the EX. Order 2 use was "up to [him/her] if [he/she] wants it or not". The surveyor inquired if there was supposed to be documentation of the EX. Order 2 being offered and denied. LPN #2 responded, "it can be". Upon review of the nursing documentation, LPN #2 stated, "it isn't documented, so [cannot] say if it was done". The surveyor also inquired about the physician's orders regarding the EX. Order 26 for EX. Order 26 EX. Order 26.(4) B1. LPN #2 reviewed the nursing documentation and reported, "I [do not] see any documentation of refusal or offering". When asked who was responsible for ensuring that physician's orders were followed, LPN #2 stated, "everyone has the responsibility to review their orders and task sheets". On 4/17/23 at 01:39 PM, the surveyor interviewed CNA #2 if the resident was supposed to be wearing EX. Order 26 CNA #2 responded, EX. Order 2 [does not] always ask to put it on. I always ensure that it is on". The surveyor pointed out that the resident was not currently wearing the EX. Order 26 CNA #2 asked Resident #152 if he/she would like the brace on and the resident responded, "yes". On 4/17/23 at 01:39 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) regarding the expectation of staffing following physician's orders. The ADON responded that everyone was expected to follow the physician's orders as written. When asked regarding residents with range of motion deficits and their EX. Order 26.1 the ADON stated the nurses were responsible to communicate to the aides and document. When asked if the EX. Order 26 and EX. Order 26	F 656		

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F 656	Continued From page 32	F 656		

physician's order were identified on Resident #152's care plan the ADON responded that she had just updated the care plan to include it.

A review of the facility's untitled policy dated November 2013, included it was the facility's policy that each resident would have a comprehensive care plan which will include possible intervention, measurable objectives and target time to meet a resident's medical, nursing, physical and psychosocial needs...the interdisciplinary team will review and revise the comprehensive care plan and all interventions thereafter during quarterly, annual and with any significant change care conference to ensure all interventions are appropriate and set up next target date...the unit manager/nursing supervisor or licensed nursing representative during the [interdisciplinary care] meeting will revise and update the care plan as necessary (Examples: incidents, infections, behaviors, new interventions, new medications, wounds...

A review of the facility's [EX. Order] Prevention Investigating and Management Policy & Procedure" dated revised January 2023, included if a resident is determined to be a [EX. Or] risk, a care plan will be initiated to promote independence and safety. Individualized interventions will be initiated based on the [EX. Or] risk score of each resident...

A review of the facility's untitled policy dated revised January 2023, included it was the facility's policy to maintain optimum function for the residents. Splints and other assistive devices will be utilized to achieve this goal...the licensed nurse will document in the [Treatment Administration Record] regarding usage...the

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F 656	Continued From page 33 CNA staff can assist with applying the splint/brace. The CNA staff will monitor the splint usage on a daily basis, and they will document said usage in the task tab in [electronic medical record]. CNA staff will report to licensed nurses any issues or concerns with resident's splint/brace or change in status for appropriate evaluations and interventions... NJAC 8:39-27.1(a)	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, review of pertinent facility documents, it was determined that the facility failed to ensure that residents who required extensive assistance from staff with activities of daily living (ADL) were provided care consistent with their needs and preferences. This deficient practice was identified for 2 of 4 residents (Resident #223 and Resident #285) reviewed for activities of daily living, and was evidenced by the following: 1. On 4/4/23 at 10:10 AM, during the initial tour of the facility, the surveyor observed Resident #223 lying in bed awake. The resident stated that they had EX. Order 26.(4) B1 related to a EX. Order 26.(4) B1 which EX. Order 26.(4) B1 Resident #223 held up his/her EX. Order 26.(4) B1	F 677	I. Corrective action(s) accomplished for resident(s) affected: Resident #223 remains in the facility for long-term care placement. Resident # 223 received EX. Ord care immediately. Resident #223's nails were EX. Order 26.(4) B1 to the resident's preference. EX. Order 26.(4 care was also provided to the resident's preference. The resident's care plan for impaired functional status was updated to include providing EX. Order 26.(4) B1 care and EX. Order 26.(4 care. These tasks were added to the Certified Nurse Aide Kardex. The Social Worker met with this resident on 05/01/2023 to provide comfort and reassurance. This resident did not verbalize any concerns with showering, EX. Order 26.(4) B1 care during their visit.	5/23/23

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F 677	Continued From page 34 and demonstrated an EX. Order 26.(4) B1 The surveyor observed that the resident's EX. Order 26.(4) B1 were long. The resident stated the staff did not offer to EX. Order 26.(4) B1 his/her EX. Order 26.(4) B1 and the resident had tried to EX. Ord them by himself/herself. The surveyor reviewed the medical record for Resident #223. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility in EX. Order 26.(4) B1 with diagnoses which included EX. Order 26.(4) B1 ; acquired absence of EX. Order 26.(4) B1]; and EX. Order 26.(4) B1 A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated EX. Order 26.(indicated the resident had a brief interview for mental status (BIMS) score of EX. Order 26.(4) B1 which a EX. Order 26.(4) B1 . Further review of the MDS revealed that the resident required extensive assistance of one-person for personal hygiene. A review of the comprehensive care plan included a focus area for EX. Order 26.(4) B1 status related to decline in EX. Order 26.(4) B1 status post recent hospitalization status EX. Order 26.(4) B1 . The resident's care plan did not include personal hygiene or EX. Order care. A review of Certified Nurse Aide (CNA) ADL tracker, a communication tool used by CNAs with specific resident care needs and preferences, reflected the CNA's documentation from 4/1/23 to	F 677	Resident #285 received EX. Order care immediately. Resident #285 was discharged to home on 0 EX. Order 26.(4) B1 as planned. II. Residents identified having the potential to be affected and corrective action taken: All residents had the potential to be affected by this practice. An audit was conducted on residents requiring EX. Order 26.(care and found no other residents affected by this practice. All residents had the potential to be affected. An audit was conducted on residents requiring EX. Order 26.(4) B1 and found no other residents affected by this practice. III. Measures will be put into place to ensure the deficient practice will not recur: The care plan template for impaired functional status was updated to include EX. Order 26.(4) B1 and EX. Order 26.(care. Both interventions have been added to the Certified Nurse Assistant Kardex. The Residents Hygiene policy was reviewed and updated by facility Administration on 05/02/2023. The facility Care Plan policy that was updated January 2023 was reviewed by Administration with no new updates required. Certified Nurse Aide #1 and Certified Nurse Aide #2 were re-educated by the facility educator/designee on the process for notifying the nurse when residents refuse showers. The aides were provided re-education by facility educator/designee on providing finger nail and mouth care to residents requiring extensive assistance	

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F 677	Continued From page 35 EX. Order 26.(4) reflected the resident only refused personal hygiene care on EX. Order 26.(4). The CNA ADL tracker did not include EX. care. On 4/11/23 at 10:29 AM, the surveyor observed Resident #223 lying in bed awake watching television. The resident's EX. Order 26 were observed with a buildup of a EX. Order 26.(4) B1. Resident #223 stated that he/she had not had a toothbrush since being moved to the unit, and it bothered him/her to not have EX. Order brush. The resident's EX. Order 26.(4) B1 remained long and were not trimmed. The resident stated his/her EX. Order 26.(4) B1 was weak, but he/she was going to peel his/her nails off. The resident stated that morning care was completed already. On 4/12/23 at 11:45 AM, the surveyor observed the resident and the resident's EX. Order 26.(4) B1 remained long and had not been EX. Order 26.(4) B. The resident stated his/her EX. Order had not been brushed. On 4/13/23 at 11:41 AM, the surveyor observed that the resident's EX. Order 26.(4) B1 had not been EX. Order 26.(4). The resident stated his/her EX. Order had not been brushed. On 4/13/23 at 11:46 AM, the surveyor interviewed CNA #1 who stated Resident #223 required complete care. CNA #1 stated that the care she provided to the resident included a complete bed bath, brief change, and linen change. The surveyor asked about the resident's EX. Order 26.(4) B1 and CNA #1 replied that the resident refused EX. Order 26.(4) B1. The surveyor asked CNA #1 to show the surveyor where the resident's EX. Order 26.(4) B1 was kept. CNA #1 responded, "they may have thrown it away." She then proceeded to open the drawer	F 677	for these tasks. EX. Order 26. care is to be provided twice daily and as needed while EX. Order 26.(4) B1 care should be provided weekly and as needed. Licensed Practical Nurse #1 was re-educated by facility educator/designee on the updated process for documenting resident refusals of showers. The nurse was re-educated by facility educator/designee on the expectation of the aides providing EX. Order and EX. Order 26.(4) care and to monitor for completion of these tasks during medication pass and rounding to assure compliance. The Licensed and Certified Nursing staff were educated by facility educator/designee on the updates to the resident care plan and Kardex to include EX. Order 26 care and EX. Order 26.(4) B1 care. Staff were re-educated by facility educator/designee on the expectation of providing EX. Order 26. care and EX. Order 26.(4) B1 care to residents requiring extensive assistance and as requested for these tasks. Licensed and Certified Nursing staff were educated by facility educator/designee on the process to follow when a resident refuses to be showered following the updated Resident Hygiene policy and procedure. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The Director of Quality Assurance Performance Improvement (QAPI)/designee will conduct one audit per week for four weeks, then monthly audits for five months on EX. Order and EX. Order 26.	

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	315159	A. BUILDING ______ B. WING ______	C 04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	**425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012**

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and noted the [EX. Order 26.(4) B1] was not in the resident's basin. CNA #1 then found an opened multiple package container that contained one [EX. Order 26.(4) B1] and stated she did not see it that morning. The surveyor asked CNA #1 if she noted the length of the resident [EX. Order] to which CNA #1 replied, "No, I did not". CNA #1 stated she would have reported it to the nurse and received permission to [EX. O] them if she did.

On 4/13/23 at 11:55 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who was assigned to Resident #223. He stated that the resident was totally dependent for ADLs. The surveyor accompanied the LPN to observe the resident's [EX. Order 26.(4) B1]. The LPN stated that the resident's [EX. Order] were uneven, the [EX. Order 26.(4) B1] were longer on the [EX. Order 26.(4) B1] than on the [EX. Ord]. The LPN agreed that the residents' [EX. Order] needed to be [EX. Order 26.(4) B1] The LPN stated he did not observe the resident's need for [EX. Or] care or [EX. Ord] care when medications were administered.

On 4/13/23 at 12:10 PM, the surveyor interviewed the Unit Manager/LPN (UM/LPN) who stated that [EX. Ord] care should be done twice daily and [EX. Ord] care should have been assessed daily to see if the [EX. Order 26.(4) B1] needed to be [EX. Order 26.(4) B]. The UM/LPN stated that at approximately 10:00 AM, she directed an extra nurse on the unit to assist with [EX. Ord] care. The UM/LPN stated she noticed that the [EX. Order 26.(4) B1] of Resident #223 were a little long that morning, and she did not believe that CNAs documented [EX. Ord] care. The UM/LPN acknowledged it was concern and that she would have an aide complete the resident's [EX. Order 26.(4) B1] care.

On 4/13/23 at 12:44 PM, surveyor interviewed

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care for residents requiring extensive assistance with these tasks. Results of these audits will be reviewed by the Director of Nursing for analysis, tracking, and trending. Any corrective actions required as a result of these audits will be addressed by the Director of QAPI with the Unit Manager.

The Director of Quality Assurance Performance Improvement (QAPI)/designee will conduct one audit per week for four weeks then monthly audits for five months on residents who refuse showers. Results of these audits will be reviewed by the Director of Nursing for analysis, tracking, and trending. Any corrective actions required as a result of these audits will be addressed by the Director of QAPI with the Unit Manager.

The Director of Nursing will report the results of the [EX. Ord] and [EX. Order 26.(] care audits to the Quality Assessment and Assurance (QAA) Committee for the next two quarters. The QAA Committee will determine the need for any additional monitoring of [EX. Order 26.(4) B1] care after the 2nd quarterly meeting.

The Director of Nursing will report the results of the shower refusal audits to the Quality Assessment and Assurance (QAA) Committee for the next two quarters. The QAA Committee will determine the need for any additional monitoring of shower refusals after the 2nd quarterly meeting.

V. Date of Compliance: 05/23/23

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LPN #2 who stated that she was asked to EX. Order the EXX. Order 26.(4) B1 of Resident #223 and she had EX. O t them. LPN #2 stated the EX. Order 2 on the resident's EX. Order 26.(4) B1 were longer than the EX. Or because the resident stated that he/she EX. Order 26.(4) B1, and that some of the resident's EXX. Order 26.(4) B1 looked like the resident had EX. Order 26. them off. LPN #2 also stated that the resident was eating their meal and did not want EX. Order 26. care at that time.

On 4/17/23 at 1:06 PM, the surveyor interviewed the Director of Nursing (DON) who stated that staff assisted with resident ADLs based on care needs. The DON stated that both EX. Order 26.(4) B1 care should be offered daily as "CNAs were taught this and know what was expected as a caregiver."

On 4/19/23 at 9:48 AM, the surveyor asked the DON what the process was when a resident refused care. The DON stated that when a resident refused, the CNA should tell the nurse and the nurse should document the refusal.

2. On 4/5/23 at 10:50 AM, the surveyor observed Resident #285 in his/her room awake in bed. The surveyor asked Resident #285 about the care he/she received with their ADLs. Resident #285 stated that they were offered showers, but preferred bed baths so staff assisted him/her with bed baths. Resident #285 stated that he/she wanted their EX. Order 26.(4) B1 cleaned, but staff never offered or provided EX. Order care. The resident stated, "I don't know how they got so dirty."

On 4/11/23 at 10:25 AM, the surveyor observed Resident #285 in bed. The surveyor observed the resident's EX. Order 26.(4) B1 were EX. Order 26.(4) B1, and

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F 677	Continued From page 38 EX. Order d with EX. Order 26.(4) B1 caked under all EX. O EX. Order 26.(4) B1. The resident stated they were never given EX. Or care. The surveyor reviewed the medical record for Resident #285. A review of the Admission Record face sheet reflected the resident was admitted to the facility in EX. Order 26.(4) B 023 with diagnoses which included EX. Or EX. Order 26.(4) B1 EX. Order 26.(4) B1 and c EX. Order 26.(4) B1 A review of the admission MDS dated EX. Order 26.(4) B reflected the resident had a BIMS score of EX. O out of EX. Ord which indicated EX. Order 26.(4) B1. A further review in "Section EX Functional Status" reflected that the resident required one-person extensive physical assistance for personal hygiene. A review of the comprehensive care plan initiated on EX. Order 26.(4), included that the resident had EX. Order 26.(4) B1 status with regards to a decline in EX. Order 26.(4) B and EX. Order 26.(4) B1 due to EX. Order 26.(4) B1. Interventions included to assist with ambulation and bed mobility, and to encourage participation in ADLs as tolerated to increase independence. The comprehensive care plan did not include nail care or hygiene. A review of the resident's electronic CNA ADL tracker reflected the CNAs documented they provided a bath/shower or sponge bath for Resident #285 daily from 4/2/23 to 4/10/23. The document revealed that the resident refused their bath/shower/sponge bath one time on 4/3/23, during that time period. The ADL tracker did not include EX. Order care.	F 677		

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F 677	Continued From page 39 On 4/11/23 at 11:25 AM, the surveyor interviewed the Unit Manager/Registered Nurse (UM/RN) who stated that CNAs and nurses provide EX. Order care to residents when needed. The UM/RN further stated the CNAs should check the residents' EX. Order 26.(4) B1 daily. The surveyor asked the UM/RN to observe Resident #285's EX. Order 26.(4) B1 and the UM/RN acknowledged that the resident's EX. Order 26.(4) B1 were EX. Order and EX. Order 26.(with EX. OrOrde EX. Order 26.(4) B1 under al EX. Order 26.(4) B1. On 4/11/23 at 11:35 AM, the surveyor interviewed the CNA #2, the resident's aide, who stated that she had never assisted Resident #285 with their EX. Order 26.(4 e because she had not noticed before this time how EX. Or y his/her EX. Order 26.(4) B1 were. CNA #2 stated that Resident #285 usually refused their shower, but she never informed the UM/RN or any nurse when the resident refused his/her shower. At that time, the UM/RN asked Resident #285 if she could EX. Order 26.(4) B1, and EX. Order 26.(4) B1 nails. Resident #285 replied, "as long as you don't EX. Ord me, EX. Order 26.(4) B1 The surveyor observed the UM/RN cleaned the resident's EX. Order 2 with the resident's permission. On 4/11/23 at 12:05 PM, the surveyor interviewed the DON who stated it was the CNA's responsibility for providing EX. Orde care and all other ADL care and that if the resident refused any care, the CNA was responsible for informing the nurse and the nurse documented the refusal in their nursing progress note. On 4/12/23 at 12:25 PM, the surveyor interviewed Resident #285, who showed the surveyor his/her EX. Order 26.(4) B1 and stated that the nurse had cleaned	F 677		

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F 677	Continued From page 40 and [EX. Order 26.4] them. The resident smiled and stated, "my [EX. Order 2] are much better." On 4/18/23 at 1:32 PM, the surveyor informed the LNHA and DON the above observations and concerns. A review of the facility's "Nursing Assistant Skills Review Checklist" dated March 2023 included ADLs Care of Resident... nail care (no toenail clipping only clipping of fingernails.)...mouth Care... A review of the facility's "Residents Hygiene" policy dated revised October 2022 included residents will be offered shower/bath at least twice weekly... upon refusal of shower/bath from the resident, CNA will notify the nurse... NJ 8:39-27.1(a)	F 677		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: NJ Complaint #159807 Based on interviews, review of closed medical	F 684	I. Corrective action(s) accomplished for resident(s)affected:	5/23/23

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F 684	Continued From page 41 records, and review of pertinent facility documents, it was determined that the facility failed to ensure appropriate care was provided with no delay in treatment for a resident with an EX. Order 26.(4) B1 who had a change in condition with EX. Order 26.(4) B1 tress on EX. Order 26.(4) B1 received a EX. Order 26.(4) B1 on EX. Order 26.(4) B1 and was hospitalized via emergency services prior to EX. Order 26.(4) B1 results. This deficient practice was identified for 1 of 45 residents (Resident #439) reviewed for quality of care, and was evidenced by the following: On 4/6/23 at 8:52 AM, the surveyor reviewed the closed medical records for Resident #439. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in EX. Order 26.(4) B1 with diagnoses which included EX. Order 26.(4) B1). A review of the admission Minimum Data Set (MDS), an assessment tool dated EX. C Order 26.(4) reflected the resident had a brief interview for mental status (BIMS) score of EX. Order 26.(4) B1, which indicated an intact cognition. A further review in "Section EX Function Status" revealed the resident required extensive assist of one person for bed mobility, transfer between surfaces, toilet use, personal hygiene and dressing. Further review revealed in "Section EX Health Conditions"	F 684	Resident #439 was discharged to the hospital on EX. Order 26.(4) B1 and admitted to the hospital the same day. II. Residents identified having the potential to be affected and corrective action taken: All residents have the potential to be affected by this deficient practice. III. Measures will be put into place to ensure the deficient practice will not recur: The Physician Order policy was reviewed by the Administrator, Director of Nursing, and Director of Quality Assurance Performance Improvement and determined no updates were required to this policy. The Physician Notification policy was reviewed by the Administrator, Director of Nursing, and Director of Quality Assurance Performance Improvement and determined no updates were required to this policy. Registered Nurse #1 was re-educated by the facility Educator on documenting physician orders under the physician who the order was obtained. Registered Nurse #1 was re-educated by the Facility Educator on obtaining physician as needed (prn) orders for treatments done outside of scheduled times and to relay changes in condition with EX. Order 26.(4) B1 EX. Order 26.(4) to the physician. All Licensed Nursing staff were re-educated by the Facility Educator on documenting physician orders under the appropriate physician prescribing the order in the electronic health record. All Licensed Nursing staff were	

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F 684	Continued From page 42 EX. Order 26.(4) B1 and when EX. Order EX. Ord Review of "Section EX. O Special Treatment, Procedures and Programs" revealed EX. Order 26.(4) therapy while at the facility. A review of the Progress Notes reflected the following notes: An Admission Summary dated EX. Order 26. at 11:30 PM, included the resident was EX. Order 26.(4) B1 and able to make their needs known. The resident had EX. Order 26.(4) B1 EX. Order 26.(4) B1. The resident had an EX. Order 26.(4) B1 EX. Order 26.(4) B1, to the EX. Order 26.(4) B1 area that was used to EX. Order 26.(4) B1 (a EX. Order 26.(4) B1 An Admission History and Physical dated EX. Order 26.(4) at 8:00 PM, written by Physician #1, included the resident had a EX. Order 26.(4) B1 that was inserted on EX. Order 26.(4) B1, due to resident's recurrent EX. Order 26.(4) B1 (a EX. Order 26.(4) B1 EX. Order 26.(4) B1 was to be EX. Order 26.(4) on EX. Order 26.(4) B1 A Nurses Note dated EX. Order 26. at 1:51 PM, EX. Order 26.(4) B1 was EX. Order 26.(4) B1 milliliters (mL) and that vital signs were stable. A Nurses Note dated EX. Order 26. at 10:24 AM, included the EX. Order 26.(4) B1 was EX. Order 26.(4) B1 mL EX. Order 26.(4) The site had no signs of infection and the dressing, EX. Order 26.(4) B1 on the EX. Order were changed. A Nurses Note dated EX. Order 26.(4) at 11:27 AM, included the EX. Order 26.(4) B1 was EX. Order 26.(4) B for a total of	F 684	re-educated by the Facility Educator on the care and maintenance of EX. Order 26.(4) B1 and reporting changes in condition of these residents with EX. Order 26.(4) B1 to the physician. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The Director of Quality Assurance Performance Improvement (QAPI)/designee will conduct one audit per week for four weeks and then monthly audits for five months on EX. Order 26.(4) B1 orders to ensure that orders are appropriately carried out The Director of Quality Assurance Performance Improvement/designee will report audit findings to the Director of Nursing for analysis, tracking, and trending. Any corrective actions required as a result of this audit will be addressed by the Director of QAPI with the nurse and Unit Manager. The Director of Quality Assurance Performance Improvement (QAPI)/designee will conduct one audit per week for four weeks and then monthly audits for five months of resident□s charts who have EX. Order 26.(4) B1 o ensure the care and maintenance of the EX. Order 26.(4) B is appropriate to monitor for quality of care. The Director of Quality Assurance Performance Improvement/designee will report audit findings to the Director of Nursing for analysis, tracking, and trending. Any corrective actions required as a result of this audit will be addressed by the Director of QAPI with the nurse and Unit Manager.	

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F 684	Continued From page 43 EX. Order mL, and there was EX. Order 26.(4) B1 and was cleansed and redressed. A Nurses Note dated EX. Order 26.(4) B1 at 12:26 PM, included the resident's EX. Order 26.(4) B1 the sight was clean and dry with EX. Order 26.(4) B1 EX. Order 26.(4) B1 area and the total EX. Order 26.(4) B1 mL. A Nurses Note written by Registered Nurse (RN #1) dated EX. Order 26.(4) B1 at 12:11 PM, included the nurse was informed by the family member that the resident had EX. Order 26.(4) B1 issues. The assessment revealed the nurse heard EX. Order 26.(4) B1 that was heard in the EX. Order EX. Order The pulse oxygenation (a method to monitor blood oxygen saturation) was EX. Order with the use of EX. Order 26.(4) B1 n received EX. Order 26.(4) B1 EX. Order 26.(4) The resident was having EX. Order 26.(4) B1 difficulty and the EX. Order 26.(4) B1 was drained of EX. Order mL of EX. Order 26.(4) B1 at that time. The resident's [Physician #1] was called and the nurse was awaiting a call back. A Nurses Note written by RN #1 dated EX. Order 26.(4) B1 at 10:00 PM, included a EX. Order 26.(4) B1 was ordered by Physician # 1. A Nurses Note written by the 3-11 Nursing Supervisor/RN dated EX. Order 26.(4) B1 at 7:20 PM, included the resident's EX. Order 26.(4) B1 dressing was soiled with EX. Order 26.(4) B1. The EX. Order 26.(4) B1 was EX. Order 26.(4), and the dressing was replaced with family at bedside. A Nurses Note written by RN # 2 dated EX. Order 26.(4) B1 at 1:03 PM, included that the resident had	F 684	The Director of Nursing will report the findings of the EX. Order 26.(4) B1 audits to the Quality Assessment and Assurance (QAA) Committee for the next two quarters. The QAA Committee will determine the need for any additional monitoring of chest EX. Order 26 orders after the 2nd quarterly meeting. The Director of Nursing will report the findings of chart reviews for residents with EX. Order 26.(4) B1 to the Quality Assessment and Assurance (QAA) Committee for the next two quarters. The QAA Committee will determine the need for any additional monitoring of residents with EX. Order 26.(4) B1 after the 2nd quarterly meeting. V. Date of Compliance: 5/23/2023	

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F 684	Continued From page 44 EX. Order 26.(4) B1 with a pulse oxygenation level of EX. Order 26.(4) B1 with a EX. Order 26.(4) B1. The EX. Order 26.(4) B1 was replaced with a EX. Order 26.(4) B1 at EX. Order 26.(4) B1. The physician was notified, and the resident was sent to the hospital via emergency response at 11:37 AM. A Nurses Note written by the 3-11 Nursing Supervisor/RN dated EX. Order 26.(4) B1 5:24 PM, included the resident was admitted to the hospital with diagnosis of EX. Order 26.(4) B1 A review of the EX. Order 26.(4) B1 Medication Review Report revealed a verbal physician's order (PO) for a EX. Order 26.(4) B1 to rule out EX. Order 26.(4) B1 one time only for one day dated EX. Order 26.(4) B1. A review of the EX. Order 26.(4) B1 Result Report with an examination date of EX. Order 26.(4) B1, for an EX. Order 26 of the EX. Order 26 revealed a EX. Order 26.(4) B1 and EX. Order 26.(4) B1) and EX. Order 26.(4) B1. Further review of the EX. Order 26.(4) B1 Medication Review Report included a PO dated EX. Order 26.(4) with a start date of EX. Order 26.(4) B1 mL to the EX. Order 26.(4) B1; and EX. Order 26.(4 call physician for EX. Order 26.(4) B1 rainage or EX. Order 26.(4) B1 of more than EX. Order 2 mL. A review of the corresponding EX. Order 26.(4) B1 Treatment Administration Record (TAR) revealed the nurses signed the EX. Order 26.(4) B1 was drained of EX. Orde mL on EX. Order 26.(4) B1 EX. Order 26 2 EX. Order 26.(4) B1	F 684		

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F 684	Continued From page 45 EX. Order 26.(4) , and EX. Order 26.(4) B1). A review of the comprehensive care plan included a focus area initiated on EX. Order 26.(4) B1 for a potential for complications related to the use of EX. Order 26.(4) B1 system due to status post EX. Order 26.(4) B1 and a diagnosis of EX. Order 26.(4) B1. Interventions included to assess EX. Order 26.(4) B1 every shift and monitor for EX. Order 26.(4) B1 during dressing changes and when EX. Order 26.(4) B; monitor site for signs and symptoms of infection and report abnormalities for prompt intervention; EX. Order using EX. Order 26.(4) B1 as ordered limi EX. Order 26.(4) B1 as ordered by physician to prevent re-expansion EX. Order 26.(4) B1 and monitor for respiratory changes in overall condition EX. Order 26.(4) B1, change in EX. Order 26.(4) B1 change in EX. Order 26.(4) B1 atus notify physician for instructions. On 4/6/23 at 10:17 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who confirmed she was one the nurses who cared for Resident #439. The LPN stated that she remembered the resident had a EX. Order 26.(4) B1 and when she administered the resident's medication, she checked vital signs and checked the dressing for EX. Order 26.(4) B; if the dressing was EX. Order she notified the Unit Manger/Registered Nurse (UM/RN). The LPN continued on that weekend she recalled the EX. Order 26.(4) B1 t was EX. Orde and she called the 3-11 Nursing Supervisor/RN. The 3-11 Nursing Supervisor/RN reapplied the dressing, and she could not recall the color of the EX. Order 26.(4) B1 on the dressing. On 4/6/23 at 10:54 AM, the surveyor interviewed RN #2, who stated she remembered Resident #439, and she had changed the EX. Order 26.(4) B1 and	F 684		

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F 684	Continued From page 46 EX. Order 26.(4) B1. She stated that on EX. Order 26.(4) at 1:13 PM, she sent the resident to the hospital. On 4/6/23 at 11:21 AM, the surveyor interviewed via telephone the 3-11 Nursing Supervisor/RN who stated on the evening of EX. Order 26.(4) B1, the resident's EX. Order 26.(4) B1 , and the family was at the bedside. She continued that she removed the dressing, and the area was "fine" and EX. Order 26.(4) B1. She stated the EX. Order 26.(4) B1 was not "EX. Order 26.(4)" and if it was leaking at the site, she would have sent EX. Ord to the hospital via emergency services. She stated the EX. Ord) was off the EX. Order and she put a new one on. On 4/6/23 at 11:21 AM, the surveyor reviewed a grievance form dated EX. Order 26.(4) B1, which included the [Resident Representative] had concerns and reported that the past weekend the [EX. Order 26.(4) B1] was EX. Order 26.(4) and the nurse used the [internet to search EX. Order 26.(4) B1 e]. The [Resident Representative] stated a EX. Order 26.(4) B1 was ordered on EX. Order 26.(4) B1 and was not done until EX. Order 26.(4). The grievance was written up by the Director of Nursing (DON). On 4/11/23 at 9:31 AM, the surveyor interviewed the DON who stated the facility had a contract with a EX. Order 26.(4) B1 and the resident's EX. Order 2 EX. Order was not ordered stat (immediately without delay), so it was completed on the next business day which was EX. Order 26.(4). On 4/12/23 at 9:15 AM, the surveyor interviewed via telephone Physician #1 who stated that she was the resident's primary physician, and the resident had a EX. Order 26.(4) B1 that the nurses EX. Order 26.(4) B	F 684		

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F 684	Continued From page 47 Physician #1 stated she was away from the facility from EX. Order 26.(4) B1 EX. Order 26.(4) B1 and she was not sure how the resident was. She continued that the Medical Director was on-call while she was away. Physician #1 stated if she was called for the resident's change in condition, she would have ordered the EX. Order 26.(4) B1 to have been completed stat. On 4/17/23 at 9:45 AM, the surveyor interviewed the DON who stated the RN #1 who received the EX. Order 26.(4) B1 order could not recall the physician that she spoke to and received the order from. The DON further stated that the Medical Director was on call for Physician #1. On 4/17/23 at 9:50 AM, the surveyor interviewed the Quality Assurance Director (QAD) who stated the nurse who took the order could not recall who the ordering physician she spoke to was. She documented Physician #1, but had not spoken to them. She also stated when she put the order in the electronic Medical Record (EMR), the primary physician's name automatically populated so that was why Physician # 1's name was associated with the order. The QAD further stated that the Medical Director was not on-call that weekend and she did not know who the on-call physician was. The QAD continued that Physician #1 filed a grievance that her name was on an order she did not give. On 4/17/23 at 10:58 AM, the surveyor via telephone interviewed RN #1 who stated that she was the nurse who received the EX. Order 26.(4) B1 order, and she was unable to recall which physician she spoke to. RN#1 stated the resident had a change in condition, and she remembered that the EX. Order 26.(4) B1 needed to be done	F 684		

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immediately. She stated that when documenting a physician's order in the EMR, the orders automatically populated with a drop-down box that indicated prn (as needed) or one time order. RN #1 stated the nurses coming on for the next shift assisted her with the physician's order because the facility's staff had access to the [EX. Order 26] company, and Agency nurses (like herself) did not have a pin number to order the [EX. Order 26].

On 4/17/23 at 11:59 AM, the surveyor via telephone interviewed the Medical Director who stated that the resident's primary physician (Physician #1) asked her to cover her residents while she was away from facility. The Medical Director stated that she was not on-call that weekend, but her Physician Service was covering, and she pulled the phone records and there was no documented call to the Physician Service about Resident #439. The Medical Director continued that she could only give her medical opinion, but if she were ordering a [EX. Order 26] [EX. Order 26] for the resident with a change in condition, she would have ordered the [EX. Order 26.(EX. Order 26.(4)] because she ordered all [EX. Order 26] stat to be done right away.

On 4/17/23 at 12:36 PM, the surveyor via telephone interviewed RN #3 who stated she thought she was the oncoming nurse for the resident on 1[EX. Order 26.(4)] and it was change of shift. RN #3 stated that typically the Agency nurses put the physician's orders into the EMR, and the facility nurses would order [EX. Order 26] so they would be done.

On 4/17/23 at 1:31 PM, the surveyor interviewed the DON who stated that Agency staff and the facility staff have the same access when putting

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in physician's orders into the EMR and laboratory access. The DON continued that there was no reason for Agency staff to think that they do not have access, and that physician's orders could not be ordered stat in the EMR.

On 4/17/23 at 2:30 PM, the surveyor interviewed the DON who stated that when she completed the grievance for the resident, the nurse who received the order for a EX. Order 26.(4) B1 did not order the EX. Order 26.(4) B1 The DON continued she would try to find out who the ordering physician was. The DON stated that it would be up to the physician as to when a EX. Order 26.(4) B1 would be ordered for a resident in EX. Order 26.(4) B1

On 4/18/23 at 10:33 AM, the surveyor re-interviewed via telephone RN#1 who stated she spoke to a physician, but did not recall who she spoke with, and she drained the resident's EX. Order 26.(4) B1 The surveyor asked if she received a physician's order to drain the EX. Order 26.(4) B1 because it was a S EX. Order 26.(4) B and the order was for EX. Order 26.(4) B1 EX. Order 26.(4) B1 RN #1 stated she could not recall, but to read her note.
.
On 4/18/23 at 1:32 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA) and the DON of the concerns.

On 4/19/23 at 9:47 AM, the DON in the presence of the LNHA and the survey team stated that Physician #1 was away from the facility at the time, and Physician #2 was covering her residents. The DON confirmed the resident's EX. Order 26.(4) B1 was EX. Order 26.(4) B on EX. Order 26.(4) without a physician's order because the resident was in EX. Order 26.(4) B The DON stated typically the nurse needed a physician's order, but if you read the

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F 684	Continued From page 50 documentation, the resident was in EX. Order 26.(4) B1 with lower EX. Order 26.(4) B1 n with EX. Order 26.(4) B1. The DON continued the next shift administered a EX. Order 26.(4) B1 and the pulse oxygenation level increased. The DON stated the resident expired at some point in the hospital. The DON confirmed Physician #2 had not spoken to RN#1, and the facility had no record of who or if RN #1 spoke to for a physician's order for a EX. Order 26.(4) B1 A review of the facility's "Physician Order policy" dated updated December 2022, included licensed nurses will administer medication and treatments as ordered by the physician...the licensed nurse will write the order in the [electronic medical record] as prescribed by the medical professional and follow up to ensure timely completion... A review of the facility's "Physician notification policy" dated revised January 2023, included nurses should not hesitate to contact the attending physician at any time for a problem and changes in resident status are reported promptly and accurately to the physician to address any concerns. Including Laboratory results normal or abnormal which the physician requests on a "stat" or "same day" basis... NJAC 8:39-27.1(a)	F 684		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and	F 692		5/23/23

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F 692	Continued From page 51 enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure resident's weights obtained were accurate after significant weight changes. This deficient practice was identified for 1 of 4 residents (Resident #47) reviewed for nutrition and the evidence was as follows: On 4/3/23 at 11:20 AM, the surveyor observed Resident #47 sitting in wheelchair in the unit's dayroom. Resident #47 was [EX. Order 26] and dressed in well-fitted clothes. On 4/6/23 9:45 AM, the surveyor observed Resident #47 sitting at table in dayroom eating their breakfast independently. The resident consumed approximately 75% of their meal. The surveyor reviewed the medical record for Resident #47.	F 692	I. Corrective action(s) accomplished for resident(s)affected: Resident #47 remains in the facility for long-term care placement. All scales were re calibrated by the maintenance department. The resident was reweighed by using two methods. First, the resident was weighed while sitting in [EX. Or] wheelchair with the weight of the wheelchair subtracted. The weight was 1[EX. Order]. Then the resident was assisted to stand on the scale and the weight was [EX. O]. The resident remains on therapeutic shakes twice daily and consumes 75-100% of meals/snacks. Weekly weights continue and are monitored by the Registered Dietitian. The resident□s care plan was reviewed and remains current. The resident□s skin remains intact. Labs were drawn on 04/24/2023 with no new	

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A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses that included EX. Order 26.(4) B1, and EX. Order 26.(4) B1.

A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated EX. Order 26.(4), reflected that the resident had a brief interview for mental status (BIMS) score of EX out of 1EX; which indicated a EX. Order 26.(4) B1 EX. Order 26.(4) B1 A further review of the MDS assessment reflected the resident had no significant EX. Order 26.(4) B1 or EX. Order in the past one, three, or six months.

A review of the resident's weights were as followed:

9/9/2022 EX. Order pounds (lb.)
10/10/2022 EX. Order lb.
11/14/2022 1EX. Order lb.
12/15/2022 EX. Order lb.
1/17/2023 EX. Order 2 lb.
2/9/2023 EX. OrOrder lb.
3/21/2023 EX. O. Order lb.

This reflected a EX. Order 2 lb. or a EX. Order 26.(4) significant EX. Order 26.(4) B1 in one month; a EX. Order 2 lb. or EX. Order significant EX. Order 26.(4) B1 in three months; a EX. Order lb. or EX. Order 26.(significant EX. Order 26.(4) B1 in six months; and a EXEX. Order lb. or a EX. Order 26.(4) significant EX. Order 26.(4) B1 in one month.

A review of the Quarterly Nutritional Assessment by the Director of Clinical Nutrition Services (DCNS) dated EX. Order 26.(4), the DCNS indicated that the resident's appetite and intake were good and

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orders recommended.
II. Residents identified having the potential to be affected and corrective action taken:
All residents have the potential to be affected by this deficient practice.
Re-weights were complete for the month of EX. Order 26.(4) B1 without any other residents noted to be affected by this practice. All residents were evaluated to determine the proper scale and method needed to obtain the weight. The scale to be utilized for each individual resident will be documented on the unit weight log. This will instruct the staff to utilize the correct method to obtain the weight. The method will also be documented in the electronic health record.

III. Measures will be put into place to ensure the deficient practice will not recur:
All residents were re-evaluated to assure the type of scale and way in which the resident is weighed is appropriate to obtain monthly weights.
A new scale has been ordered for one of the units to prevent sharing of scales.
Scales have been anchored on the units to prevent moving of scales to reduce calibration issues.
All facility scales have been calibrated by the maintenance department to assure there are no issues with calibration.
Scales are calibrated monthly by the maintenance department.
The Weight Policy has been reviewed by the Director of Nursing, Director of Quality Assurance Performance Improvement, and the Registered Dietitian. No new

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F 692	Continued From page 53 physically the resident had appeared to maintain the same weight. The DCNS also documented "Question accuracy of August and November weights" and that the resident was "Currently on weekly weights." A review of the comprehensive care plan included a focus area dated EX. Order 26.(and last revised EX. Order 26.(4 that the resident was a EX. Order 26.(4) B1 , diagnoses of EX. Order 26.(4) B1 ." Intervention included to monitor weekly weights times four weeks, then continue monthly; and weekly as needed weights. On 4/6/23 at 12:07 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) about obtaining residents' weights. The LPN stated the Certified Nurse Aides (CNAs) received a report in the morning who needed to be weighed, and the CNA weighed that resident, and the weights were faxed or emailed to DCNS who reviewed the weights and entered the weights in the electronic Medical Record (EMR). The LPN stated if there were significant weight changes, the DCNS asked the staff to re-weigh the resident. On 4/17/23 at 11:39 AM, the surveyor interviewed the DCNS who was resident's Registered Dietitian. The DCNS stated if there was a significant weight change of plus or minus five pounds, the resident would be re-weighed immediately to confirm the weight obtained. Weights were entered in the EMR and the "Meal Tracker" (a nutrition management software). The surveyor reviewed the resident's weights with the DCNS, and questioned the varying weights	F 692	updates to the policy were required. The Dietitian was re-educated by the Director of QAPI that weights must addressed factoring in the documented weight obtained, not just clinical judgement of the resident□s status, physical appearance, and eating habits. A new process has been implemented for the monthly May weights which will continue for three months then be re-evaluated. The Dietitians will weigh each resident with staff to assure accurate weights are obtained by the 8th of the month. Re-weights will be done by the 10th of the month. Residents have been grouped together per unit based on the type of scale/way they are weighed (i.e., wheelchair, standing, lift) to streamline the process for weighing residents. Licensed and Certified Nursing staff have been re-educated by the facility educator/designee on the facility Weight Policy and the new process of weighing residents with the dietitians based on the resident grouping and method for weighing. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The Dietitian/designee will conduct one audit per week for twelve weeks on accuracy of resident weights. Any fluctuations will be addressed by the Dietitians with the Unit Managers for follow-up interventions and care plan updating. The Director of Quality Assurance Performance Improvement	

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F 692	Continued From page 54 documented in the resident's medical record. The DCNS stated the weight of EX. Order lb. in EX. Order 26.(4) B1 EX. Order 26 and EXEX. Order lb. in EX. Order 26.(4) B1 were likely errors. The DCNS stated re-weighs would be done immediately, and if the results were the same, her clinical judgement of the resident's status, including eating habits and their physical appearance were considered, to determine if it was an error. The DCNS stated weekly weights were done for an identified EX. Order 26.(4) B1 and she documented in her notes. The surveyor then asked the DCNS about the response to the identified weight errors, and she stated it was a scale versus human error. It would be reported to Maintenance to check for any issues with the scale. There were monthly weight meetings held with unit managers, nursing management, and interdisciplinary staff to discuss significant weight changes. The DCNS was asked about the errors in weights that have occurred and replied that she believed the weight errors had improved. The surveyor asked about the weekly weights for Resident #47. The DCNS stated weekly weights were entered in the "Meal Tracker" and would not be found in the resident's EMR. The DCNS provided a print-out copy for the surveyor of all the resident's weights recorded. The surveyor reviewed the "Meal Tracker" provided by the DCNS, which revealed the following additional weights were obtained: 12/22/22 EXEX. Or lb. 12/28/22 EX. Order lb. 2/21/23 EX. Order 2 lb. 3/20/23 EX. Order 26 lb. There was no evidence that re-weights were completed for a five-pound weight loss or gain. It	F 692	(QAPI)/designee will conduct one audit per week for four weeks then monthly audits for five months on the accuracy of monthly weights and to assure any fluctuations are addressed by nursing and the Dietitian. Results of these audits will be reviewed by the Director of Nursing for analysis, tracking, and trending. Any corrective actions required as a result of these audits will be addressed by the Director of QAPI with the Unit Manager and Dietitian. The Director of Quality Assurance will report the results of the weight audits to the Quality Assessment and Assurance (QAA) Committee for the next two quarters. The QAA Committee will determine the need for any additional monitoring monthly weights after the 2nd quarterly meeting. V. Date of Compliance: 5/23/23	

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F 692	Continued From page 55	F 692		

was documented that on [EX. Order 26.(4)] and [EX. Order 26.(4) B] the weights were both [EX. Order 26] lb. which contradicted DCNS's statement that the weight of [EX. Order 26.] lb. in [EX. Order 26.(4) B1] was not accurate. There was no documentation that the resident's weights were obtained weekly.

A further review of the EMR revealed a weight of [EX. Order] lb. obtained on [EX. Order 26.(4)].

On 4/18/23 at 10:11 AM, the surveyor informed the Director of Nursing (DON) about the concerns of the varying weights for Resident #47 and their discussion with the DCNS. The DON stated staff were trained on the use of scales and the process to obtain weights. The DON stated for a significant weight change, the resident should be re-weighed, and if there was a concern about the scale's accuracy, Maintenance should be notified to check the scale. The surveyor asked the DON if she was made aware by the DCNS or other staff about the concern of inaccurate weight results due to scale or human error. The DON stated "No". The surveyor asked the DON if it was expected for weights in the EMR to be accurate and the DON replied "yes".

On 4/19/23 at 9:47 AM, the surveyor informed the DON and the Licensed Nursing Home Administrator (LNHA) about the concerns with the varying weights recorded for Resident #47. The DON stated she discussed the concern with the DCNS, and Maintenance checked the scale yesterday and the calibration was fine. The DON acknowledged she reviewed the weights of Resident #47 and there were concerns with the varying weights.

On 4/19/23 at 10:14 AM, the surveyor observed

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F 692	Continued From page 56	F 692		

the Unit Manager/LPN (UM/LPN) weigh Resident #47 while seated in a wheelchair using a wheelchair scale. The resident's weight obtained was EX. Order lb. minus the weight of the wheelchair. The UM/LPN stated the resident weighed 98 lb. yesterday EX. Order 26.(4) B), which was documented in the EMR. The surveyor asked the UM/LPN about the varying weights, since it was documented in the EMR that the resident weighed EX. Ord lb. on EX. Order 26.(4) B The UM/LPN could not speak to this and stated that Maintenance came to calibrate scales and if any issues with weights, the Registered Dietitian was notified. The UM/LPN further stated the CNAs were trained to use the scales to weigh residents and were familiar with the process. The UM/LPN stated Resident #47 ate well, consumed his/her EX. Order 26.(4) B1 (supplement drink), and there were no concerns with the resident's nutrition.

On 4/19/23 at 11:00 AM, the surveyor informed the DON and LNHA of the weight observation. The surveyor asked the DON regarding the most recent weights: today's weight of EX. Order lb., yesterday's weight of EX. O lb., and the weight on EX. Order 26.(4) B of EX. O lb. The DON stated that Maintenance checked the scale, and it was calibrated. The DON stated the CNAs were provided education on weighing residents, but would look into re-educating staff. The DON acknowledged it was concerning about the weight discrepancies.

A review of the facility's undated "Weight Policy" included...Purpose to ensure resident's weight is monitored regularly/accurately. Any significant weight changes/potential nutritional risks are identified and managed appropriately...reweigh will be obtained upon dietician's request. Reweigh

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F 692	Continued From page 57 is required if the resident has weight change of plus or minus 5% (if over 100 lbs.) or plus or minus 3% (if 100 lbs. or less). Dietitian will follow up with any weight discrepancy [As soon as possible]...Dietician will review all weights and request reweighs, as needed... Dietitian will assess weights for any significant changes... Weight committee will meet on monthly basis to discuss any significant weight concerns... NJAC 8:39-27.2(a)	F 692		
F 693 SS=E	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:	F 693		5/23/23

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F 693	Continued From page 58 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure the appropriate management of EX. Order 26.(4) B1 and EX. Order 26.(4) B1 2 of 3 residents (Resident #77 and #88) reviewed for EX. Order 26.(4) B1, and was evidenced by the following: 1. On 4/3/23 at 10:50 AM, the surveyor observed Resident #88 in bed asleep with an EX. Order 26.(4) B1 milliliters (mL) per hour. The surveyor observed the EX. Order 26.(4) B1 bottle of EX. Order 26.(4) B1 had approximately EX. Order 26.(4) B1 remaining, and the label was not filled out with the resident's EX. Order 26.(4) B1). The surveyor also observed a EX. Order 26.(4) B1 kit (used to EX. Order 26.(4) B1 dated EX. Order 26.(4). There was also no name labeled on the bag that contained the EX. Order 26.(4) B1. The surveyor reviewed the medical record for Resident #88. A review of the Admission Record face sheet (an admission summary) reflected the resident was re-admitted to the facility in EX. Order 26.(4) B1 and had diagnoses which included EX. Order 26.(4) B1 EX. Order 26.(4) B1 (a disease that EX. Order 26.(4) B1, EX. Order 26.(4) B1, and EX. Order 26.(4) B1 . A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated EX. Order 26.(4) B1 reflected that the resident had a brief interview for mental status (BIMS) score of EX. out	F 693	I. Corrective action(s) accomplished for resident(s)affected: Resident #77 remains in the facility for long-term care placement. The resident□s weight remains stable at EX. Order 26 lbs. as last recorded. The EX. Order 26.(4) EX. Order 26.(4) B1 set dated EX. Order 26.(4) B1 and undated bottle of EX. Order 26.(4) B1 was discarded. A new dated set was provided for the resident. The resident did not have any negative effects from this practice. Resident #88 remains in the facility for long-term care placement. The EX. Order 26.(4) set dated EX. Order 26.(4) B1 was discarded and a new dated set was provided for the resident. The resident did not have any negative effects from this practice. The identified licensed nursing staff was re-educated by the facility educator on the proper procedure for labeling and dating EX. Order 26.(4) B1 and EX. Order 26.(4) B1 sets per facility policy and the administration of EX. Order 26.(4) B1 to assure that the complete amount of EX. Order 26.(4) B1 per the physician order. II. Residents identified having the potential to be affected and corrective action taken: All residents receiving EX. Order 26.(4 sets used had the potential to be affected. An audit of residents with EX. Order 26.(4) B1 with EX. Order 26.(4) B1 sets in use was conducted by facility educator/designee and found no other residents affected by this practice. III. Measures will be put into place to	

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F 693	Continued From page 59 EX. Order 26 which indicated a EX. Order 26.(4) B1 . A further review of EX. Order 26.(4) B1 for Nutritional Status" reflected that the resident received EX. Order 2 or more of their nutrition through an EX. Order 26.(4) B1 and resident also received EX. Order 26.(4) B1 diet. A review of the Physician Order Summary Report dated as of EXEX. Order 26 included the following physician's orders (PO): A PO dated EX. Order 26.(4) B1 to provide EX. Order 26.(4) B1 EX. Order 26.(4) B1 A PO dated EX. K. Order 2, for EX. Order 26.(4) B1 administered EX. O r for a EX. Order 26.(4) B1 mL. A PO dated EX. Order 26, to EX. Order 26.(4) B1 every twenty-four hours. A PO dated EX. Order 26, to EX. Order 26.(4) B1 equipment (EX. Order 26.(4) B1 kit) every twenty-four hours. A review of the corresponding EX. Order 26.(4) B1 Record EX. Order 2) reflected that the nurses had signed the administration of the EX. Order 26 daily. Further review revealed the nurses had signed that the equipment for the EX. Order 26.(4) B1 was hung every twenty-four hours since EX. Order 26.(4 A review of the comprehensive care plan dated EX. Order 26.(4), included a focus area that the resident received EX. Order 26.(4) B1 to meet nutrition and hydration needs. The goal of the care plan reflected that the resident would benefit EX. Order 26.(4 without complications. The interventions included to administer EX. Order 26.(4) B as ordered and to administer EX. Order 26.(4) as ordered. On 4/3/23 at 11:10 AM, the surveyor interviewed the Unit Manager/Registered Nurse UM/RN who	F 693	ensure the deficient practice will not recur: " The EX. Order 26.(4) B1 Management policy was reviewed by the Director of Nursing, Registered Dietitian, and Director of Quality Assurance Performance Improvement. No updates were required to the policy. All Licensed Nursing staff were re-educated by the facility educator/designee on the proper procedure for labeling and dating EX. Order 26.(4 and EX. Order 26.(4) B1 per facility policy. All Licensed Nursing staff were re-educated by the facility educator/designee on the administration of EX. Order 26.(4) B1 to assure that the complete amount of EX. Order 26.(4) EX. Order 26.(4) B1.(4) B1 the physician order. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The Facility Educator/designee will conduct one audit per week for four weeks then monthly audits for five months to ensure EX. Order 26.(4) B1 are EX. Order 26.(4) as ordered. Any discrepancies will be addressed by the Facility Educator with the Unit Manager and assigned nurse for follow-up. The Infection Prevention Nurse/designee will conduct one audit per week for four weeks then monthly audits for five months to ensure EX. Order 26.(4) B1 and EX. Order 26.(4) B1 are labeled and dated per facility policy. Any discrepancies will be addressed by the Infection Prevention Nurse with the Unit	

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F 693	Continued From page 60 stated that the nurses were responsible for the care of the resident's FT. On 4/3/23 at 11:50 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) in Resident #88's room, who acknowledged that the bottle of EX. Order 26.(4) B1 was not dated, and she was not sure how much EX. Order 26.(4) the resident should have received. She stated that the 3:00 PM to 11:00 PM shift nurse hung a new bottle, and the bottle should be filled out. On 4/3/23 at 11:55 AM, the surveyor interviewed the UM/RN who stated that EX. Order 26.(4) B1 EX. Order 26.(4) B1 kits were changed every shift, and the EX. O stopped at the EX. Order 26.(4) B1 the EX. Order 26.(4) was set to. She stated that the EX. Order 26.(4) B1 bottle should be filled out, so the nurses knew the time and date the bottle was EX. O. Orde because the EEX. Order 26.(4 was not good after twenty-four hours of being opened. The UM/RN also acknowledged that the EX. Order 26.(4) B1 dated EX. Order 26.(4) for the resident was not acceptable. She further stated that during rounds, she noticed that the EX. Order 26.(4) B1 for Resident #88 was dated EX. Order 26.(4), and discarded the EX. Order 26.(4) B1 set. On 4/10/23 at 12:13 PM, the surveyor interviewed the Staff Educator/LPN who stated all nursing staff were educated on EX. Ord. She stated that the EX. Order 26.(4) B1 kits were changed at night, and should be labeled and dated with the resident's name, date, and room number. The Staff Educator/LPN stated that the EX. Order 26.(4) B1 bottles were expected to be labeled with the resident's name, date, the EX. Order 26.(4) B1, and the time the bottle was EX. Order 26 The Staff Educator/LPN stated that was the nurse's responsibility to make sure they were labeled and dated, and if they were not	F 693	Manager and assigned nurse for follow-up. The Facility Educator/designee will report the results of the EX. Order 26.(4) B1 audits to the Quality Assessment and Assurance (QAA) Committee for the next two quarters. The QAA Committee will determine the need for any additional monitoring of EX. Order 26.(4) B1 after the 2nd quarterly meeting. The Infection Prevention Nurse/designee will report the results of the EX. Order 26.(4) B1 and EX. Order 26.(4) B1 labeling audits to the Quality Assessment and Assurance (QAA) Committee for the next two quarters. The QAA Committee will determine the need for any additional monitoring of EX. Order 26.(4) B1 set labeling after the 2nd quarterly meeting. Date of Compliance: 5/23/23	

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F 693	Continued From page 61 labeled, the nurse had to replace the EX. Order 26.(4) B and obtain a EX. Order 26.(4) B1 set. The Staff Educator/LPN confirmed if the bottle was not labeled, the nurse would not know how long the bottle was up which would be an infection control issue and would not want the resident to get sick. On 4/17/23 at 9:41 AM, the surveyor interviewed the Director of Nursing (DON) who stated the EX. Order 26.(4) bottles and the EX. Order 26.(4) B1 kits needed to be labeled and filled out because that was the facility's policy. The DON acknowledged that the EX. Order 26.(4) should have been labeled and dated, and the EX. Order 26.(4) B1 EX. Order 26.(4) B1 kits be changed daily. 2. On 4/3/23 at 11:25 AM, the surveyor observed Resident #77 in bed awake and alert, but non-responsive to surveyor questions. The surveyor observed on the resident's dresser a EX. Order 26.(4) B1 kit dated EX. Order 26.(4) B. The resident had a EX. O that was not being administered and there was no EX. Order 26.(4) B hanging. The surveyor reviewed the medical records for Resident #77. A review of the Admission Record face sheet reflected that the resident was admitted to the facility in EX. Order 26.(4) B1 with diagnoses which included EX. Order 26.(4) B1 and EX. Order 26.(4) B1 EX. Order 26.(4) B1 A review of the most recent quarterly MDS dated EX. Order 26.(4), reflected that the resident had a BIMS	F 693		

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F 693	Continued From page 62 score of EX. Order 26.(4) B1; which indicated a EX. Order 26.(4) B1 EX. Order 26.(4) B1. A further review in "Section EX. Order 26.(4) B1 Nutritional Status" reflected that the resident received EX. Order 26.(4) B1 or more of their EX. Order 26.(4) B1 EX. Order 26.(4) B1, and the resident also received a EX. Order 26.(4) B1 EX. Order 26.(4) B1 A review of the Ap EX. Order 26.(4) B1 Physician Order Summary Report included a PO dated EX. Order 26.(4) B1 for an EX. Order 26.(4) B1 order for EX. Order 26.(4) B1 of EX. Order 26.(4) B1 mL EX. Order 26.(4) B1 hours. Further reviewed reflected a PO dated EX. Order 26.(4) B1, for EX. Order 26.(4) B1 to change equipment EX. Order 26.(4) B1 kit) every twenty-four hours. A review of the corresponding EX. Order 26.(4) B1 EAR reflected that the nurses were signing that the equipment was being changed daily at 2:00 PM. A review of the comprehensive care plan dated EX. Order 26.(4) B1 2, included a focus area that the resident required an EX. Order 26.(4) B1 EX. Order 26.(4) B1 to meet EX. Order 26.(4) B1 and EX. Order 26.(4) B1 needs. The goal was to benefit from the EX. Order 26.(4) B1 without complications. The interventions included to administer EX. Order 26.(4) B1 as ordered and to administer EX. Order 26.(4) B1 as ordered. On 4/3/23 at 11:10 AM, the surveyor interviewed the UM/RN who stated that the nurses were responsible for the care of the FT. On 4/3/23 at 11:50 AM, the surveyor interviewed the LPN who acknowledged that EX. Order 26.(4) B1 EX. Order 26.(4) B1 kits were changed every shift and stated that she did not use the EX. Order 26.(4) B1 kit that was dated EX. Order 26.(4) B1. The LPN stated she did not leave the EX. Order 26.(4) B1 that she used for Resident #77 in the room that day. She confirmed that the kit dated EX. Order 26.(4) B1 should not	F 693		

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F 693	Continued From page 63 have been available at the bed side. On 4/3/23 at 11:55 AM, the surveyor interviewed the UM/RN who stated that EX. Order 26.(4) B1 changed every shift. The UM/RN stated the EX. Order 26.(4) B1 dated EX. Order 26.(4) B1 for the resident was not acceptable. On 4/10/23 at 12:13 PM, the surveyor interviewed the Staff Educator/LPN who stated that all nursing staff were educated for FT. She stated that the EX. Order 26.(4) B1 kits were changed at night, and they should be labeled and dated with the resident's name, the date, and the room number. The Staff Educator/LPN stated that she expected that they would be labeled, and it was the nurse's responsibility to make sure they were labeled and dated. The Staff Educator/LPN continued if they were not labeled, the nurse replaced the bottle and got a EX. Order 26.(4) B1 EX. Order 26.(4) B1 kit because it was an infection control issue and would not want the resident to get sick. On 4/17/23 at 9:41 AM, the surveyor interviewed the DON who stated the EX. Order 26.(4) B1 kits needed to be labeled and filled out because that was the facility's policy. The DON acknowledged that the EX. Order 26.(4) B1 kit dated EX. Order 26.(4) should not have been used or in the resident's room on EX. Order 26.(4 A review of the facility's "EX. Order 26.(4) B1 Management" policy and procedure dated revised 1/26/23 included, feeding sets are to be labeled and dated and are replaced every 24 hours... A review of the facility's EX. Order 26.(4) B1 Management" policy and procedure include...The nurse shall label the EX. Order 26.(container with the	F 693		

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F 693	Continued From page 64 date and time the [EX. Order 26.(4)] was started... NJAC 8:39-27.1(a)	F 693		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced	F 755		5/23/23

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	315159	A. BUILDING ______ B. WING ______	C 04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	**425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012**

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F 755	Continued From page 65 by: Based on observation, interview, and review of pertinent facility documents, it was determined the facility failed to a.) ensure an accurate ordering and receiving of narcotic medications on the required Federal narcotic acquisition forms (DEA 222 forms) were completed with sufficient detail to enable accurate reconciliation for 6 of 6 forms provided; and b.) to accurately document the administration of controlled medication for 2 sampled residents (Resident #19 and Resident #216) identified upon inspection of 1 of 6 medication carts (EX. Order 26.(4) B1 hall cart). The evidence was as follows: 1. On 4/17/23 at 1:37 PM, the surveyor reviewed the facility provided DEA 222 forms which revealed on six of the six provided forms Part 5, had not been completed upon receipt of the medications from the Provider Pharmacy as instructed on the reverse of the ordering form. The forms were as follows: Order form number: 221704808; 221704809; 221704810; 221704811; 221704812; and 221704816. On 4/17/23 at 2:13 PM, the surveyor and Director of Nursing (DON) reviewed the provided DEA 222 forms. The DON acknowledged she should have completed the Part 5 as instructed on the reverse of the DEA 222 form as required. A review of the Instructions for DEA Form 222, under Part 5. Controlled Substance Receipt, 1. The purchaser fills out this section on its copy of the original order form. 2. Enter the number of packages received and date received for each line item...	F 755	I. Corrective action(s) accomplished for resident(s)affected: Resident #19 remains in the facility for long-term care placement. The resident received the administered narcotic as ordered on 04/17/2023. This resident had no negative effects from this practice. Resident #216 remains in the facility for long-term care placement. The resident received the administered narcotic as ordered on 04/17/2023. This resident had no negative effects from this practice. II. Residents identified having the potential to be affected and corrective action taken: All residents administered narcotic medication by the identified Licensed Practical Nurse (LPN) had the potential to be affected. An audit was conducted by the facility Educator/Designee on 4/19/2023 on residents who received medications from the identified LPN on 04/17/2023. No other residents were identified as affected by this practice. All residents receiving narcotic medications at this facility had the potential to be affected. No other residents were noted as affected by this practice. III. Measures will be put into place to ensure the deficient practice will not recur: The Medication Administration General Guidelines for the Administration of Medications policy updated in March 2023 was reviewed. No updates were required for the policy. The Licensed Practical Nurse	

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Continued From page 66

2. On 4/17/23 at 11:40 AM, the surveyor in the presence of the Licensed Practical Nurse (LPN) inspected the EX. Order 26.(4) B1 hall medication cart. The surveyor and the LPN reviewed the narcotic medication located in a secured and locked narcotic box. When the narcotic inventory was compared to the corresponding declining inventory sheet, the surveyor identified the following concerns.

Resident #19's EX. Order 26.(4) B1 EX. Order 26 milligram (mg) tablet, a medication used to relieve EX. Order 26.(4) B1 not match the physical inventory. The blister pack contained 24 tablets and the declining inventory sheet indicated there should be 25 tablets remaining.

Resident #216's EX. Order 26.(4) B1 mg tablets also did not match. The blister pack contained 27 tablets and the declining inventory sheet indicated there should be 28 tablets remaining.

At this time, the surveyor interviewed the LPN who stated he had administered the medications earlier to both residents, and he had forgotten to sign the declining inventory sheet for the doses he had administered. The LPN acknowledged the declining inventory sheet should be signed when the medication was removed from the packaging.

On 4/17/23 at 12:24 PM, the surveyor interviewed the EX. Order 26.(4 Unit Manager/LPN (UM/LPN) who acknowledged the LPN should have signed the declining inventory sheet immediately after removing the medication from the packaging. She further acknowledged this was the process to ensure the accurate inventory of all controlled

F 755

addressed in this deficiency received 1:1 re-education by the facility Educator/Designee on the proper procedure for documenting narcotics on the declining inventory sheet.

The Director of Nursing was re-educated by the Regional Nurse on the proper procedure for completing Drug Enforcement Agency (DEA) 222 forms including Part 5 as instructed on the reverse of the DEA 222 form as required.

All Licensed Nursing staff were re-educated by the Facility Educator on the proper procedure for documenting narcotics on the declining inventory sheet when removing narcotic medications.

IV. Corrective actions will be monitored to ensure the deficient practice will not recur:

The Director of Quality Assurance Performance Improvement (QAPI) will conduct one audit per week for four weeks then monthly audits for five months to ensure DEA 222 forms are filled out as required per DEA 222 form instructions. Any discrepancies will be addressed by the Director of QAPI with the Director of Nursing for immediate follow-up.

The Director of Quality Assurance Performance Improvement (QAPI)/designee will conduct one audit per week for four weeks then monthly audits for five months to ensure documentation of narcotics on the declining inventory sheet are in compliance. Any discrepancies will be addressed by the Director of QAPI/designee with the nurse assigned

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F 755	Continued From page 67 medications. On 4/17/23 at 1:18 PM, the surveyor interviewed the DON who stated as soon as medication was removed from the packaging, the nurse must sign the declining inventory sheet. This was the process to ensure accountability and ensure the medication counts were correct. A review of the facility's provided "Medication Administration General Guidelines for the Administration of Medications" policy dated updated March 2023 included Administration of Controlled Dangerous Substances is also recorded on the Declining Inventory Form as soon as medication is removed... NJAC 8:39- 29.2(d), 29.7(c)	F 755	for follow-up. The Director of Quality Assurance Performance Improvement will report the results of the DEA 222 form documentation audits to the Quality Assessment and Assurance (QAA) Committee for the next two quarters. The QAA Committee will determine the need for any additional monitoring of DEA 222 form documentation after the 2nd quarterly meeting. The Director of Quality Assurance Performance Improvement will report the results of the documentation of narcotics audits to the Quality Assessment and Assurance (QAA) Committee for the next two quarters. The QAA Committee will determine the need for any additional monitoring of narcotic documentation after the 2nd quarterly meeting. V. Date of Compliance: 5/23/2023	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		5/23/23

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F 761	Continued From page 68 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 review of pertinent facility documents, it was determined that the facility failed to properly label and date medication in accordance with manufacturer recommendations. This deficient practice was observed in 1 of 3 medication storage rooms EX. Order 26.(inspected and was evidenced by the following: On 4/17/23 at 12:07 PM, the surveyor in the presence of the Licensed Practical Nurse (LPN) inspected the EX. Order 26.(4 medication room refrigerator. The surveyor observed an opened and undated bottle of EX. Order 26.(4) B1 milligrams per 1 milliliter (mg/ml) EX. Order 26.(4) B1 in active inventory. The prescription label as well as the product label instructed "Discard opened bottle after 90 days". The LPN acknowledged that neither the medication bottle nor the medication box had been dated when opened or when to discard and should have been. On 4/17/23 at 12:24 PM, the surveyor interviewed	F 761	I. Corrective action(s) accomplished for resident(s)affected: No residents were identified as affected by this practice. II. Residents identified having the potential to be affected and corrective action taken: All residents had the potential to be affected by this practice. An audit was conducted by the facility educator/designee and found no other concerns. III. Measures will be put into place to ensure the deficient practice will not recur: An audit was conducted by the facility Educator/Designee to ensure medications were properly labeled and dated in accordance with manufacturer recommendations. No other medications were found out of compliance. The Medication Storage policy was	

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F 761	Continued From page 69 the Unit Manager/LPN (UM/LPN) for the 1 West nursing unit. The surveyor and the UM/LPN reviewed the lorazepam in the EX. Order 26.(4) medication room refrigerator, and the UM/LPN acknowledged there was no date on the EX. Order 26.(4) B1 bottle as to when the bottle was opened or when the bottle should be discarded. The UM/LPN also acknowledged the manufacturer label which indicated short dating, and to discard the opened medication bottle 90-days after being opened. The UM/LPN confirmed that if the medication bottle was not dated, then the expiration date cannot be calculated properly. On 4/17/23 at 1:18 PM, the surveyor interviewed the Director of Nursing (DON) and together they reviewed the findings of the inspection of the EX medication storage room. The DON stated the EX. Order 26.(4) B1 should have been dated when it was opened. The DON acknowledged the short dating for EX. Order 26.(4) B1 EX. Order 26.(4) B1 solution, that opened bottles must be discarded after 90 days. A review of the facility's "Medication Storage Policy" dated revised March 2023 included multidose vials will be dated when opened and discarded as per guidelines... NJAC 8:39-29.4(h)	F 761	reviewed by the Director of Nursing and Director of Quality Assurance Performance Improvement. No updates to the policy were required. All Licensed Nursing staff were re-educated by the Facility Educator on the proper procedure for labeling and dating medications in accordance with manufacturer recommendations. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The Director of Quality Assurance Performance Improvement (QAPI)/designee will conduct one audit per week for four weeks then monthly audits for five months to ensure medications are properly labeled and dated in accordance with manufacturer recommendations. Any discrepancies will be addressed by the Director of QAPI with the assigned nurse for immediate follow-up. The Director of Quality Assurance Performance Improvement will report the results of the labeling and dating of medication audits to the Quality Assessment and Assurance (QAA) Committee for the next two quarters. The QAA Committee will determine the need for any additional monitoring of labeling and dating medications after the 2nd quarterly meeting. V. Date of Compliance: 5/23/2023	
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp	F 804		5/23/23

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F 804	Continued From page 70 CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure appetizing and palatable temperature of food for 1 of 1 lunch meals observed on 1 of 6 nursing units (EX. Order 26.(4)). This deficient practice was evidenced by the following: On 4/10/23 at 10:14 AM, the surveyor conducted a Resident Council meeting which included six residents (Residents #87, #118, #135, #208, #212, and #260). All six residents informed the surveyor that the food was served cold on all shifts to which they attributed to short staffing. On 4/14/23 at 8:35 AM, the surveyors informed the Assistant Food Service Director (AFSD) that they wanted to observe the lunch meal service for that day including food temperatures. The AFSD acknowledged the request and stated that lunch service began at 11:15 AM. On 4/14/23 at 11:20 AM, the surveyor observed the Chef Manager (CM) who had already began to serve food on the tray line. When interviewed, the CM stated that the food temperatures were	F 804	I. Corrective action(s)accomplished for resident(s)affected: Residents #87, #118, #135, # 208, #212 and #260 had no negative outcomes related to having their food served cold on all shifts. II. Residents identified having the potential to be affected and corrective action taken: All residents residing in the facility have the potential to be affected by this deficient practice. Dietary staff were educated regarding checking and recording temps at the beginning of tray line and half way through tray line. The Plate warmer has been repaired. New Thermal Pellet Under liners have been ordered. New lids for the tray line have been ordered and received and implemented to ensure the food remains at appropriate temperature.	

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F 804	Continued From page 71 already completed by the AM Cook. The CM stated that she obtained plates from the hot box to warm them prior to plating food on them, as the pellet warmer (heated plate liner) was not working. The CM utilized plastic insulated domes and bases and heated plates to maintain temperature. On 4/14/23 at 11:33 AM, the surveyors requested to have a regular tray and a pureed tray prepared and placed on the second food truck for [EX. Order 26.4] nursing unit as a test tray. The surveyor requested that the CM record temperatures of the food in the presence of the surveyors on the nursing unit using a calibrated (procedure used to confirm accuracy) thermometer. On 4/14/23 at 12:07 PM, the CM calibrated a digital, thin probe thermometer in an ice bath to 32 degrees Fahrenheit (F). The CM and the surveyors then immediately proceeded to leave the kitchen and followed the food cart to the [EX. Order 26.4] nursing unit. On 4/14/23 at 12:09 PM, the Dietary Aide (DA) arrived on the [EX. Order 26.4] nursing unit with the food truck and the aides began to deliver meal trays to the residents. On 4/14/23 at 12:18 PM, the CM confirmed that the last resident's meal tray had been served. The surveyor asked the CM what temperature should hot foods and cold foods be served at, and the CM responded that hot food should be served at 135 F or above and cold food should be served at 40 F or below. At this time, the surveyor observed the CM obtain the following temperatures using the calibrated	F 804	III. Measures will be put into place to ensure the deficient practice will not recur: A new measure has been put in to place the Tray Line Temp Log has been updated to include food temperature monitoring during tray line. The Dietician/Designee will perform four weekly test tray audits for 24 weeks on Nursing Units to ensure meals are provided at appropriate temperatures. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The FSD/designee will conduct an audit 3X weekly to include all meals for four weeks, then 4X times monthly for the next 6 months to include all meals to validate that Dietary Staff is checking and recording temps at the beginning of tray line and half way through tray line to assure meals are provided at appropriate temperatures. Corrective action will be taken as needed. The FSD/designee will conduct one test tray audit weekly for 6 months to assure residents are receiving their meals at appropriate temperatures. Corrective action will be taken as needed. The Administrator/Designee will analyze and trend Audit findings and report outcomes of each to the next scheduled Quality Assessment and Assurance (QAA) Committee meeting for recommendations as necessary. V. Date of Compliance: 5/23/2023	

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F 804	Continued From page 72	F 804		

thermometer for the regular lunch meal tray:

Fish 104.4 F
Peas 106.6 F
Sweet Potatoes 109 F
Blueberries 37 F
Apple Juice 45 F
Milk 47 F
Coffee 132 F

At that time, the CM stated that the coffee was cold. She further stated that she received one to two resident complaints about cold coffee per day.

On 4/14/23 at 12:27 PM, the CM obtained the following temperatures from the pureed texture lunch meal using a calibrated thermometer:

Fish 123 F
Peas 122 F
Sweet potatoes 128 F
Milk 48 F
Apple Juice 48 F
Yogurt 57 F
Coffee 125 F

At that time, the CM stated that the yogurt was not safe to eat and could make someone sick.

On 4/14/23 at 12:41 PM, the surveyors returned to the kitchen with the CM and requested to review the food temperature logs from today's lunch meal. The CM reviewed the log and stated that the AM Cook failed to obtain both the breakfast and lunch temperatures today, which was contradictory to what the CM informed the surveyors earlier when they requested to observe the food temperatures taken. The CM stated that

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F 804	Continued From page 73 if temperatures were not completed prior to the meal service, the residents could get sick. On 4/14/23 at 1:53 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) in the presence of the survey team, who acknowledged and expressed their shared concerns regarding the food temperatures. A review of the facility's undated "Temperatures" policy, included all hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 F. Take temperatures often to monitor for safe temperatures ranges of at or below 41 F for cold foods and at or above 135 F for hot foods... NJAC 8:39-17.4(a)(2)	F 804		
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		5/23/23

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F 812	Continued From page 74 §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 pertinent facility documents, it was determined that the facility failed to: a.) store, label, date and properly document and cool potentially hazardous foods to prevent food-borne illness; b.) discard potentially hazardous foods past their date of expiration; c.) ensure that dented cans were removed from storage; d.) ensure that serving trays were dried in a safe and sanitary manner prior to meal service; e.) ensure that food was served in a safe and sanitary manner to prevent contamination; f.) ensure that the dish machine in use maintained the appropriate temperature and sanitizer levels according to the manufacturer's specifications; and g.) maintain multiuse food-contact surface cutting board and can opener in a manner to prevent microbial growth. This deficient practice was evidenced by the following: On 4/3/23 at 9:33 AM, the surveyors entered the kitchen and asked to tour with the Food Service Director (FSD). The surveyors met with the FSD who stated that both the hot water booster and chemical sanitizer were down on the dish machine and the repair technician was notified. At this time, the surveyors and the FSD toured the kitchen and observed the following: 1. In the walk-in refrigerator, there was an 84 count box of frozen omelettes that were stored in a plastic bag within a box that was opened to air and did not have an opened date or use by date.	F 812	I. Corrective action(s)accomplished for resident(s)affected: The identified omelets in the refrigerator were thrown out. The two pounds of cheese dated 8/22 in the deep freezer were immediately discarded. The seven pound can of beets, five pound can of artichokes, six pound can of tropical fruit, six pound and twelve ounce can of rice pudding were placed on the dented can rack. The staff member□s lunch box and bottle of soda were immediately removed from Unit #6 refrigerator. The cook was immediately re-educated regarding recording and monitoring of temperatures and to cover food loosely during the cooling process. The Dietary Aides (DA) were re-educated regarding wet nesting prevention. The identified DA #3 was re-educated by Regional Food Service Director regarding not touching her mask while working on the food line and hand hygiene. The identified Cook Manager (CM) was re-educated by the Dietician regarding serving utensils should not be placed on stainless-steel surfaces and then placed on a plate to be served to a resident due to a potential of cross contamination.	

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The FSD reached into the box with his bare hands and removed one omelette for demonstrative purposes. He stated, "I will throw this one out."

2. In the milk-box, on the top shelf of a rolling cart there was a 50-pound pork roast (according to the FSD) that was loosely covered with aluminum foil and the meat was largely exposed to air on the right side and partially exposed to air on the top. The FSD stated, "It should be kept open to air so that you do not get steam regeneration." The FSD stated that cooling process was to get the temperature to 135 degrees Fahrenheit (F) in two hours, then to 40 F in four hours. The FSD stated the pork roast was to be served on Wednesday. The FSD stated that the pork was 170 F when removed from the oven and cooled down to 135 F before it was placed in the refrigerator. The FSD agreed to furnish the cooling temperature logs.

3. In the deep freezer, there were two-pounds of cheese dated 8/22. The FSD stated that it should have been thrown out after six months.

4. In the dry storage room, on the can rack, there was a seven-pound can of beets that was dented. The FSD removed the can from the rack and placed it on the dented can rack.

5. In the dry storage room, on the can rack, there was a five-pound can of artichokes that was dented. The FSD removed the can from the rack and through it to the ground. He stated, "It hit the floor, I have to throw it away."

6. In the dry storage room, on the rear can rack, a six-pound can of tropical fruit was dented.

The can opener that was mounted to the surface of the prep station was immediately washed, rinsed, and sanitized.
The empty low temp dish machine sanitizer was immediately replaced.
The identified three large red cutting boards, seven large white cutting boards and four large green cutting boards were discarded. New cutting boards were purchased.

II. Residents identified having the potential to be affected and corrective action taken:
Residents residing in the facility had the potential to be affected by the deficient practice.
The Regional Food Service Director re-educated the Food Service Director regarding labeling, dating, food storage, wet nesting prevention, the dented can policy, the daily cleaning schedule, the procedure for testing the dishwasher at low temperature sanitizer, temperatures recording and monitoring, the policy for storing foods from the outside, and the cooling and reheating food process.
The Regional Food Service Director re-educated the Chef Managers (CM), cooks and cook preps regarding the cooling and reheating food process.
The Regional Food Service Director re-educated the Dietary Managers and Supervisors on the procedure for testing low temperature sanitizer.
The Regional Food Service Director re-educated cooks, Chef Mangers (CM), Cooks and Dietary Managers (DM) on

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7. In the dry storage room, on the rear can rack, a six-pound and twelve-ounce can of rice pudding both dented. The FSD stated, it was debatable, as there was a small dent on both the top and bottom of the can.

8. In the Unit #6 refrigerator, there was a staff member's lunch box and a bottle of soda. The FSD stated that it should not be in there.

9. The FSD stated that the dish machine was reportedly repaired according to the repair technician who was present in the kitchen. The FSD stated that it was a low temperature machine that operated on chemical sanitizer. A Dietary Aide (DA #1) was observed running dishes through the dish machine. She stated, "It was not up to temperature and a lot of the plates were not coming clean all of the way." DA #1 stated they had to be sent back, sprayed with water, and ran back through the dish machine. At that time, the FSD ran a rack of dishes through the dish machine and tested some water that had pooled on a dish with a chlorine test paper strip. The FSD stated, "No sanitizer level was detected." The FSD stated that the lunch meal service was to be served on paper products until the dish machine was repaired. The FSD reviewed the dish machine log and noted that it was not filled in on 4/3/23. The FSD stated that a maintenance request for assessment of the dish machine was placed at 8:30 AM. The FSD stated that with the booster, the wash cycle should have been 160 F and the final rinse cycle should have been between 180 F and 190 F.

On 4/3/23 at 1:40 PM, the surveyors returned to the kitchen and the FSD confirmed that the dish

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temperatures recording and monitoring.

The IP Nurse/Designee re-educated the dietary staff regarding infection control practices, potential cross contamination, and hand hygiene.

III. Measures will be put into place to ensure the deficient practice will not recur:

The Food Service Director (FSD)/ designee re-educated Dietary staff regarding labeling, dating, food storage, daily cleaning schedule, wet nesting and the dented can policy.

The Dietary Staff has been provided with a designated refrigerator for food brought in from the outside.

The staff was re-educated regarding the Cooking/Re-Heating & Cooling Log. The FSD/Designee will audit logs for completeness weekly with follow up as needed.

New dryer racks have been ordered and received. All trays will be removed from the dishwashers and placed on the drying rack to allow air drying.

The infection control rounds tool was updated to include observations of Dietary staff regarding infection control practices, potential cross contamination, and hand hygiene.

The Infection Preventionist/Designee will conduct ongoing once weekly infection control rounds to focus on infection control practices, potential cross contamination, and hand hygiene.

The daily cleaning schedule has been updated to include the can opener to be washed, rinsed, and sanitized after every use.

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machine had been repaired and agreed to furnish the surveyor with a work order from the repair technician.

On 4/4/23 at 2:35 PM, the surveyor reviewed the "Daily Cooling Log for Hot Potentially Hazardous Foods" which specified: Remember to use ice bath and/or shallow pans to decrease cooling times and reviewed an entry dated 4/2/23 for a pork loin. The start time was 5:30 AM and the recorded temperature was 178 F and the end time was 11:50 AM. The surveyor requested to speak with the Cook who completed the entry on the log.

At that time, the Cook stated that the Main Cook arrived at work at 4:00 AM, and she arrived at work at 6:15 AM. The Cook stated that when she arrived, she checked the pork loin temperature for doneness with a thermometer and it should be 165 F or higher. The Cook stated that she also slit the middle to ensure there was no pinkness or bleeding. The Cook stated that she returned it to the oven as it looked raw, and was more than a little pink. The Cook stated that there were eight pans total. The pork came out whole and we cut it in half. Then cut the pork to fit in little pans once done. Then we placed it into one large pan and split it three ways. The Cook stated that her process was to place the pan in the freezer to cool it at 178 F, then go back later and check again and pulled it out of the freezer and the temperature was 80 F to 90 F so it had to be put back in the freezer. The Cook stated that she did not want the meat to freeze. The Cook stated she thought at 11:50 AM, she put the meat back in the walk-in refrigerator. The Cook explained that even though the log indicated that the documented time was 11:50 AM, that was the last

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A new Dish Machine Temp Log has been implemented to include the low temp dish machine sanitizer will be checked for supply along with the Parts Per Millions (PPM) Tests. The FSD/designee will audit logs for completeness daily.

New cutting boards have been ordered and received.

IV. Corrective actions will be monitored to ensure the deficient practice will not recur:

FSD/Designee will report the findings from the Cooking/Re-Heating & Cooling Log and Dish Machine Temp Log to the administrator monthly for six months. FSD/designee will report trends to the QAA committee for the next two quarters to ensure compliance.

The IP will report findings from the audits of once weekly infection control rounds to the Director of Nursing (DON). The DON will trend the audit findings and report outcomes to the Quality Assessment and Assurance (QAA) Committee quarterly for two quarters with follow-up recommendations as necessary.

The QAA committee will determine the need for any additional monitoring of this area after the second quarter.

V. Date of Compliance: 5/23/2023

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obtained temperature of the meat at 58 F when it went into the second walk-in refrigerator; otherwise known as the milk-box. The Cook stated that though she did not record the temperature, she checked the temperature again at 2:00 PM. The Cook stated that she had obtained the final temperature and covered it with foil before she left for the day. The Cook stated the meat was cooled down and she placed foil over it tightly. The Cook stated that the FSD informed her this morning that the meat was not fully covered. The Cook stated that no one ever said anything to her about having the meat exposed to air in the milk-box. The Cook stated that she assumed that it was okay because it was cold in there. The surveyors requested to go to the kitchen to see the pork loin and the Cook stated that the pork loin had already been sliced down to be served tomorrow.

On 4/4/23 at 2:48 PM, the surveyor interviewed the FSD who stated, there was a remote possibility of air particles on the pork loin if it was not fully covered which could cause cross-contamination. The FSD then explained the cooling process of the pork loin. He stated that the pork loin came out of the oven in two or three pieces, then it was placed in a pan and then placed into the freezer to cool. The FSD stated that according to [Food Safety Course] cooling process, the meat was cut into smaller pieces and cooled to 130 F. The FSD stated that you could cool it in the refrigerator or freezer, "dealer's choice." The FSD stated that no matter how he cooled it, the meat was exposed.

At that time, the FSD clarified that there was eighty-pounds total of pork loin; twelve long pieces cut into six to eight pound loins. The Cook

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who was present stated, when she placed the meat in the freezer, it was not covered at all. The FSD stated the pork loin was then loosely covered to allow it to cool down. The Cook stated she covered it at 2:00 PM and placed it in the refrigerator and left at 2:30 PM. The Cook stated that she had to cool the pork loin from 135 F to 70 F in two hours then from 70 F to 40 F in two hours. Then the foil was removed, and the meat was put in sheet pans. The Cook stated that today the pork loin was likely reheated to between 165 F to 170 F. The Cook further stated that their process was to cook it twice. The Cook further stated, "We do that with turkey and pot roast also."

At that time, the FSD stated that if there was any cross-contamination of the pork loin roast it was still safe to serve as long as it was reheated to 170 F. The FSD stated that all food was exposed to air. The FSD stated that we should have taken a temperature of the pork loin yesterday while you were there so we could see. The FSD stated that what was missing from the log was: the starting point of 135 F when it was time to start the clock on the cooling process, and the final temperature taken when it was placed in the milk-box at 2:00 PM. The surveyor asked why the pork loin temperature was not monitored after the Cook left at 2:00 PM by the dietary staff? The FSD stated that the Night Cooks did not get involved with any roasting because they prepared food for residents. The FSD stated, "I am going to eliminate the roasting process." "I need staff to do it safely." The FSD stated that "steam regeneration was worse than anything you could imagine, it was bacteria." The Cook stated, "To avoid this, I put it in the freezer to cool it quicker." The FSD stated, "I am going to speak with

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corporate because I did not have the staff [take the temperature] safely as it takes ten hours." The FSD stated to the Cook, when you left at 2:00 PM, the problem was that we did not know at what point the pork loin hit 135 F. The FSD maintained that the pork loin was still safe to serve, "because the reheating process was everything." The FSD stated that every food was a potentially hazardous food.

On 4/5/23 at 9:56 AM, the surveyor observed the FSD who calibrated a thermometer probe in an ice bath to 32 F. The FSD then obtained a temperature of sliced pork with sauerkraut which was 180 F. The FSD stated that the pork loin was held in a warmer at 170 F.

On 4/5/23 at 11:31 AM, the surveyor interviewed the Registered Dietician (RD) who stated that the freezer stopped the growth of bacteria, the faster the better. The RD stated it would be appropriate in cooling. The RD stated that once the pork loin reached 135 F it was placed in the refrigerator. The RD stated that the threshold was to cool from 135 F to 70 F in two hours and from 70 F to 41 F in four hours for a total of a six hour process. The RD reviewed the, "Daily Cooling Log for Hot Potentially Hazardous Foods" and agreed that the form did not illustrate that the pork loin met the time and temperature required for proper cooling and did not illustrate the detailed cooling from 135 F to 70 F within two hours and then cooled from 70 F to 41 F within four hours. The RD stated that the form only showed the starting time and the end time. The RD stated that there was no one in the kitchen at 5:30 AM in the morning who could confirm the times. The RD stated that she had suggested that the cooling process was done correctly in the refrigerator. The RD confirmed

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that the cooling logs were incomplete and were not filled out to include the critical point. The RD stated that she did not dispute the 58 F that was recorded as the end temperature of the pork loin was a temperature in the danger zone and the bacteria could continue to grow at that temperature. The RD stated she did not like the log because they were confusing. The RD further stated that it was important to know the time and temperature for food safety.

On 4/14/23 at 11:20 AM, during a follow-up visit to the kitchen, the surveyor observed the following in the presence of the Chef Manager (CM):

1. During the food line observation, the surveyor noted that the trays that were used to serve the residents' lunch meal were wet, and DA #2 used a disposable dish cloth to dry them. The CM stated that if the trays were not fully dried prior to service, that it could result in contamination. The Assistant Food Service Director (AFSD) was present and stated, "The trays were not properly dried in the dish room." The AFSD stated that it was acceptable to wipe the trays down that were wet to dry them before they went out because the facility did not have enough trays to fully dry them between meal services.

2. The surveyor observed DA #2 who wiped the wet trays which had napkins and silverware on them. When interviewed, she stated that wet trays were placed in the food truck in stacks of nine. DA #3 who assisted on the food line, stated that she had loaded the trays onto the food truck in bundles of nine. When interviewed at that time, the CM confirmed that the trays were wetnested (a build up of bacteria caused by stacking wet dishes) while they were stacked wet in groups of

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nine inside of the food truck prior to use.

3. The surveyor observed the DM who placed a metal serving utensil on the stainless steel edge of the steam table. The CM then placed the serving utensil to a plate. The CM then picked up the plate and placed food on it and then passed it to DA #3 who placed it on a meal tray to be served to a resident.

4. The surveyor observed DA #3 who used her gloved hands and touched her face mask three times before she touched the lid of a tray and continued to work on the food line.

On 4/14/23 at 12:32 PM, the CM stated that serving utensils should have been placed on a plate or in the food when food was served and should not have been laid on the stainless steel surface and then placed on a plate to be served to a resident due to a potential of contamination. The CM stated that the DA #2 and DA #3 should have washed their hands after they touched their masks and then touched plates and lids as it could lead to cross-contamination. The CM stated that the DA's have been told about that prior.

On 4/14/23 at 12:48 PM, the surveyor returned to the kitchen with the CM to review temperature logs and dish machine function. At that time, the surveyor noted a can opener that was mounted to the surface of a prep station. The CM pulled the can opener out of the holder and showed the surveyor the blade which contained a thick black substance. When interviewed, the CM stated that the can opener blade was not clean and should have been cleaned once or twice per day.

On 4/14/23 at 12:51 PM, the surveyor observed

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the Food Service Worker (FSW) who operated the dish machine. When interviewed, he stated that he had worked at the facility since 2006 as a pot washer. The surveyor requested that the FSW demonstrate use of the dish machine. The FSW took a test strip from the three compartment sink and attempted to use it to test the function of the dish machine.

On 4/14/23 at 12:56 PM, the Night Operations Manager (NOM) who was present, stated that the FSW should not have used the test strip from the three compartment sink to test the dish machine as the results were not accurate. The surveyor requested to view the dish machine log at that time. The NOM stated that the dish machine function was not tested today, and was not recorded on the log. The NOM stated, "We cannot guarantee that the dishes used to serve residents were effectively cleaned." The NOM stated that the log was supposed to be done first thing in the morning to ensure everything was rinsed, cleaned, and sanitized. He further stated, "Otherwise, we could be serving dirty dishes to residents."

On 4/14/23 at 1:12 PM, the NOM obtained a chlorine test strip to test the function of the dish machine and touched the test strip inside the entrance of the dish machine under the jet stream of water and held it there for one second and pulled it out. The NOM stated that the test strip did not yield a result because the bleach base liquid was empty. The surveyor noted an empty bottle that hung on the wall next to the dish machine. A new replacement bottle was available directly below it. The kitchen staff was unable to state how long the dispenser had been empty.

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On 4/14/23 at 1:17 PM, the AFSD stated that the staff were responsible to test the function of the dish machine in the morning, make sure there was chemical cleaner available to run the machine, test the sanitizer level, and complete the log.

On 4/14/23 at 1:20 PM, the AFSD stated that the chlorine test strip should have been dipped after a load was run through the machine, not at the beginning of the cycle as the NOM had incorrectly demonstrated. The AFSD stated that the dish machine was required to meet a minimum wash temperature of 120 F and a rinse temperature of 140 F. The AFSD stated that the log was required to be documented at the time it was done. The AFSD stated the test strip should be held in the water for twenty seconds. The AFSD then proceeded to hold the test strip in the water that came out of the dish machine for twenty seconds. The AFSD repeated the test after holding the test strip in against a wet plate for ten seconds.

On 4/14/23 at 1:27 PM, the surveyor reviewed the directions on the side of the chlorine test strips which directed to dip and remove the strip quickly, blot with a paper towel, compare to color chart (desired level was 50 to 200 parts per million). The surveyor asked the AFSD for a policy related to the test strips. The AFSD stated, "we do not have a policy on everything." The AFSD stated that staff "only needed to know how to scrape and wash the dishes." The AFSD stated that the FSD, AFSD and the NOM did the chemical sanitizer testing. The AFSD stated that staff were not in-serviced on dish machine function on low operating temperature settings and processes.

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On 4/14/23 at 1:36 PM, the surveyor noted plastic cutting boards that were on a drying rack. There were three large red cutting boards, seven large white cutting boards and four large green cutting boards that were pitted, and discolored. The AFSD stated that the cutting boards were not supposed to be used due to the potential for bacterial growth. The AFSD stated, "We do not even use those."

On 4/14/23 at 1:54 PM, the surveyors met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) to discuss their concerns that were identified in the kitchen regarding dish machine function and food service.

On 4/17/23 at 10:39 AM, the LNHA informed the surveyor that he called in the Regional Food Service Director (RFSD) on Friday (4/14/23) at 4:00 PM, and he had worked twelve hour shifts all weekend to ensure that the staff was in-serviced and the policies were reviewed.

A review of the facility's "Food Storage" policy dated revised 1/22/21, included...dented, bulging or leaking cans will be discarded, or returned to vendors for appropriate credit...all food shall be protected from contamination and spoilage...

A review of the facility's "Food Preparation Standards" policy dated revised 1/22/21, included...only nonabsorbent cutting boards are used...meat, fish, eggs, and milk products will be prepared as close to serving time as possible...

A review of the facility's "Food Preparation Standards" policy dated revised 1/22/21,

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F 812	Continued From page 86 included...foods will be held below 40 F or above 140 F to prevent growth of micro-organisms...foods will be prepared and served in small batches to prevent long holding periods...all foods shall be covered, labeled and dated... A review of the facility's "Dishwashing" policy dated revised 1/22/21, included...supervisors will record dish machine temperatures daily. A dish machine temperature log is maintained to document that temperatures meet the established standards...employees will ensure dish washer temperatures are accurate according to standards before running items through the dish washer to be cleaned and ensure proper sanitation...if proper dish washing temperatures can not be maintained, management will not serve food on un-sanitized serving pieces. Paper and disposables will be used until dish machine is repaired and items are properly sanitized. A review of the facility's undated "Dishwashing" policy included...be sure the wash and rinse temperatures are appropriate for your dish machine. Document temperatures regularly on a temperature log. Use one staff to load dirty dishes and another to pull clean dishes. Air dry-use drying racks if needed; do not stack dishes immediately before or after washing. never dry with a towel... NJAC 8:39-17.2(g)	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		5/23/23

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F 880		F 880		

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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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F 880	Continued From page 88 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to ensure that infection control practices were followed by ensuring a.) appropriate personal protection equipment was worn for residents on transmission-based precautions; b.) appropriate hand hygiene including donning (put on) and doffing (removing) of gloves and hand washing; c.) appropriate disposal of resident's garbage in the room; d.) appropriate storage of EX. Order 26.(4) B1 equipment; and e.) sanitizing of reusable equipment in accordance with nationally accepted guidance and facility policy. This deficient practice	F 880	I. Corrective action(s)accomplished for resident(s)affected: • Residents #33 & #19 physicians were notified, and the resident was maintained on vital signs every shift and monitored for any documented signs and symptoms of infection for a 72-hour period. Resident #33 had no negative outcomes related to infection control practices with the storage of the EX. Order 26.(4) B1 Resident #19 had no negative outcomes related to deficient infection control practices. • The identified LPN #2 was re-educated by the Infection Preventionist	

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F 880	See below	F 880	See below	

F 880 — Summary Statement of Deficiencies

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was identified in 4 of 6 nursing units ([EX. Order 26.(4) B1] [EX. Order 26] and [EX. Order 26]) with multi-disciplinary staff and was evidenced by the following:

1. On 4/5/23 at 10:30 AM, the surveyor observed outside Resident Room [EX. Order 26] a sign that indicated the resident was on transmission-based precautions (TBP) and prior to entering and exiting room you must perform hand hygiene; wear gloves when entering room; and wear a gown upon entering the room. The surveyor observed outside the door a plastic cart with drawers which contained personal protective equipment (PPE) of disposable gowns and gloves. At that time, the surveyor observed an Occupational Therapist (OT) inside the room wearing a surgical mask, goggles, and gloves. The surveyor observed no gown. The OT assisted the resident out of the bathroom, and transferred the resident from the wheelchair to their bed. The OT picked up the walker, and left the room without removing her gloves or performing hand hygiene. The surveyor interviewed the OT who stated that she did not need to wear a gown in the room because it was the roommate that was on the TBP. The OT further stated that she did not need to disinfect the walker since the resident did not use it. The OT acknowledged that she should have removed her gloves and performed hand hygiene before she left the room.

On 4/5/23 at 10:41 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) on the S2 nursing unit. LPN #1 stated that all staff entering a room on TBP were instructed to wear full PPE including mask, gown, eye protection, and gloves prior to entering the room even if providing care to the resident that was not on TBP.

F 880 — Provider's Plan of Correction

(IP) regarding storage of nebulizer masks.

- The identified Occupational Therapist (OT) was re-educated by the Infection Preventionist (IP) regarding entering Transmission Based Precaution (TBP) rooms, following signage, donning and doffing personal protective equipment, hand hygiene, and disinfecting multiuse equipment prior to leaving the room.
- The identified Certified Nursing Assistant (C.N.A.) #1 was re-educated by the Infection Preventionist (IP) regarding hand hygiene and not wearing gloves in the hall.
- The identified Housekeeper (HK) #1 was re-educated by the Infection Preventionist (IP) regarding hand hygiene.
- The identified HK #2 was re-educated by the Infection Preventionist (IP) regarding entering Transmission Based Precaution (TBP) rooms, following signage, donning and doffing personal protective equipment, hand hygiene, not wearing gloves in the hall and cleaning TBP rooms last.
- The identified HK #3 was re-educated by the Infection Preventionist (IP) regarding entering Transmission Based Precaution (TBP) rooms, following signage, donning and doffing personal protective equipment, hand hygiene and proper removal of garbage.
- The identified Social Worker (SW) was re-educated by the Infection Preventionist (IP) regarding entering Transmission Based Precaution (TBP) rooms, following signage, donning, and doffing personal protective equipment, hand hygiene, and disinfecting the pen

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Continued From page 90

On 4/14/23 at 10:05 AM, the surveyor interviewed the Infection Preventionist/Registered Nurse (IP/RN) who stated that all staff and visitors entering a room with TBP must wear full PPE including mask, eye protection, gown, and gloves regardless of which resident they are seeing. The IP/RN further stated that all multiuse equipment that was brought into the room; whether or not it was used should be disinfected prior to leaving the room.

On 4/18/23 at 1:32 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) the above concerns.

2. On 4/5/23 at 10:43 AM, the surveyor observed the Certified Nursing Assistant (CNA #1) exit Resident Room #[EX. Order 2] wearing gloves and carrying two plastic bags; one with soiled linen and one with trash. The surveyor interviewed CNA #1 who stated that she should not wear gloves in the hallway and further stated that she should have removed them before leaving the room but stated she "forgot."

On 4/14/23 at 10:05 AM, the surveyor interviewed the IP/RN who stated that gloves should not be worn in the hallway; staff must remove gloves and perform hand hygiene prior to exiting room.

On 4/18/23 at 1:32 PM, the surveyor informed the LNHA and DON the above concerns.

3. On 4/10/23 at 12:10 PM, the surveyor observed Housekeeper (HK #1) on the [EX. Or] nursing unit cleaning Resident Room #[EX. Order 2]. The surveyor observed HK #1 leave the room without

F 880

and clipboard prior to leaving the room.

- The identified Licensed Practical Nurse (LPN) #3 was re-educated by the Infection Preventionist (IP) regarding entering Transmission Based Precaution (TBP) rooms, following signage, donning, and doffing personal protective equipment and hand hygiene.
- The identified HK #4 was re-educated by the Infection Preventionist (IP) regarding entering Transmission Based Precaution (TBP) rooms, following signage, donning and doffing personal protective equipment and hand hygiene.
- The identified HK #4 was re-educated by the Housekeeping Director regarding proper room cleaning.

II. Residents identified having the potential to be affected and corrective action taken:

- All residents residing in this facility have the potential to be affected by this deficient practice.
- All staff have been re-educated by the Infection Preventionist (IP)/ Designee regarding Transmission Based Precaution (TBP) rooms, following signage, donning and doffing proper personal protective equipment, hand hygiene and disinfection of shared multiuse equipment.
- All Licensed Nurses have been re-educated regarding the proper storage of nebulizer masks.
- All residents utilizing nebulizer masks have been audited to ensure the masks are stored properly.

III. Measures will be put into place to ensure the deficient practice will not recur:

- Infection Control Preventionist was

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removing her gloves or performing hand hygiene. HK #1 removed the wet mop she had used in Resident Room [EX. Order 26.4] removed her gloves, applied a new pair of gloves and without performing hand hygiene, proceeded to clean Resident Room [EX. Order 26.4]

On 4/10/23 at 12:15 PM, the surveyor interviewed HK #1 who stated, "I forgot the sanitizer, I left it in my locker, I'm sorry." HK #1 removed a container of purple-top sanitizer wipes from the cart and stated, "I sometimes use these to clean my hands." The surveyor and HK #1 observed that the label on the sanitizer wipes warned to avoid contact with skin.

On 4/14/23 at 10:05 AM, the surveyor interviewed the IP/RN who stated that staff were expected to remove their gloves and perform hand hygiene prior to changing gloves or exiting a resident's room. The IP/RN further stated that staff should not use the purple-top sanitizing wipes to clean their hands; sanitizer was on the housekeeping carts and in resident rooms.

On 4/18/23 at 1:32 PM, the surveyor informed the LNHA and DON the above concerns.

4. On 4/11/23 at 10:40 AM, the surveyor observed HK#2 on [EX. O] nursing unit wet mopping Resident Room [EX. Order 26.4] wearing a surgical mask, goggles and gloves. The surveyor observed HK #2 leave the room without removing her gloves or performing hand hygiene. HK#2 then removed the wet mop in the hallway, removed her gloves, applied a new pair of gloves, with no observed hand hygiene, and proceeded to clean Resident Room [EX. Order 26.4] which had a TBP sign outside the door which indicated to wear gown and gloves

F 880

re-educated by the Director of Nursing (DON) regarding performing routine surveillance audits on all staff.

- A new Infection Prevention Observation audit tool will be utilized to perform surveillance rounds on all staff to ensure they are adhering to infection practice guidelines.
- The Weekly Infection Control Rounds tool has been updated to include nebulizers to ensure staff are following proper procedures regarding storage of nebulizer masks.

IV. Corrective actions will be monitored to ensure the deficient practice will not recur:

- The Infection Preventionist/ Designee will conduct weekly Infection Prevention rounds on all staff to track and trend infection surveillance ongoing.
- The Infection Control Preventionist/Designee will conduct weekly infection control rounds to include nebulizer observations to ensure staff are following proper procedures regarding storage of nebulizer masks.
- The Infection Control Preventionist / Designee will formulate recommendations regarding infection control activities based on weekly surveillance rounds and data analysis and report outcomes to the Director of Nursing (DON) weekly for four weeks, then for five months with follow up actions as necessary.
- The Director of Nursing (DON) will trend the audits findings and report outcomes to the Quality Assessment and Assurance (QAA) Committee quarterly for two quarters with follow-up recommendations as necessary. The

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F 880	Continued From page 92 inside room. The surveyor observed HK#2 enter the resident's room wearing a surgical mask, eye protection, gloves, and no gown. HK#2 brought in one bottle of cleaner and went into the bathroom, sprayed the chemical in the bathroom, then proceeded to [EX. Order 26.4] sprayed the chemical, cleaned the room, then proceeded back to the hallway and placed the bottle on the housekeeping cart. There was no observed glove change or hand hygiene. HK #2 then grabbed the wet mop, mopped the bathroom floor and room floor. HK #2 removed her gloves, and donned a new pair of gloves without performing hand hygiene. HK #2 went back into the room and removed the garbage from [EX. Order 26.4] then she removed and discarded her gloves and left the room without performing hand hygiene. On 4/11/23 at 11:00 AM, the surveyor asked HK #2 what PPE should be worn in Resident Room [EX. Order 26.4] since the sign indicated that Resident Room [EX. Order 26.4] was on TBP? HK #2 replied that she had not noticed the TBP sign until the surveyor pointed it out to her. HK #2 further stated that she should have cleaned that room after she was done cleaning all of the other rooms that were not on TBP. HK#2 further stated that she should have performed hand hygiene using soap or water or sanitized her hands with alcohol-based hand rub (ABHR) before leaving the resident's room and acknowledged she should not wear gloves in the hallway. On 4/11/23 at 11:10 AM, the surveyor interviewed the Director of Housekeeping (DH) who stated that HK #2 was expected to clean the TBP rooms last. The DH further stated that HK #2 should not enter a room on TBP without the proper PPE which included a surgical mask, goggles, gown,	F 880	QAA committee will determine the need for any additional monitoring of this area after the 2nd quarter. V. Date of Compliance : 5/23/23	

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F 880	Continued From page 93 and gloves, and she should remove the gown and gloves in resident rooms, perform hand hygiene using soap and water for at least twenty seconds prior to exiting the room. On 4/14/23 at 10:05 AM, the surveyor interviewed the IP/RN who stated that all staff and visitors entering a room with TBP must wear full PPE including mask, eye protection, gown, and gloves. The IP/RN stated gowns and gloves should be removed prior to exiting the room, and hand hygiene performed. On 4/18/23 at 1:32 PM, the surveyor informed the LNHA and DON the above concerns. 5. On 4/11/23 at 9:41 AM, the surveyor toured the EX. Order nursing unit and observed Resident #33 in their room sitting in a wheelchair. The surveyor observed the resident's EX. Order 26.(4) B1 down on top of the EX. Order 26.(4) B1 machine. There was no storage bag observed in the resident's room for the EX. Order 26.(4) B1. The resident stated EX. Order 26.(4) B1 treatments were given at 6:00 AM, 11:00 AM, 4:30 PM, and 10:00 PM. On 4/11/23 at 1:21 PM, the surveyor observed the resident's EX. Order 26.(4) B1 on top of the EX. Order 26.(4) B1 machine. There was no storage bag observed in the resident's room for the EX. Order 26.(4) B1. At that time, the surveyor interviewed the assigned LPN #2 who was outside the resident's room. LPN #2 stated she prepared the resident's EX. Order 26.(4) B1 that day and stayed the entire duration of the EX. Order 26.(4) B1 treatment. She stated after the EX. Order 26.(4) B1 was finished, she washed it out, dried it	F 880		

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and placed it on a holder. The surveyor brought LPN #2 into the resident's room. LPN #2 acknowledged that the EX. Order 2 was face down on the EX. Order 26.(4) B1 machine and connected the EX. Order 26 to a EX. Order 2 r on the machine. LPN #2 stated she was not aware the EX. Order 2 should not have been placed face down on the EX. Order 26.(4) B1, and she was not aware of any other way to store the EX. Order 2.

On 4/13/23 at 10:35 AM, the surveyor interviewed the IP/RN regarding storage of EX. Order 26.(4) B1. The IP/RN stated after the EX. Order 26.(4) B1 was wiped down, the nurse should have stored it in a bag for infection control.

On 4/19/23 at 10:23 AM, the DON and LNHA spoke about the above concerns. The DON stated that the nurse should have ensured Resident #'33's EX. Order 26.(4) B1 was stored properly.

6. On 4/13/22 at 9:33 AM, the surveyor toured the EX. Order 26.(4 nursing unit and observed signage outside of Resident Room # EX. Order that indicated, "Stop Contact Precautions". The signage indicated TBP, and instructed the to perform hand hygiene before entering and before leaving the room; wear gloves when entering room or cubicle, and when touching patient's intact skin, surfaces, or articles in close proximity; wear gown when entering room or cubicle and whenever anticipating that clothing will touch patient items or potentially contaminated environmental surfaces; and use patient dedicated or single use disposable shared equipment or clean and disinfect shared equipment (BP, Cuff, thermometers) between patients.

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At that time, the surveyor observed an open bag of garbage which included used isolation gowns inside the resident's room located directly on the resident's floor. HK #3 was inside the room wearing a mask, eyewear, gown, and gloves. HK #3 stated to the resident, "I'm going to leave this here, if anyone asks, I'll be right back." HK #3 doffed (removed) her gown and gloves and exited the room.

On 4/13/23 at 9:43 AM, HK #3 returned to the resident's room. At that time, the surveyor interviewed HK #3 who stated that the garbage should not have been opened and on the floor, and that she should have taken it directly to the soiled utility room.

On 4/17/23 at 10:32 AM, the surveyor interviewed the IP on the resident rooms who were on contact precautions. The IP stated that all staff were educated on PPE and should be following the contact precaution instructions on the signage for both of the residents in the room for [EX. Order 26]. She stated that garbage should not be on the floor and should be bagged in the resident's room and taken to soiled utility.

On 4/19/23 at 10:23 AM, the DON and LNHA spoke about the above concerns. The DON stated that HK #3 should have removed the garbage when she left the room.

7. On 4/14/23 at 10:02 AM, the surveyor toured the [EX. Order 26] unit and observed signage outside of Resident Room [EX. Order 26] which revealed that the residents were on TBP. The surveyor observed a Social Worker (SW) inside the resident's room holding a pen and a clipboard. The SW was wearing eyewear and a surgical mask. The SW

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gave her pen and the clipboard to the resident to write on a piece of paper. The SW took the pen and clipboard from the resident and placed the clipboard on the resident's bedside table, picked it back up and exited the room without performing hand hygiene or sanitizing her pen and clipboard. At that time, the surveyor interviewed the SW about the signage outside the resident's room. The SW stated she was supposed to wear a gown and stated that she used hand sanitizer prior to exiting the resident's room.

On 4/17/23 at 10:32 AM, the surveyor interviewed the IP on the resident rooms who were on contact precautions. The IP stated that all staff were educated on PPE and should be following the TBP instructions on the signage for both of the residents in the room for TBP.

On 4/19/23 at 10:23 AM, the DON and LNHA spoke about the above concerns. The DON stated that the SW should have followed the signage for the required PPE for the rooms on TBP and sanitized their hands. She added that the SW should not have used her pen and clipboard for the resident to use.

8. On 4/4/23 at 9:18 AM, during the initial tour of the facility, the surveyor observed signage for TBP outside of Resident Room [Ex. Order 2] which indicated that a gown and gloves were required to be worn when entering the room and when touching the resident's intact skin, surfaces, articles in close proximity or potentially contaminated environmental surfaces. The surveyor observed LPN #3 who wore a surgical

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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 880	Continued From page 97	F 880		

mask and goggles, but failed to don a gown and gloves that were readily available outside of the room before she entered the room. The surveyor observed LPN #3 as she placed her ungloved hands on the foot board of the first bed inside the room. When interviewed, LPN #3 stated that she was an Agency nurse and did not see the TBP sign or PPE bin outside of the room. LPN #3 stated, "I just walked in." LPN #3 stated that she did not know why the resident was on TBP as she was only assigned to check the dates on the resident's EX. Order 26.(4) B1 today. LPN #3 stated that since she had not worn PPE into the room as required, there was a chance that she could spread disease.

On 4/4/23 at 9:30 AM, the surveyor interviewed LPN #4 who stated that LPN #3 was an Agency nurse who had just begun her shift, and she did not know that Resident Room EX. Order 26 was on TBP for EX. Order 26.(4) B1 in the EX. Order 26

On 4/11/23 at 11:13 AM, the surveyor interviewed the Unit Manger/LPN (UM/LPN) who stated that there were signs posted outside of Resident Room EX. Order 2, and we educated all staff to look at the signs before entering the room to observe the required precautions. The UM/LPN stated that no matter what, if a resident was on TBP, gloves were required to be worn and hand hygiene was required to be performed as you could not be sure if the resident had touched anything in the room.

On 4/12/23 at 12:17 PM, the surveyor interviewed the IP/RN who stated that for contact isolation

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(TBP), gown and gloves were required to enter the room and for activities. The IP/RN further stated, "The policy is to don a gown and gloves in case the foot board was contaminated."

9. On 4/12/23 at 10:09 AM, the surveyor observed signage for TBP outside of Resident #19's room, which indicated that a gown and gloves were required to be worn when entering the room and when touching the resident's intact skin, surfaces, articles in close proximity or potentially contaminated environmental surfaces. The surveyor observed HK #4 who wore a gown, mask, and goggles as she cleaned Resident #19's room. Resident #19 was present in the room and was seated in a wheelchair at the bedside. HK #4 exited the room with her gown and accessed the housekeeping cart and obtained a roll of trash bags. HK #4 went back into the room and placed her right ungloved hand on the foot board of the resident's bed while she conversed with the resident. HK #4 laid a roll of trash bags on the resident's bed and donned a pair of gloves. HK #4 then entered the bathroom with a mop and mopped the bathroom floor. HK #4 then proceeded to use the same microfiber cloth that covered the mop head to mop the bathroom to mop the floor in the hallway outside of the resident's room. HK #4 then doffed her gloves, and she untied the gown at her waist level posteriorly (behind) and left the ties secured around her neck posteriorly. HK #4 then proceeded to doff the gown by lifting the gown over her head and discarded both the gown and gloves in the trash receptacle on the housekeeping cart.

At that time, Resident #19 called HK #4 back into the room to receive holy water that the resident

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	315159	A. BUILDING ______ B. WING ______	C 04/19/2023

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F 880	Continued From page 99 had in a small bottle. HK #4 returned to the room without performing hand hygiene or donning any PPE. Resident #19 placed the holy water in HK #4's ungloved hands. HK #4 stated, "I just realized that I was not supposed to come in here like this (without PPE on)." HK #4 did not perform hand hygiene before she pushed her housekeeping cart across the hall to Resident Room [EX. Order] (another resident's room), which did not have any signage or PPE outside of the room to indicate that it was an isolation (TBP) room. At that time, HK #4 proceeded to don a pair of gloves without first performing hand hygiene, before she entered Resident Room [EX. Order]. HK #4 went into the resident's bathroom and proceeded to clean the bathroom. When finished, she bagged the microfiber cloths that she used to clean the bathroom and placed them on the housekeeping cart. HK #4 then proceeded to mop the floor. When finished, she moved the resident's cell phone, and a sealed pack of crackers from the television cart and placed it on the resident's bed with her gloved hand before she cleaned the top of the television cart. When finished, she returned both the cell phone and crackers to the television cart. HK #4 began to mop the area around the resident's bed when she noted the resident's urinal was full. With resident permission, she carried the [EX. Order] into the bathroom and proceeded to empty the urinal into the toilet. HK #4 informed the resident that she planned to hang the [EX. Order] bottle in a plastic bag at the bottom of the bed until the resident received another. HK #4 then proceeded to clean the shelf of the television stand when she noted the resident's shoehorn, wiped it, and placed it on the resident's bed. HK #4 then exited the room, doffed her gloves and failed to perform hand	F 880		

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F 880	Continued From page 100 hygiene as she prepared to clean the next room in the hall. On 4/12/23 at 10:44 AM, the surveyor interviewed HK#4 who stated that she worked on this hall today because the facility was short staffed. HK #4 stated that a gown, gloves, and mask were required to be worn in isolation (TBP) rooms to prevent staff from getting hurt and to provide protection from body fluids. HK #4 stated that she was not permitted to return to Resident #19's room after she had doffed her PPE. HK #4 stated that she had already doffed her gloves when she received holy water from Resident #19 in her ungloved hands and then touched her forehead and uniform to mark the sign of the cross on her body. HK #4 stated that she may have contaminated her uniform in the process. HK #4 stated that she should have washed her hands because there was hand sanitizer available in every room. On 4/12/23 at 10:58 AM, the surveyor interviewed the DH who stated that housekeeping staff were trained to pay attention to signage. The DH further stated that contact isolation (TBP) required gloves, gown, mask or goggles. He stated that staff were never permitted to go into the room without PPE in order to protect themselves and residents from spreading and passing germs from room to room, as there was a chance of contamination. The DH stated that housekeeping staff were trained to clean isolation (TBP) rooms last to prevent from spreading anything. The DH stated staff were not permitted to doff their gloves without performing hand hygiene. The DH stated that when HK #4 failed to perform hand hygiene after she doffed her gloves and went into another resident's room and	F 880		

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F 880	Continued From page 101 touched personal effects like a cell phone, crackers, shoehorn and urinal there was a chance of contamination. The DH stated that if HK #4 did not wash her hands after surveyor inquiry there was a chance of contamination. The DH further stated, she should know, she has been here for a long time. On 4/12/23 at 12:17 PM, the surveyor interviewed the IP/RN who stated that HK #4 should have had gloves on regardless of isolation status. The IP/RN stated that PPE should be doffed and disposed of inside of resident rooms. The IP/RN stated that if HK #4 lifted the soiled gown over her head after she left Resident #19's room, she could spread EX. Order 26, as there could be germs on her hair and face. The IP/RN stated that if HK #4 mopped the room of a resident who was EX. Order 26.(4) for EX. Order 26 and then mopped the hallway with the same mop head there was a potential for contamination. IP/RN stated that HK #4 should have performed hand hygiene when she left the room. The IP/RN stated that HK #4 should not have emptied a EX. Order 26. The IP/RN stated that housekeeping was trained to clean from clean to dirty and isolation should have been cleaned last to stop the spread of infection. On 4/17/23 at 12:49 PM, the surveyor interviewed the DON who stated that all donning and doffing of PPE should have been done inside the room. The DON stated that HK #4 should have declined the holy water. The DON stated that HK #4 was required to round from clean to dirty to avoid cross contamination and prevent the spread of infection. The DON stated that when HK #4 emptied the urinal, there was a chance of contamination and spread of EX. Order 26	F 880		

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F 880	Continued From page 102 A review of a facility's "EX. Order 26.(4) B1 and EX. Order 26.(4) B1 Products" policy dated revised in January 2023, included that all EX. Order 26.(4) B1 and equipment should be kept in a bag and dated... A review of a facility's "Resident Room Cleaning -Occupied Isolation Room- Non EX. Order 26.(4 dated revised August 2022, included...gather waste, place sealed plastic bags from waste containers into a second clearly tagged and/or labeled liner and seal that liner... A review of the facility's "Isolation Precautions/COVID-19" policy dated revised January 2023, included facility will ensure that appropriate isolation precautions are maintained as advised by attending physician...remove gloves promptly before leaving resident's room and wash hands immediately to avoid transfer of microorganisms to other residents and environment...isolation precautions...transmission based precautions will be used for identified residents...contact precautions: contact measures that are intended to prevent transmission of infectious agents...gloves are to be worn if patients items in room are to be touched. gowns and gloves are worn if rendering personal care and contact with infected body fluids is expected.... A review of the facility's "Hand Hygiene" policy dated revised January 2023, included...wash hands or use alcohol-based hand sanitizer after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. wash hand or use an alcohol-based hand sanitizer after removing gloves...	F 880		

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F 880	Continued From page 103 NJAC 8:39-19.3(b); 19.4(a)(b)(c)(k)(i)(n)	F 880		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060411 Y1	A. Building B. Wing Y2	6/8/2023 Y3

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This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 05/23/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
4/19/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO