STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315351	A. BUILDING _____ B. WING _____	C 06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF EDISON	1801 OAKTREE ROAD EDISON, NJ 08820

(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 000	INITIAL COMMENTS	F 000		

Complaint #'s: NJ 00164615, NJ00163977, NJ00162042

Standard Survey: 6/27/2023

Census: 27

Sample Size: 12 + 3 closed records

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.

The survey team identified an Immediate Jeopardy (IJ) situation for F600.

During a Standard Survey conducted from 6/19/23 through 6/27/23, the survey team identified the following:

F600 Free from Abuse and Neglect at level J

The facility failed to ensure immediate action was taken after a resident (Resident #15) reported to the facility's Director of Nursing (DON) and Licensed Social Worker (LSW) on 6/20/23 of a witnessed verbal abuse toward another resident (Resident #31) who was NJ Exec. Order 26:4.b.1 by a CNA. This posed a likelihood of serious harm to Resident #31 and to other residents under the CNA's care.

The facility failed to immediately notify all necessary parties and governing agencies and failed to implement additional measures to protect other residents on 6/20/23 when the

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

Electronically Signed | 07/21/2023

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F 000	Continued From page 1 facility's DON and LSW received the report from Resident #15. The facility was notified of the IJ situation on 6/22/23 at 5:56 pm. The facility submitted an acceptable removal plan on 6/23/23 at 4:30 PM. The facility continued to remain out of compliance for no actual harm with the potential for more than minimal harm that is not IJ.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to treat a resident in a dignified manner. This deficient practice was identified for 1 of 1 resident observed for NJ Exec. Order 26:4.b.1 [redacted], Resident #14. On 6/19/23 at 12:27 PM, the surveyor observed Resident #14 in the room seated in their wheelchair. The resident was alert and verbally responsive. The surveyor further observed that the resident had a NJ Exec. Order 26:4.b.1.	F 557	Deficiency F557 1.Immediate action(s) taken for the resident(s) found to have been affected include: Interviewed Resident # 14 on 6/21/23 who stated that she had no concerns concerning dignity. This was a NJ Exec. Order 26:4.b.1 [redacted] The licensed practical nurse who provided the NJ Exec. Order 26:4.b.1 for	7/21/23

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F 557	Continued From page 2 On 6/21/23 at 9:35 AM, the surveyor observed the Licensed Practical Nurse (LPN) perform NJ Exec. Order 26:4.b.1 of Resident #14. At the conclusion of the NJ Exec. Order 26:4.b.1, the LPN NJ Exec. Orde and then proceeded to write her initials including the date 6/21/23, on the tape after it had been applied to the resident. The LPN stated to the surveyor that it was her practice to initial the tape for the other staff to know when the NJ Exec. Order 26:4.b.1 was performed. The surveyor reviewed Resident #14's medical record. The Admission Record reflected that Resident #14 was admitted to the facility on NJ Exec. Order 26:4 with medical diagnoses which included but not limited to, NJ Exec. Order 26:4.b.1 . A review of the Admission Minimum Data Set, an assessment tool used to facilitate the management of care, dated NJ Exec. Order 2 reflected that the resident had a Brief Interview for Mental Status of NJ Exec out of 15, indicating that the resident was NJ Exec. Order 26:4.b.1. A review of the June 2023 Physician Order Summary revealed a physician's order dated NJ Exec. Order 26:4 for NJ Exec. Order 26:4.b.1 A review of the facility's Policy and Procedure titled, "Skin Care & Pressure Ulcer Management Program" did not specifically indicate the	F 557	resident #14 was provided refresher training by the DNS (Director of Nursing Services) on the right to dignity during NJ Exec. Order 26:4.b.1. 2.Identification of other residents having the potential to be affected was accomplished by: The facility interviewed a sample of residents with documented wounds to identify any dignity concerns that had the potential to be present and none were identified. 3.Actions taken/systems put into place to reduce the risk of future occurrence include: Observe nurse signing and dating dressing prior to application to monitor correct process. DNS s observes 2 dressings a week for the next 3 months, beginning 06/23/2023. 4.How the corrective action(s) will be monitored to ensure the practice will not recur: Licensed nurses providing dressing changes to residents will continue to be in-serviced on the proper procedures for signing dressings prior to application to ensure resident dignity is maintained. DNS will observe 2 dressings a week for the next 3 months. Starting on 6/23/2023 and for the next 3 months, to confirm that the processes	

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F 557	Continued From page 3 procedures of wound dressing changes. On 6/21/23 at 2:05 PM, the surveyor met with the facility's Licensed Nursing Home Administrator, Director of Nursing, Senior Director of Nursing Services, and Associate Executive Director to discuss the above concerns. There was no additional information provided. On 6/21/23 at 2:05 PM, the surveyor met with the facility's Licensed Nursing Home Administrator, Director of Nursing, Senior Director of Nursing Services (SDNS), and Associate Executive Director. The SDNS stated to the surveyor that nurses should not sign and date the dressing on the resident once the surgical dressing has been applied on the resident. The SDNS added that the surgical dressing should be signed and dated prior to applying it on the resident. There was no additional information provided. N.J.A.C. 8:39-4.1, 12	F 557	outlined above are sustained, the Administrator and/or designee will report the findings of the above observations and audits to the QAPI Committee. During and at the conclusion of the 3- month period, the Committee will reevaluate and initiate any necessary action or extend the review period. The administrator is responsible for ensuring implementation and ongoing compliance of this POC and addressing and resolving any variances that may occur.	
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or	F 600		8/3/23

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F 600	Continued From page 4 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of pertinent documents, it was determined that the facility failed to protect a resident (Resident #31) from verbal abuse by a Certified Nurse Aide (CNA #1) by failing to ensure: a.) the facility policy was followed to identify an allegation of abuse, b.) that upon receiving an allegation of abuse on 6/20/23 during the 7:00 AM to 3:00 PM shift, the facility immediately protected Resident #31, and other residents from potential abuse, and c.) a thorough investigation was immediately initiated. This deficient practice occurred for 1 of 3 residents reviewed for abuse. The facility's failure to ensure the abuse policy was followed to protect a resident from abuse and ensure a process was in place to protect all residents from potential abuse resulted in an Immediate Jeopardy (IJ) situation that began on 6/22/23 when a fellow resident (Resident #15) informed the surveyor that CNA #1 "on 6/19/23 the CNA was NJ Exec. Order 26:4.b.1 [redacted] (Resident #31)", and the facility failed to immediately initiate an investigation and CNA #1 proceeded to work on the same resident unit that day, 6/20/23, and was assigned to ten residents as well as being scheduled to work on 6/22/23. The facility administration was notified of the IJ situation on 6/22/23 at 5:56 PM. The facility submitted an acceptable removal plan on 6/23/23 at 4:30 PM. On 6/23/23 at 4:30 PM, the removal plan was verified as implemented by the survey team during the survey.	F 600	Deficiency F600¿ 1. Immediate action(s) taken for the resident(s) found to have been affected include: On 6/22/2023, upon notification of allegation of abuse, the Administrator immediately verified the safety of the resident named in complaint, and had a nurse complete a physical assessment of the resident. No concerns were identified. The resident's physician and responsible party were notified. On 6/22/2023, upon notification of allegation of abuse, the Administrator immediately placed team member named in complaint, the Social Services Coordinator (Social Worker) and the Director of Nursing on administrative leave, pending internal investigation. On 6/22/2023, upon notification of allegation of abuse, the Administrator immediately reported the event to the state Department of Health, and the Office of the Ombudsman. 2.Identification of other residents having the potential to be affected was accomplished by: Residents that reside in the facility can be affected by abuse from a staff member. On 6/22/2023, the residents who were	

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F 600	Continued From page 5 The evidence is as follows: On 6/22/23 at 11:30 AM, during Resident Council Interview, Resident #15 informed the surveyor on 6/19/23 that CNA #1 had dropped flowers in a vase belonging to Resident #15. Resident #15 explained to CNA #1 that the flowers had special meaning and that Resident #15 would like the flowers put back into the vase. As per Resident #15, CNA #1 responded, "Who cares? They're dead anyway." Resident #15 further described that CNA #1 aggressively threw their roommate's (Resident #31) call bell onto the roommate's bed and was verbally abusive toward the roommate. Resident #15 explained to the surveyor that they felt frightened and alerted the Director of Nursing (DON) the following morning, 6/20/23. On 6/22/23 at 12:15 PM, the surveyor reviewed the Electronic medical records (EMAR) for Residents #31 and #15. Resident #31's EMAR revealed the resident had diagnoses including but not limited to: NJ Exec. Order 26:4.b.1 [redacted]. An assessment for Resident #31's cognition called Brief Interview for Mental Status (BIMS) Skilled, completed on [redacted] revealed that Resident #31 had a BIMS score [redacted] which shows the resident has a NJ Exec. Order 26:4.b.1 [redacted]. The Admission Minimum Data Set, an assessment tool dated [redacted], revealed that Resident #31 was NJ Exec. Order 26:4.b.1 [redacted]. Resident #15 EMAR revealed the resident had diagnoses which included but was not limited to: NJ Exec. Order 26:4.b.1 [redacted]	F 600	cared for by the individual named in the complaint, were interviewed to identify any concerns they may have about the care they received or about any of the caregivers they interacted with. Other team members who work in skilled nursing were interviewed to identify any concerns they may have about how care is provided and interactions between staff and residents. Any concerns identified will be addressed per our policy and procedures. Beginning 6/22/2023, the Administrator and/or designee provided training to the direct care staff and Department Coordinators on Reportable Event requirements and the Sunrise Abuse and Neglect Policy. This training will be completed by the next shift worked by individual team members. On 6/28/2023 the Administrator re-enrolled all team members in an Abuse and Neglect Prevention course through the Online Learning Management System. 3.Actions taken/systems put into place to reduce the risk of future occurrence include: Starting on 8/03/2023, upon hire, of a staff person, and annually, training will be provided on Residents Rights and appropriate interactions with residents, and Abuse and Neglect Education. Starting on 8/03/2023, The Department Coordinators will observe team member interactions with residents as part of their routine rounds throughout the community for at least 5 days a week for the next three months. If any concerns arise, the Department Coordinator will intercede	

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F 600	Continued From page 6 NJ Exec. Order 26:4.b.1 . An assessment for Resident #15's cognition called Brief Interview for Mental Status (BIMS) Skilled, completed on NJ Exec. Order 26:4.b.1, revealed that Resident #15 had a BIMS score of NJ Exec which shows the resident is NJ Exec. Order 26:4.b.1 . On 6/22/23 at 2:15 PM, the surveyors interviewed the DON, who stated the facility did not have any reportable events for the month of June but remembered Resident #15 informing him of the incident. The DON stated he does not handle these investigations and informed the Social Worker (SW), who investigated the abuse incident as a grievance. CNA #1 continued to be scheduled to work one full shift of 10+ resident assignments on 6/20/22 and was scheduled to work on 6/22/23. On 6/22/23 at 2:30 PM, the SW provided the survey team with a copy of the grievance report. The SW stated her investigation still needed to be completed. The report includes a copy of statements made by Resident #15 and CNA #1 and a copy of the CNA #1 resident assignment sheet for the 3-11 PM shift, including both Resident #15 and #31. On 6/22/23 at 3:00 PM, the survey team interviewed the DON and SW, who agreed that the Licensed Nursing Home Administrator (LNHA) was unaware of the incident. On 6/22/23 at 4:00 PM, the survey team interviewed LNHA, who stated, "The incident should have been reported to the NEW Jersey Department of Health (NJDOH), investigated, and the CNA should have been suspended pending	F 600	immediately to protect the resident and will implement the investigation, notification, and reporting procedures. Starting 8/03/2023, the Administrator and/or designee will meet with three residents weekly to discuss their care and address any concerns for next three months. When invited or requested by the residents, the Administrator and/or designee will attend the Resident Council meeting to be informed of and address concerns reported by the residents. The Administrator and/or designee will follow-up with the resident council on any concerns that cannot be addressed during the meeting. Additional actions will be taken by the Administrator and/or designee to implement the abuse and neglect investigation and reporting procedures as needed. Starting on 6/23/2023, upon a Department Coordinator being notified of an allegation of abuse, the Department Coordinator will intercede immediately to protect the resident and will implement the investigation, notification, and reporting procedures. Starting on 6/23/2023, during the daily Department Coordinator meeting, the Department Coordinator will report on any notifications of allegations of abuse, investigation activities and reporting that has been completed. During the meeting additional actions to be taken will be determined. Starting on 6/23/2023 the Administrator and/or designee began attending shift crossover three times per week to talk	

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F 600	Continued From page 7 the investigation. A review of the facility policy titled, Abuse, Neglect & Exploitation - prevention, Reporting and Investigation, Effective Date: 5/31/16 revealed under the Action Steps section 2, subsection a) "All team members are mandated reporters and are required to report allegations or a known episode of abuse, neglect and/or exploitation to applicable state authorities within the time frame established by law." h) "Steps to take to ensure the safety and protection of residents in situations of known or suspected abuse, neglect and/or exploitation, including escalation to the Executive Director/designee." Section 8 The SNA/designee, subsection b) "Removes the individual alleged to be involved in the abuse, neglect or exploitation from the area, part i. Ensures that any team member alleged to be involved in the abuse, neglect or exploitation is placed on administrative leave, pending the results of the investigation. c) Ensures that the resident's (i) physician, (ii) legal representative and (iii) family member or other individual regularly involved in the resident's day to day care are notified as soon as practicable within timeframes established within laws/regulations." On 6/27/23 at 10:00 AM, the surveyor met with LNHA, which stated that the facility should have reported the abuse to the New Jersey Department of Health (NJDOH), the allegation was made, and per the facility policy, an investigation should have begun as well as the CNA #1 being suspended until the outcome of the investigation was reached. The LNHA also stated the DON and SW were going through retraining on abuse and reporting as part of the plan of correction.	F 600	directly with care staff and verify that information communicated from care staff to the Department Coordinators are being addressed according to policy, and reporting procedures followed. An emphasis being placed on raising awareness and early identification, as well as prevention and early intervention to protect residents that reside in the community. 4.How the corrective action(s) will be monitored to ensure the practice will not recur: Starting on 6/23/2023 and for the next 3 months, to confirm that the processes outlined above are sustained, the Administrator and/or designee will report the findings of the above observations and audits to the QAPI Committee. During and at the conclusion of the 3- month period, the Committee will reevaluate and initiate any necessary action or extend the review period. The administrator is responsible for ensuring implementation and ongoing compliance of this POC and addressing and resolving any variances that may occur.	

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F 600	Continued From page 8 N.J.A.C. 8:39-4.1 (a)5,12; 27.1(a)	F 600		
F 609 SS=D	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 for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to report to the New Jersey	F 609	Deficiency F609 1. Immediate action(s) taken for the resident(s) found to have been affected	8/2/23

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F 609	Continued From page 9	F 609		

Department of Health (NJDOH) an allegation of staff-to-resident verbal abuse. This deficient practice was identified for 1 of 3 reportable investigations reviewed, involving Resident #31 and Resident #15.

This deficient practice was evidenced by the following.

On 6/22/23 at 11:30 AM, during Resident Council Interview Resident #15 informed the Surveyor that on 6/19/23 CNA #1 had dropped flowers in a vase belonging to Resident #15. Resident #15 explained to CNA #1 that the flowers had special meaning and that Resident #15 would like the flowers placed back into the vase. Resident #15 continued to explain that CNA #1 responded, "Who cares they're dead anyway."

Resident #15 further described that CNA #1 aggressively threw the roommate's (Resident #31) call bell onto the roommate's bed and was verbally abusive toward the roommate. Resident #15 explained to the surveyor that they felt frightened. Resident #15 informed the surveyor that on the morning of 6/20/23 they alerted the Director of Nursing (DON).

On 6/22/23 at 12:15 PM, the surveyor reviewed the Electronic medical records (EMAR) for Resident #31. Resident #31's EMAR revealed diagnoses which included, but were not limited to: [redacted]

The Quarterly Minimum Data Set (MDS) an assessment tool used to facilitate the management of care, dated [redacted] for Resident #31 provided a Brief Interview for Mental Status

include:

On 6/22/2023, The residents who were cared for by the individual named in the complaint were interviewed to identify any concerns they may have about the care they received or about any of the caregivers they interacted with. Other team members who work in skilled nursing were interviewed to identify any concerns they may have about how care is provided and interactions between staff and residents. Any concerns identified were addressed as per policy. On 6/22/2023, Mandatory Abuse education was added to each team members Online Learning Management System. On 6/27/2023, the Administrator provided the Director of Nursing and Social Services Coordinator individualized training on Abuse and Neglect Prevention and investigating / reporting procedures.
2. Identification of other residents having the potential to be affected was accomplished by:
The facility determined that all residents have the potential to be affected.
Beginning 6/22/2023, the Senior Director of Nursing and/or designee began to re-educate all skilled nursing team members on Sunrise abuse policies, as well as abuse prevention and reporting. This training will be completed by the next shift worked by individual team members.
3. Actions taken/systems put into place to reduce the risk of future occurrence include:

Starting on 6/23/2023 the Administrator

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F 609	Continued From page 10 (BIMS) with a score [redacted] revealing [redacted] On 6/22/23 at 12:20 PM, the surveyor reviewed the EMAR for Resident #15. The EMAR revealed that Resident #15 had diagnoses which included but not limited t NJ Exec. Order 26:4.b.1 [redacted] Review of the Admission MDS dated [redacted] for Resident #15 documented a BIMS score [redacted] revealing that the resident has NJ Exec. Order 26:4.b.1 cognition. A review of the Progress Notes starting 6/20/23 for Resident #31 and Resident #15, did not provide any information that there was an incident reported about either resident. On 6/22/23 at 2:15 PM, the surveyor team interviewed the DON, who stated that the facility did not have any reportable events for the month of June but remembered Resident #15 informing him of an incident. The DON stated he informed the Social Worker (SW). On 6/22/23 at 3:00 PM, the survey team interviewed the DON and SW, who informed the team that this incident was investigated as a grievance. Both the DON and SW agreed that the Licensed Nursing Home Administrator (LNHA) was not informed of the incident. On 6/22/23 at 4:00 PM, the survey team interviewed the LNHA, who stated, "The incident should have been reported to the New Jersey Department of Health (NJDOH), investigated, and the CNA involved should have been suspended	F 609	and/or designee began attending shift crossover three times per week to talk directly with care staff and verify that information communicated from care staff to the Director of Nursing, Social Services Coordinator and other Community leaders is being addressed according to policy and reporting procedures followed. Starting on 6/23/2023, the Administrator and/or designee began attending the morning Department Head meeting, to verify any resident concerns or allegations are addressed as appropriate. Starting on 6/23/2023, the administrator or designee reviews all reported incidents daily for the next three months and verifies they have been submitted to the department of health. 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur. Starting on 8/2/2023 and daily for the next 3 months, to confirm that the processes outlined above are sustained, the Administrator and/or designee will report the findings of the above observations and audits to the QAPI Committee. During and at the conclusion of the 3- month period, the Committee will reevaluate and initiate any necessary action or extend the review period. The Administrator is responsible for ensuring implementation and ongoing compliance of this POC and addressing	

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	315351	A. BUILDING _____ B. WING _____	C 06/27/2023

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F 609	Continued From page 11 pending the investigation. A review of the facility policy titled, Abuse, Neglect & Exploitation - prevention, Reporting and Investigation, Effective Date: 5/31/16 revealed under the Action Steps section 2, subsection a) "All team members are mandated reporters and are required to report allegations or a known episode of abuse, neglect and/or exploitation to applicable state authorities within the time frame established by law." Continued review of the policy section h) "Steps to take to ensure the safety and protection of residents in situations of known or suspected abuse, neglect and/or exploitation, including escalation to the Executive Director/designee." On 6/27/23 at 10:00 AM, surveyor met with the LNHA who stated that the facility should have reported the abuse to the NJDOH at the time that facility staff was informed of the allegation.	F 609	and resolving any variances that may occur..	
F 610 SS=D	NJAC 8:39-9.4(f) 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.	F 610		8/2/23

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F 610	Continued From page 12 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, the facility failed to implement their abuse policy to investigate an allegation of verbal abuse between a Certified Nursing Assistant (CNA #1) and resident. This deficient practice was identified for 1 of 3 resident's (Resident #31) reviewed for abuse. The deficient practice is evident by the following: On 6/22/23 at 11:30 AM, during Resident Council Interview Resident #15 informed the Surveyor on 6/19/23 that CNA #1 had dropped flowers in a vase belonging to Resident #15. Resident #15 explained to CNA #1 that the flowers had special meaning and that Resident #15 would like the flowers put back into the vase. As per Resident #15, CNA #1 responded, "Who cares they're dead anyway." Resident #15 further described that CNA #1 aggressively threw their roommate's (Resident #31) call bell onto the roommate's bed and was verbally abusive toward the roommate. Resident #15 explained to the surveyor that they felt frightened and alerted the Director of Nursing (DON), on the following morning 6/20/23. On 6/22/23 at 12:15 PM, the surveyor reviewed the Electronic medical records (EMAR) for Resident's #31 and #15. Resident #31 EMAR	F 610	Deficiency F610 1.Immediate action(s)taken for the resident(s) found to have been affected include: Upon notification on 6/22/2023 of allegation of abuse, Administrator, placed individual named in complaint on paid administrative leave, pending internal investigation. The event was promptly reported to the state department of health, and the Office of the Ombudsman. The physician and responsible party were notified. The social worker and director of nursing were put on paid administrative leave effective 6/23/23, pending outcome of internal investigation reporting, abuse prevention and reporting training beginning 6/22/2023, to be completed by next shift worked by individual team members. The Summary and conclusion were provided to DOH and Ombudsman following all timeframe guidelines. 2.Identification of other residents having the potential to be affected was accomplished by: The facility determined that all residents have the potential to be affected. Interviews with staff and residents were completed 06/22/2023 to determine if there were other concerns that would	

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F 610	Continued From page 13 revealed the resident had diagnoses which included, but were not limited to: NJ Exec. Order 26:4.b.1 [redacted] An assessment for the Resident #31 cognition called Brief Interview for Mental Status (BIMS) Skilled completed on NJ Exec. Order 26:4 revealed that Resident #31 had a BIMS score NJ Exec. Orde which shows the resident has NJ Exec. Order 26:4.b.1 The Admission Minimum Data Set, an assessment tool, dated NJ Exec. Order 26:4, revealed the Resident #31 was NJ Exec. Order 26:4.b.1 [redacted]. Resident #15 EMAR revealed the resident had diagnoses which included, but were not limited to: NJ Exec. Order 26:4.b.1 [redacted] An assessment for the Resident #15 cognition called Brief Interview for Mental Status (BIMS) Skilled completed on NJ Exec. Order 26:4 revealed that Resident #15 had a BIMS score NJ Exec. Orde, which shows the resident is NJ Exec. Order 26:4.b.1 [redacted]. On 6/22/23 at 2:15 PM, the surveyors interviewed the DON, who stated the facility did not have any reportable events for the month of June but remembered Resident #15 informing him of the incident. The DON stated he does not handle these investigations and informed the Social Worker (SW), who investigated the incident of abuse as a grievance. On 6/22/23 at 2:30 PM, the SW provided the survey team with a copy of the grievance report. The SW stated her investigation was not completed. The report includes a copy of	F 610	require investigation. Any issues were addressed per policy. 3.Actions taken/systems put into place to reduce the risk of future occurrence include: Director of Nursing Services and/or designee began re-education of all skilled nursing team members on the Sunrise abuse policies, as well as abuse prevention before the team members first worked shift from 6/22/23 with emphasis on the need to immediately report, prior to the beginning of the investigation process. Any team member named in allegation regardless of their title will be immediately put on paid administrative leave pending the investigation. Witness statements and an investigation will begin immediately. All investigations will conclude with a summary and finding that will be reported to DOH and LTC Ombudsman. Administrator and/or designee monitors all Reportables daily to verify that all steps of the investigation and reporting process have been carried out accordingly and reports findings and observations during monthly QAPI meetings for the next three months. 4.How the corrective action(s) will be monitored to ensure the practice will not recur: Starting on 8/2/2023, daily for the next 3 months, to confirm that the processes outlined above are sustained, the Administrator and/or designee will report the findings of the above observations and audits to the QAPI Committee. During	

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F 610	Continued From page 14	F 610		

statements made by Resident #15 and CNA #1 as well as a copy of CNA #1 resident assignment sheet for the 3-11 PM shift which included both Resident #15 and #31.

On 6/22/23 at 3:00 PM, the survey team interviewed the DON and SW who both agreed that the Licensed Nursing Home Administrator (LNHA) was not made aware of the incident.

On 6/22/23 at 4:00 PM, the survey team interviewed LNHA, who stated, "The incident should have been reported to the New Jersey Department Of Health (NJDOH), investigated, and the CNA should have been suspended pending the investigation.

A review of the facility policy titled, Abuse, Neglect & Exploitation - prevention, Reporting and Investigation, Effective Date: 5/31/16 revealed under the Action Steps section 2, subsection a) "All team members are mandated reporters and are required to report allegations or a known episode of abuse, neglect and/or exploitation to applicable state authorities within the time frame established by law." h) "Steps to take to ensure the safety and protection of residents in situations of known or suspected abuse, neglect and/or exploitation, including escalation to the Executive Director/designee." Section 8 The SNA/designee, subsection b) "Removes the individual alleged to be involved in the abuse, neglect or exploitation from the area, part i. Ensures that any team member alleged to be involved in the abuse, neglect or exploitation is placed on administrative leave, pending the results of the investigation. c) Ensures that the resident's (i) physician, (ii) legal representative and (iii) family member or other individual

and at the conclusion of the 3- month period, the Committee will reevaluate and initiate any necessary action or extend the review period.
The Administrator is responsible for ensuring implementation and ongoing compliance of this POC and addressing and resolving any variances that may occur..

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F 610	Continued From page 15 regularly involved in the resident's day to day care are notified as soon as practicable within timeframes established within laws/regulations." On 6/27/23 at 10:00 AM, surveyor met with LNHA with stated, that the facility should have reported the abuse to the New Jersey Department of Health (NJDOH) well the allegation was made and per the facility policy an investigation should have begun as well as the CNA #1 being suspended until the outcome of the investigation was reached. The LNHA also stated the DON and SW were going through retraining on abuse and reporting. NJAC: 8:39-27.1 (a)	F 610		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to accurately code resident's Minimum Data Set (MDS), an assessment tool used to facilitate the management of care. This deficient practice was identified for one 1 of 12 residents, (Resident #21) reviewed for accurate coding of MDS. This deficient practice was evidenced by the following: On 6/20/23 at 10:01 AM, Resident #21 was observed lying in bed awake, alert, and responded appropriately to the surveyor. The	F 641	Deficiency F641 1.Immediate action(s) taken for the resident(s) found to have been affected include: The licensed professional who was responsible for completing the MDS was provided refresher training by the Senior DNS on accurate data collection and accurate documentation. MDS with ARD [redacted] was modified 06/23/2023 and accepted 06/23/2023.	7/21/23

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F 641	Continued From page 16 surveyor observed floor mats against the wall by the window in the resident's room. Resident #21 had their call bell within reach. On 6/21/23 at 9:43 AM, Resident #21 was observed lying in bed awake, alert, and verbally responsive. The resident informed the surveyor that they were ok. The resident had [redacted] The floor mats for Resident #21 were noted against the wall by the window. The surveyor reviewed the resident's hybrid medical chart which included review of paper as well as computerized medical chart. A review of Resident #21's Face Sheet (a one-page summary of important information about the resident) documented the resident's diagnosis which included but was not limited to [redacted] A review of the Health Status Progress Note dated [redacted] documented, [redacted]. Further review of the Health Status Progress Note dated [redacted]3 documented, "Resident was heard [redacted]. The care manager went to the room and found the resident [redacted] Review of the Minimum Data Set (MDS), an assessment tool used to facilitate the	F 641	2.Identification of other residents having the potential to be affected was accomplished by: Falls for the previous 60 days were reviewed beginning 07/13/2023, and MDS coding is being verified for accuracy. 3.Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service education was conducted by the Sr. Director of Nursing Services with the MDS Coordinator(s) 07/13/2023 addressing the importance of identifying falls in the look back period. The MDS was modified and accepted by CMS. A plan has been initiated to provide the MDS Coordinator with a list of weekly falls prior to the IDT meeting. IDT will continue to discuss all falls during morning meeting. RAI Manual Steps for Assessment 1. If this is the first assessment/entry or reentry (A0310E = 1), review the medical record for the time period from the admission date to the ARD. 2. If this is not the first assessment/entry or reentry (A0310E = 0), the review period is from the day after the ARD of the last MDS assessment to the ARD of the current assessment. 3. Review all available sources for any fall since the last assessment, no matter whether it occurred while out in the	

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F 641	Continued From page 17 management of care dated [redacted], indicated that Resident #21 had a Brief Interview for Mental Status (BIMS) score [redacted]. This score established that Resident #21 had [redacted]. A review of Resident #21's MDS dated [redacted], Section J1800 - Any Falls Since Prior Assessment coded as [redacted] The documentation in the MDS contradicted the resident's [redacted] Health Status Progress Notes dated from [redacted] On 6/22/23 at 11:02 AM, the surveyor along with MDS Coordinator reviewed the Quarterly assessment dated [redacted] which documented [redacted] and the Health Status Progress Notes dated [redacted], which revealed that Resident #21 had a [redacted]. The MDS Coordinator reviewed her [redacted] in the presence of the surveyor, which revealed that Resident #21 had [redacted]. The MDS Coordinator confirmed that she missed coding [redacted]. Further review of Health Status Notes dated [redacted], with the MDS Coordinator documented that Resident #21 had [redacted] The MDS Coordinator reviewed her [redacted] and confirmed that she had also missed coding the [redacted] as well. No further information was provided. NJAC 8:39-33.2(d)	F 641	community, in an acute hospital, or in the nursing home. Include medical records generated in any health care setting since last assessment. 4. Review nursing home incident reports, fall logs and the medical record (physician, nursing, therapy, and nursing assistant notes). 4.How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services, or designee, will conduct a random audit of three (3) residents per week for three (3) consecutive months. These residents and their medical records will be assessed for all falls to be accurately identified, properly evaluated and documented in the MDS. Starting on 6/23/2023 and for the next 3 months, to confirm that the processes outlined above are sustained, the Administrator and/or designee will report the findings of the above observations and audits to the QAPI Committee. During and at the conclusion of the 3- month period, the Committee will reevaluate and initiate any necessary action or extend the review period. The administrator is responsible for ensuring implementation and ongoing compliance of this POC and addressing and resolving any variances that may occur.	

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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 §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	F 656		7/28/23

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F 656	Continued From page 19 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- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to carry out a comprehensive care plan (CP) for 1 of 12 residents reviewed for the fulfillment of a care plan, Resident #21. This deficient practice was evidenced by the following: On 6/20/23 at 10:01 AM, Resident #21 was observed lying in bed awake, alert, and verbally responsive. The surveyor observed floor mats that were leaning against the wall by the window. On 6/21/23 at 9:43 AM, Resident #21 was observed lying in bed awake, alert, and verbally responsive. The surveyor observed floor mats that were leaning against the wall by the window. The surveyor reviewed the resident's hybrid (paper and electronic) medical chart which revealed the following: A review of Resident #21's Face Sheet (a one-page summary of important information about the patient) documented the resident's diagnoses included but were not limited to [redacted].	F 656	Deficiency F656 1. Immediate action(s) taken for the resident(s) found to have been affected include: Identified on 06/23/2023 that resident had order [redacted] while in bed; ensured that [redacted] were in place per order. Licensed staff will continue to be in-serviced to follow floor mat procedures: placing floor mats as ordered while resident is in bed. 2. Identification of other residents having the potential to be affected was accomplished by: All residents with floor mat orders have care plans reviewed and verified for accuracy of documentation and care planning. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Care plans and orders are being reviewed for accuracy of documentation weekly for the next three (3) months.	

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F 656	Continued From page 20 A review of the Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that the resident had a Brief Interview for Mental Status (BIMS) score [redacted] indicating that Resident #21 had NJ Exec. Order 26:4.b.1 . A review of Resident #21's CP with an effective date of NJ Exec. Order 26:4.b.1 presented a goal that "[Resident #21] will NJ Exec. Order 26:4.b.1 [redacted] through the next review date." An intervention in the CP, dated [redacted] read "The resident uses NJ Exec. Order 26:4.b.1 ordered by MD. Ensure the NJ Exec. Order 26:4.b.1 at bedtime." A review of the Physician's Orders (PO) indicated an order, dated [redacted], for NJ Exec. Order 26:4.b.1 [redacted] On 6/21/23 at 9:48 AM, the surveyor interviewed the Registered Nurse (RN) assigned to Resident #21. The RN stated [redacted] were used at night time only, placed on both sides of the bed, and that in the morning [redacted] were not needed because the resident was being supervised. The surveyor reviewed with the RN the resident's PO, which revealed the physician order for [redacted] while the resident was in bed for every shift. The RN stated that [redacted] should be at both sides of the bed while the resident was in bed as per the physician's order. On 6/21/23 at 2:05 PM, the surveyor informed the Director of Nursing, Senior Director of Nursing Supervisor (DNS), Licensed Nursing Home Administrator, and Associate Executive Director, of the above concerns. The DNS stated it was expected that when the resident was in bed that	F 656	4. How the corrective action(s) will be monitored to ensure the practice will not recur: Care plans are reviewed weekly in accordance with the care plan review schedule by the MDS Coordinator(s) or designee. All care plans will be updated as indicated. The Director of Nursing Services (DNS), or designee, will complete random weekly audits of three (3) care plans for three (3) consecutive months. Starting on 7/28/2023, weekly for the next 3 months, to confirm that the processes outlined above are sustained, the Administrator and/or designee will report the findings of the above observations and audits to the QAPI Committee. During and at the conclusion of the 3- month period, the Committee will reevaluate and initiate any necessary action or extend the review period. The administrator is responsible for ensuring implementation and ongoing compliance of this POC and addressing and resolving any variances that may occur.	

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	315351	A. BUILDING _____ B. WING _____	C 06/27/2023

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F 656	Continued From page 21 the [NJ Exec. Order 26:4.b.1] should have been in place. There was no further information provided by the facility. N.J.A.C. 8:39-11.2; 27.1 (a)	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to	F 657	Deficiency F657 1. Immediate action(s) taken for the	7/28/23

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F 657	Continued From page 22 revise a comprehensive care plan for 2 of 18 residents reviewed, Resident #14 and Resident #21. This deficient practice was identified by the following: On 6/19/23 at 12:27 PM, the surveyor observed Resident #14 in the room seated in their wheelchair. The resident was alert and verbally responsive. The surveyor further observed that the resident had NJ Exec. Order 26:4.b.1 [redacted] The surveyor reviewed Resident #14's hybrid medical records. The Admission Record reflected that Resident #14 was admitted. to the facility with medical diagnoses which included but were not limited t NJ Exec. Order 26:4.b.1 [redacted] A review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident had a Brief Interview for Mental Status (BIMS) of [redacted] of 15 indicating that the resident had NJ Exec. Order 26:4.b.1 . A review of the June 2023 Physician Order Summary revealed a physician's order dated [redacted] for NJ Exec. Order 26:4.b.1 [redacted] A review of the form titled; NJ Exec. Order 26:4.b.1 [redacted] dated [redacted] revealed that Resident	F 657	resident(s) found to have been affected include: Care plan was reviewed and updated 07/05/2023 for NJ Exec. Order 26:4.b.1 for Resident # 14. Care plan reviewed 07/05/2023 for [redacted] for Resident # 21. 2.Identification of other residents having the potential to be affected was accomplished by: All residents with floor mat orders and care plans were reviewed and verified for accuracy. All residents with wounds have had care plans reviewed and verified for accuracy. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Care plans and orders will be reviewed weekly for all residents with fall mats or wounds during interdisciplinary team meetings for the next three months. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The DNS, or designee, will conduct a weekly random audit of three (3) residents for a period of three (3) consecutive months to ensure that the resident care plan has been updated/revised with falls and wounds documentation. Starting on 7/28/2023 weekly for the next 3 months, to confirm that the processes outlined above are sustained, the Administrator and/or designee will report	

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F 657	Continued From page 23 #14 had an NJ Exec. Order 26:4.b.1 [redacted]). The surveyor reviewed the resident's care plan (provides direction on the type of nursing care for an individual) which had no documentation indicating that Resident #14 had NJ Exec. Order 26:4. [redacted]. On 6/21/23 at 10:30 AM, the Licensed Practical Nurse (LPN) who was assigned to care for Resident #14, stated that the care plan was not updated to indicate the resident's NJ Exec. Order 26:4.b.1. The LPN verified that Resident #14's care plan should have included the resident's NJ Exec. Order 26:4.b [redacted] 2. On 6/20/23 at 10:01 AM, the surveyor observed Resident #21 lying in bed awake, alert, and responded appropriately to the surveyor. The Surveyor observed floor mats standing against the wall by the window of the resident's room. Resident #21 had their call bell within reach. On 6/21/23 at 9:43 AM, the surveyor observed Resident #21 lying in bed awake, alert, and verbally responsive. The resident informed the surveyor that they were doing ok. Resident #21 had NJ Exec. Order 26:4.b.1 [redacted]. Once again, the surveyor observed the floor mats standing against the wall by the window of the resident's room. A review of Resident #21's Face Sheet (a one-page summary of vital information about the patient) revealed the resident had diagnoses	F 657	the findings of the above observations and audits to the QAPI Committee. During and at the conclusion of the 3- month period, the Committee will reevaluate and initiate any necessary action or extend the review period. The administrator is responsible for ensuring implementation and ongoing compliance of this POC and addressing and resolving any variances that may occur.	

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F 657	Continued From page 24 which included but were not limited to [redacted] Review of the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted], the resident had a Brief Interview for Mental Status (BIMS) score [redacted] out of 15, indicating that Resident #21 had [redacted]. A review of the Health Status Progress Notes revealed that Resident #21 had [redacted] Resident #21 had a total [redacted] since admission to the facility. A review of the resident's care plan (CP) initiated on [redacted] identified Resident #21 was [redacted] which included a list of dates when Resident #21 had [redacted] The CP Focus section failed to include the [redacted] that occurred on [redacted] and [redacted]. Further review of the Resident #21's CP identified an initiation date of [redacted] for [redacted]. The CP was revised on [redacted], with a new documented intervention of "resident [redacted] ordered by MD. Ensure [redacted]." The CP was again revised on [redacted], with a new intervention for "educate resident about [redacted] s needed." The CP had the most recent revision on [redacted],	F 657		

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F 657	Continued From page 25 adding a new intervention for "NJ Exec. Order 26:4.b.1 [redacted]." On 6/22/23 at 11:40 AM, the surveyor interviewed the Director of Nursing Supervisor (DONS) and the Director of Nursing (DON) in reference to updating fall interventions when there is a new fall. The DNS explained that all fall interventions are documented on progress notes, the task section, and/or care plans. The DNS added that interventions documented in the progress notes or task section should be included in care plan interventions. A review of the facility's policy titled, Incident and Event Reporting presented, "The intent of this policy is that the community identifies each resident at risk for events/incidents and/or falls, and adequately plans care and implements procedure to prevent accidents." On 6/26/23 at 2:17 PM, the surveyor interviewed the Acting DON who confirmed that all nurses or other disciplines can update the CP. The Acting DON verified that CPs should be updated and reviewed every time a fall occurs. No further information was provided. NJAC 8:39-11.2(i)	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F 658		7/21/23

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F 658	Continued From page 26 This REQUIREMENT is not met as evidenced by: 1) Based on observation, interviews, and record review, it was determined the facility failed to consistently follow standards of clinical practice with regard to a.) accurately documenting medication administration, and b.) correctly following physician's orders for 2 of 12 residents, Resident #19 and Resident #15. The deficient practice is evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."	F 658	Deficiency F658 1.Immediate action(s) taken for the resident(s) found to have been affected include: EMAR software/PCC was updated on 06/22/2023 to include NJ Exec. Order 26:4.b.1 [redacted] documentation as per medical doctor's order for resident #19. Duplicate medication order was discontinued 06/22/2023 for Resident # 15. Senior DNS provided in-service to nurse on proper transcription and documentation on 06/21/2023. 2.Identification of other residents having the potential to be affected was accomplished by: Residents with anti-hypertensive medications were audited for parameters and documentation 07/18/2023. Findings were addressed. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: On 06/21/2023, the Senior Director of Nursing Services/DNS provided in-service for the licensed staff regarding following of procedure for medication transcriptions. On 07/20/2023, the Senior Director of	

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F 658	Continued From page 27 1. The surveyor reviewed the hybrid medical records of Resident #19, which revealed the following: The resident's Admission Record listed diagnoses that included but were not limited to [redacted] The Quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], indicated that the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored [redacted] out of 15, which indicated that the resident had [redacted] A review of the Order Summary Report and the electronic Medication Administration Record (eMAR) indicated Resident #19 had physician orders dated [redacted], that read: [redacted] A review of the June 2023, May 2023, and April 2023 eMAR for Resident #19 revealed that at the time of the administration of the [redacted] there was no documentation of the resident's [redacted] On 6/21/23 at 11:28 am, the surveyor interviewed LPN #1 about the [redacted] order and any special instructions for the medication. LPN #1	F 658	Nursing Services and DNS initiated in-service for the licensed staff regarding procedure for duplicate order. 4.How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services or designee will audit all residents for duplicate orders and resident parameters weekly for the next three (3) months. The Director of Nursing Services or designee will audit all residents on anti-hypertensive medications weekly for parameters for the next three (3) months. Starting on 6/23/2023 and for the next 3 months, to confirm that the processes outlined above are sustained, the Administrator and/or designee will report the findings of the above observations and audits to the QAPI Committee. During and at the conclusion of the 3- month period, the Committee will reevaluate and initiate any necessary action or extend the review period. The administrator is responsible for ensuring implementation and ongoing compliance of this POC and addressing and resolving any variances that may occur.	

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stated he was aware Resident #19 had parameters to NJ Exec. Order 26:4.b.1 LPN #1 stated he checked the resident's NJ Exec. Order 26:4.b.1 to administering the medication. He acknowledged that he did not enter the NJ Exec. Order 26:4.b.1 in the electronic medical record at the time of the medication's administration.

On 6/21/23 at 11:57 am, the surveyor interviewed the Licensed Practical Nurse/Charge Nurse (LPN/CN) about the NJ Exec. Order 26:4.b.1 medication order and documentation of the resident's NJ Exec. Order 26:4 medication administration. The LPN/CN stated the eMAR would prompt at the time of medication administration for the nurse to document the resident's NJ Exec. O LPN/CN reviewed the physician's order and the eMAR with the surveyor and stated she did not know why it was not picked up by the nurses and why the order was not clarified in the eMAR. LPN/CN acknowledged it would be expected for the nurse to enter NJ Exec. Order 2 at the time of the medication administration on the eMAR.

On 6/21/23 at 12:12 pm, the surveyor interviewed the Director of Nursing (DON) about the above concerns. The DON stated it was expected for the NJ Exec. Order 26:4.b.1 to be checked and documented prior to the medication's administration. The DON stated that the nurses and pharmacy consultant should have caught that NJ Exec. Order 2 was not being documented at the time that the medication was administered.
On 6/21/23 at 2:05 pm, the surveyor informed the Administrator, Senior Director of Nursing Services, Associate Executive, and DON of the above concerns.

The surveyor reviewed the facility provided policy

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titled "Medication Administration", with a date of 01/23. Under Medication Administration, it read: "1. Medications are administered in accordance with written orders of the prescriber ...2. Obtain and record any vital signs as necessary prior to medication administration."

2.) On 6/19/23 at 12:22 PM, the surveyor observed Resident #15 in the room, lying in bed, awake, alert, and verbally responsive.

The surveyor reviewed the resident's hybrid medical records, which revealed that Resident #15 was admitted to the facility with diagnosis which included but were not limited to [redacted]

A review of the Admission Minimum Data Set, an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident had a Brief Interview for Mental Status [redacted] out of 15, indicating that the resident had [redacted].

A review of the resident's June 2023 Order Summary Report indicated a physician's order (PO) having a start date of [redacted] for [redacted]

There was also another PO having a start date of [redacted] for [redacted]

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A review of the June 2023 eMAR revealed the PO for NJ Exec. Order 26:4.b.1 with a start date of [redacted] was scheduled to be administered to Resident #15 at 9:00 AM.

Further review of the eMAR revealed the PO with a start date of [redacted] for NJ Exec. Order 26:4.b.1 [redacted] was scheduled to be administered to Resident #15 at 9:00 AM and 5:00 PM.

On 6/22/23 at 1:43 PM, the surveyor interviewed the Licensed Practical Nurse #1 (LPN #1), assigned to care for Resident #15, regarding the two different PO for the same medication to treat [redacted]. LPN #1 explained that she administered NJ Exec. Order 26:4.b.1 [redacted] for the 9:00 AM dose. LPN #1 informed the surveyor that the LPN/CN obtained the [redacted] PO from the physician.

On 6/22/23 at 1:50 PM, the surveyor interviewed LPN/CN, who acknowledged that when she obtained the PO dated NJ Exec. Order 26:4.b.1 [redacted] LPN/CN explained that she should have discontinued the PO dated [redacted] for [redacted] one time a day and not have both POs active. LPN/CN stated that both orders should not have been active and administered to Resident #15 together.

On 6/26/23 at 2:00 PM, the surveyor discussed the above concern with the facility's Licensed Nursing Home Administrator and Director of Nursing, who did not provide any further information.

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F 658	Continued From page 31 NJAC 8:39-11.2 (b); 29.2(d)	F 658		
F 755 SS=D	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 by:	F 755		8/2/23

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F 755	Continued From page 32 Based on observation, interview, and record review, it was determined that the facility failed to ensure that medications were 1. stored in a secure locked environment, 2. expired medications were removed from a resident's active inventory after it had expired and/or been discontinued by the physician in accordance with professional standards of clinical practice, 3. removed expired narcotics kept in a locked backup box. This deficient practice was identified for 1 of 1 units reviewed during the facility unit inspection process. This deficient practice was evidence by the following: 1. On 6/19/23 at 10:03 AM, a surveyor along with another surveyor requested from the Unit Clerk (UC), "if someone could open the medication room door for inspection." At that time the UC volunteered to open the locked medication room door, and had access to the passcode. The UC entered the keypad code unlocking the medication room door. 2. Once within the locked medication room, the surveyors noted that there were 3 cassette boxes filled with numerous non-narcotic prescription back up medications secured with zip ties on the counter of the medication room. These medications were accessible to the UC, and any other non medical person who would have the access code to the keypad locking and securing the medication room. 2. Once in the medication room, the surveyor asked if the locked refrigerator could be opened. The UC stated that she'd be right back and left the medication room.	F 755	Deficiency F755 1.Immediate action(s) taken for the resident(s) found to have been affected include: On 6/21/2023, the DNS immediately secured the keys for the medication room from the concierge, locked the door to secure all resident medications, and changed code to the door. On 6/21/2023, the DNS collected the extra keys to the medication room and the refrigerator and placed the keys in a lockbox. On 6/21/2023, the Two (2) IV ABT bags/medications of the resident that was discharged were disposed of by the DNS. On 6/21/2023, the discontinued and expired medications Vancomycin 1250mg and Ceftriaxone 1gm were removed from the medication carts and disposed as per facility protocols by the DNS. On 06/21/2023, the expired Lyrica 50mg and Morphine Sulfate 15 mg, were removed from the medication carts by DNS, removed from active inventory and are awaiting DEA authorization for destruction. 2.Identification of other residents having the potential to be affected was accomplished by: On 6/22/2023, the DNS interviewed staff to determine if they are aware of how to	

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F 755	Continued From page 33 The UC returned to the medication room with the key to the refrigerator, opening the locked refrigerator for the surveyors. On 6/19/23 at 12:11 PM, the surveyor interviewed the UC in the presence of another surveyor, the UC informed the surveyor that she was given the refrigerator key by the Registered Nurse (RN), who was busy administering medications. On 6/19/23 at 12:34 PM, the surveyors interviewed the DON in the presence of the Licensed Practical Nurse in charge of the unit (LPN), who stated that only nurses should have access to the medication room. "The Concierge (UC) should not have access to the medication room." The LPN added that the access keys to the medication room and refrigerator are kept in the drawer of the nursing office and only nurses should have access to the keys. The LPN stated that the UC should not have had access or knowledge of the keypad code to the medication room. An interview of the UC on 6/19/23 at 12:40 PM, stated that the RN gave her the keys to the refrigerator. On 6/19/23 at 12:40 PM, the surveyor interviewed the RN who stated that she gave her refrigerator keys to the UC. "I shouldn't have done that. She shouldn't have access." 3. On 6/19/23 at 12:12 PM, the surveyors encountered the LPN who entered the medication room to help the surveyors. The surveyors	F 755	open/unlock door to the medication room. Code was changed and provided to personnel that require access. On 6/22/2023, the DNS completed a medication audit to verify all discontinued and expired medications, including narcotics, were removed from the medication carts and disposed as per facility protocols. 3.Actions taken/systems put into place to reduce the risk of future occurrence include: Starting 6/20/2023, upon hiring a staff person that requires access to the medication room, who is lawfully authorized to administer medications, the DNS will provide the door code to the secured medication room. Starting 8/2/2023, DNS will change the medication room door code quarterly and will distribute the door code to only licensed personnel. On 6/20/2023, the Senior Director of Nursing and the DNS in-serviced staff that the medication supply room will be accessible to only licensed personnel. Starting 06/21/2023, upon receipt of a discontinuation medication order the licensed personnel will remove the medication from the medication cart/ room and dispose of the medications per policy. Starting 06/21/2023, upon identification of an expired medication the licensed	

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F 755	Continued From page 34 inspected the refrigerator and found 2 intravenous medication bags that had expired. The surveyors found Vancomycin 1250 mg (antibiotic therapy) 262.5 milliliters (ml) that had been manufactured by the Provider Pharmacy on 6/8/23 and had a documented expiration date of 6/17/23. In the presence of the LPN, the surveyors also found Ceftriaxone 1 gm (antibiotic therapy) 50 ml that had been manufactured by the Provider Pharmacy on 5/18/23 and had a documented expiration date of 6/7/23. The LPN explained that both of these medications were discontinued and should have been immediately removed from the refrigerator by the nursing staff and discarded. The LPN added that the Consultant Pharmacist (CRPh) performs unit inspections monthly. The LPN stated that he should have picked this up. 4. On 6/20/23 at 10:10 AM, the DON in the presence of the surveyor completed a narcotic inventory of all narcotics double locked in the wall lock box located in the medication room. During the narcotic inventory review, the surveyor found #10 tablets of Lyrica (non-narcotic pain reliever) 50 mg which had expired on 4/2023 and #10 tablets of Morphine Sulfate (Opioid narcotic pain reliever) 15 mg tablets which had expired 2/2023. On 6/20/23 at 12:29 PM the surveyor interviewed the LPN who stated that all narcotics are counted every shift by nursing, and they should have noticed the expired narcotics in the wall lock box and removed them from active stock.	F 755	personnel will remove the medication from the medication cart/ room and dispose of the medications per policy. Starting 08/2/2023, a weekly Medication cart audit by a licensed professional will be completed to verify all discontinued and expired medications are removed from active inventory and disposed of per facility protocols. On 06/21/2023, the Senior Director of Nursing/DNS in-serviced staff regarding medications to ensure medications are stored properly and that expired medications are removed from active inventory for destruction per policy. Beginning on 6/21/2023, the SDNS and DNS began to in-service nurses to check medication cart and the medication room for discontinued and expired medications and to remove and dispose of expired and discontinued medications per policy. On 6/22/2023 the administrator met with the consulting pharmacist and reviewed the findings from the inspection that were related to the expired and discontinued medications. Starting 7/03/2023 the monthly consultant pharmacist visit will include an audit for expired medication in the medication cart and the medication room. The administrator will request audit results monthly. 4.How the corrective action(s) will be	

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F 755	Continued From page 35 The LPN added that the Consultant Pharmacist (CRPh) performs unit inspections monthly. The LPN stated that he should have picked this up. 5. The surveyor reviewed the Consultant Pharmacist Unit Inspection Reports received from 1/2023 to the last inspection dated June 8, 2023. There were no documentations that alerted the facility of Ceftriaxone 1 gm (antibiotic therapy) 50 ml that had a documented expiration date of 6/7/23, Lyrica (non-narcotic pain reliever) 50 mg which had expired on 4/2023 and #10 tablets of Morphine Sulfate (Opioid narcotic pain reliever) 15 mg tablets which had expired 2/2023. On 6/26/23 at 11:26 AM, the surveyor interviewed the Consultant Pharmacist (CRPh) who stated that he was not aware of backup narcotics stored in the wall lock box. The CRPH admitted that he should have removed Ceftriaxone 1 gm (expiration 6/7/23) from the refrigerator when he performed the last facility unit inspection of the refrigerator on 6/8/23. The Storage of Medication policy was reviewed, "Medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations, to maintain their integrity and to support safe effective administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications." Continued review of the procedures of The Storage of Medication policy, "3. In order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully	F 755	monitored to ensure that the practice will not reoccur. Starting 7/28/2023 the DNS or designee will conduct random observations selecting two (2) unlicensed team members weekly to inquire if they have access to the medication room. Starting 8/2/2023 DNS or designee will monitor the weekly medication cart and the medication room audit every two weeks as well as, the monthly audit results from the consultant pharmacist for the next three months to verify compliance with process. Starting 7/21/2023 and for the next three months, to confirm that the processes above are sustained, the administrator or designee will report the findings of the above observations and audits to the QUAPI committee. During and at the conclusion of the three month period, the committee will reevaluate and initiate any necessary action or extend the review period. The administrator is responsible for ensuring implementation and ongoing compliance of this POC and addressing and resolving any variances that may occur.	

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authorized to administer medications (such as medication aides) are allowed access to medication carts. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access."

In addition to the above documentation of The Storage of Medication policy, "14. Outdated, contaminated, discontinued, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy."

Review of the Controlled Medication Storage policy, "Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and record keeping in the nursing care center in accordance with federal, state and other applicable laws and regulations." Under, "PROCEDURES 1. The director of nursing and the consultant pharmacist monitor for compliance with federal and state laws and regulations in the handling of controlled medications."

Continued review of the Controlled Medication Storage policy, "PROCEDURES 8. The consultant pharmacist, or pharmacy designee, routinely reviews a sampling audit of controlled medication storage, records, and expiration dates during medication storage inspections."

On 6/21/23 at 2:05 PM, the surveyor discussed concerns related to the unit inspection findings with the DON, Senior Director of Nuring Services,

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F 755	Continued From page 37 Licensed Nursing Home Administrator (LNHA), and Associate Executive Director. There was no additional information provided. On 6/26/23 at 3:43 PM, the surveyor discussed concerns related to the interview with the CRPh that had transpired, with the LNHA, the temporary replacement DON, Director of Operations and Assistant DON. There was no additional information provided. NJAC 8:39-29.4(g)	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the	F 756		7/21/23

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F 756	Continued From page 38 resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the Consultant Pharmacist (CP) failed to identify and notify the facility of medication irregularities. These irregularities were identified for 2 of 12 residents reviewed, Resident #19, and Resident #21. The deficient practice was evidenced by the following: 1. The surveyor reviewed the hybrid medical records of Resident #19 which revealed the following: The resident's Admission Record listed diagnoses that included but were not limited to NJ Exec. Order 26:4.b.1 [redacted] The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], indicated that	F 756	Deficiency F756 1.Immediate action(s) taken for the resident(s) found to have been affected include: Parameters for NJ Exec. Order 26:4.b.1 [redacted] were added 06/22/2023 for Resident # 19. As of 06/22/2023 duplicate medication order for Resident # 21 was discontinued. CP (Consultant Pharmacist) in-serviced by Administrator on 06/27/2023 on eMAR use and access, need to alert facility for duplicate orders and lack of parameters after review of resident□s medications. 2.Identification of other residents having the potential to be affected was accomplished by: Residents with anti-hypertensive medications were audited for parameters and documentation 07/18/2023.	

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F 756	Continued From page 39 the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored [redacted] out of 15 which indicated that the resident had [redacted] A review of the Order Summary Report and the electronic Medication Administration Record (eMAR) indicated Resident #19 had physician orders, dated [redacted] A review of the June 2023, May 2023, and April 2023 eMAR for Resident #19 revealed that at the time of the administration of the [redacted], there was no documentation of the resident's [redacted] prior to administration of the medication. A review of the Consultant Pharmacist Progress Notes revealed the CP visited and documented comments monthly. There were no comments or recommendations documented informing the facility of the lack of documentation for the [redacted] order evaluating [redacted] for December 2022 through to June 2023. On 6/21/23 at 11:28 AM, the surveyor interviewed LPN #1 about the [redacted] order and any special instructions for the administration of the medication. LPN #1 acknowledged that he did not document the [redacted] result in the eMAR at the time of the medication's administration. On 6/21/23 at 11:57 AM, the surveyor interviewed the Licensed Practical Nurse/Charge Nurse (LPN/CN) about the [redacted] medication order	F 756	3. Actions taken/systems put into place to reduce the risk of future occurrence include: On 06/21/2023, the Senior Director of Nursing Services/DNS provided in-service education for the licensed staff regarding following of procedure for medication transcriptions. On 07/20/2023, the Senior Director of Nursing Services and DNS initiated an in-service for the licensed staff regarding procedure for not having duplicate orders. Licensed staff was in-serviced on 07/20/2023 on reviewing eMAR for duplications and missing parameters for anti-hypertensive medications by SDNS and DNS. Monthly CP visit will include audit for expired medications in med carts and med room. The administrator will request audit results monthly. 4.How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services or designee will review every two (2) weeks to identify that there are no duplicate orders and resident parameters for anti-hypertensive medications are in place. The consultant pharmacist will review monthly to identify that there are no duplicate orders and resident parameters for anti-hypertensive medications are in place. Starting on 6/23/2023 and for the next 3 months, to confirm that the processes outlined above are sustained, the	

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F 756	Continued From page 40 and the documentation of the resident's [NJ Exec. Order 26:4.b] medication administration. The LPN/CN explained that the electronic medical record has a prompt associated with the eMAR at the time of [NJ Exec. Order 26:4.b.1] administration that should alert the nurse to monitor and document the resident's [NJ Exec. Ord] The LPN/CN reviewed the physician's order and the eMAR with the surveyor, revealing that the prompt to alert the nurses for monitoring [NJ Exec. Ord] was not turned on when the order was entered into the eMAR. The LPN/CN could not explain why it was not picked up by the nurses and why the order was not clarified in the eMAR. The LPN/CN acknowledged it would be expected for the nurse to enter [NJ Exec. Order 2] at the time of the medication administration on the eMAR. On 6/21/23 at 12:12 pm, the surveyor interviewed the Director of Nursing (DON) about the above concerns. The DON stated it was expected for the [NJ Exec. Order 26:4.b.1] to be monitored and documented prior to the medication's administration. The DON stated that the nurses should have corrected the eMAR to alert for the documentation of [NJ Exec. Order 26:4.b]. The DON also remarked that the CP should have alerted the facility staff that [NJ Exec. Order 26:4.b] was not being monitored or documented on the eMAR at the time that the medication was administered. On 6/21/23 at 2:05 PM, the surveyor informed the Administrator, Senior Director of Nursing Services, Associate Executive and DON of the above concerns.	F 756	Administrator and/or designee will report the findings of the above observations and audits to the QAPI Committee. During and at the conclusion of the 3- month period, the Committee will reevaluate and initiate any necessary action or extend the review period. The administrator is responsible for ensuring implementation and ongoing compliance of this POC and addressing and resolving any variances that may occur.	

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F 756	Continued From page 41 On 6/26/23 at 11:26 am, the surveyor interviewed the CP about the process for reviewing medications with [NJ Exec. Order 26:4.b.1]. The CP explained that he did not review the eMAR for irregularities. The CP indicated that the nurses administering medication ordered by the physician with parameters, are expected to monitor and document [NJ Exec. Order 26] on the eMAR. The surveyor interviewed the CP asking if an accurate and comprehensive monthly medication review could be conducted without reviewing the eMAR to verify correct transcription of medication orders and that the physician orders were being administered accurately. The CP provided no verbal response. On 6/26/23 at 12:35 pm, the surveyor interviewed the Associate Executive Director (AED) who informed the surveyor that the CP had access to the electronic medical records and eMAR. The surveyor reviewed the facility document titled, "Pharmaceutical Consultant Services Contract Developed for Brighton Gardens of Edison Skilled", from June 2016. The contract indicated the CP would be responsible for the general supervision of the facility's pharmaceutical services and services included: " ...Help establish policies and procedures to ensure safe and appropriate administrations of medications ...Review all medication records on a monthly basis for the skilled sub-acute facility ..." The surveyor reviewed the facility provided policy titled, "Medication Administration", with a facility review date of 1/23. Under Medication Administration it read: "1. Medications are administered in accordance with written orders of	F 756		

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the prescriber ...2. Obtain and record any vital signs as necessary prior to medication administration."

2. On 6/20/23 at 10:01 AM, Resident #21 was observed lying in bed awake, alert, and responded appropriately to the surveyor. The surveyor observed floor mats against the wall by the window in the resident's room. The call bell was observed within reach for Resident #21's use.

The surveyor reviewed the resident's hybrid chart which included a paper as well as a computerized medical chart.

A review of Resident #21's Face Sheet (a one-page summary of relevant information about the patient) that documented the resident's diagnosis which included but was not limited to NJ Exec. Order 26:4.b.1 [redacted].

Review of Resident #21's Physician's orders (PO) presented active orders with start dates of NJ Exec. Order 26:4.b.1 for NJ Exec. Order 26:4.b.1 [redacted]

Review of the eMAR for the month of June 2023 and May 2023, revealed 2 separate sections for NJ Exec. Order 26:4.b.1 [redacted]

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above. Documentation on the eMAR revealed that Resident #21 had not received either one of the ordered [NJ Exec. Order 26:4] as needed medications.

A review of the Consultant Pharmacist Progress Notes revealed that the CP visited and documented comments monthly, with the last documented visit and comment [NJ Exec. Order 26:4.b.1]. A review of the initial pharmacy recommendations for Resident #21 dated [NJ Exec. Order 26:4] documented, "no NJ Exec. Order 26:4.b.1". There were no other comments or recommendations documented related to the resident's duplicate [NJ Exec. Order 26:4] order for August 2022 to June 2023.

On 6/26/23 at 11:45 AM, the surveyor interviewed the CP who stated that he reviews all resident's medications once a month. The CP added that his review of medications includes as needed medications based on the resident's PO. The CP revealed that he does not review the eMAR. The CP identified that he would document any duplicate in his report making recommendations to discontinue one of them.

During the interview with the CP about the two as needed [NJ Exec. Order 26:4] orders, the CP stated, "I must have missed those orders based on what the order is stated." The CP agreed that he had never notified the facility of the duplicate [NJ Exec. Order 26] as needed orders.

The surveyor reviewed the facility document titled, "Pharmaceutical Consultant Services Contract Developed for Brighton Gardens of Edison Skilled", created June 2016. The contract indicated the CP would be responsible for the general supervision of the facility's pharmaceutical services and services including:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315351	A. BUILDING _____ B. WING _____	C 06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF EDISON	1801 OAKTREE ROAD EDISON, NJ 08820

(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 756	Continued From page 44 "A review of all medication records on a monthly basis for the skilled subacute facility. Provide written reports to the Administrator and the Director of Nursing on a monthly basis for the skilled sub-acute facility." On 6/26/23 at 3:35 pm, the surveyor informed the Licensed Nursing Home Administrator, Acting DON, and Director of Operations of the interview with the CP. The Administrator stated that she would follow up with the CP. No further information was provided. On 6/27/23 at 9:37 AM, the surveyor along with the Registered Nurse (RN) reviewed Resident #21's PO, and the duplicate order for the as needed [redacted]. The RN explained that one of [redacted] as needed orders should have been discontinued. The RN acknowledged that there should not have been duplicate orders for as needed [redacted] NJAC 8:39- 29.3	F 756		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (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	F 812		7/21/23

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F 812	Continued From page 45 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of facility policies, it was determined the facility failed to properly label and date potentially hazardous foods in a safe and sanitary environment to prevent the development of food borne illness. This deficient practice was evidenced by the following. On 6/19/23 from 09:45 AM through 10:30 AM, the surveyor completed the initial kitchen tour located in the Assisted Living (AL) section of the building with the Food Service Director (FSD) and observed the following: 1. On top of the Sandwich/Deli counter prep area, the surveyor observed multiple opened bags of assorted loaves of bread with received dates but no open and/or use-by dates: a. One loaf of Rye bread, with a received date of 6/16/23 b. One loaf of Wheat bread, with a received date of 6/16/23 c. One loaf of White bread, with a received date of 6/16/23 d. One loaf of Raisin bread, with a received date of 6/16/23 e. One bag of Hamburger buns, with a received date of 6/16/23. The FSD stated all bread is discarded 7 days after opening and have not been labeling the bread with an open and/or a	F 812	Deficiency F812 1.Immediate action(s) taken for the resident(s) found to have been affected include: The specific deficiency cited for failure to label dry food, including the opening and use-by-date was corrected immediately. The correction for the specific deficiency cited began with labeling all items in the dry storage area. An in-service education was conducted by Dining Service Manager with all dietary staff regarding the proper procedure for labeling of dry foods, which includes the opening date and use-by-date. In-service was completed before the start of each team members next worked shift. The labels were placed on 06/19/2023. The deli prep area was audited 06/19/2023.The dry storage area was audited 06/19/2023. Worcestershire sauce was immediately disposed of on 06/19/2023 due to expiration. 2.Identification of other residents having the potential to be affected was accomplished by:	

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F 812	Continued From page 46 use-by date. 2. In the Dry storage area, the surveyor observed multiple containers opened without opened and/or use-by dates: a. Two 1-gallon apple Cider Vinegar both with the received dates of 12/31/22 b. One 1-gallon Soy Sauce with the received date of 4/29/23 c. One 1-gallon Worcestershire Sauce with the received date 4/29/23. The FSD could not indicate the open dates of the items mentioned above were opened or the use-by date. Surveyor requested a copy of the facility's food labeling and storage policy. The FSD acknowledged having the open and use-by dates on all products are needed to ensure the facility has the information on the estimated period of time for which the product will be of best. On 6/21/23 at 9:19 AM, the FSD provided the surveyor with a facility policy titled, Labeling and Dating for Safe Storage of Food, with a revised date of 3/6/2020 which revealed, "All products should be dated upon receipt. All products should be dated when opened. The Dry, Refrigerated, and Freezer Storage Charts note for staples, refrigerated, and freezer storage recommended storage time for unopened and opened products." On 6/21/23 at 2:05 PM, the survey team met with the Director of Nursing (DON), Administrator, and Associate Executive Director, who all stated that all items in the kitchen need to have received, open, and use-by dates. NJAC 8:39-17.2(g)	F 812	Dry storage, refrigerator and kitchen area were audited for expired products. Verified all products were labeled, sealed and dated. 3.Actions taken/systems put into place to reduce the risk of future occurrence include: Define the food storage process: -When dry storage food item is received it should be labeled with receipt date - When item is opened the date is written on the product along with discard date Dry storage labeling in-service was completed 06/19/2023. The Dining Service Manager will conduct once weekly audits of storage and kitchen area to verify the correct labeling and dating of all food items. 4.How the corrective action(s) will be monitored to ensure the practice will not recur: All audits and spot checks will be reported to the monthly Quality Assurance and Performance Improvement meeting. The Dining Services Coordinator will be responsible for implementing the acceptable plan of correction. Starting on 6/23/2023 and for the next 3 months, to confirm that the processes outlined above are sustained, the Administrator and/or designee will report the findings of the above observations	

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F 812	Continued From page 47	F 812	and audits to the QAPI Committee. During and at the conclusion of the 3- month period, the Committee will reevaluate and initiate any necessary action or extend the review period. The administrator is responsible for ensuring implementation and ongoing compliance of this POC and addressing and resolving any variances that may occur.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		7/21/23

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F 880	Continued From page 48	F 880		

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
(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

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F 880	Continued From page 49 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain proper infection control practices, which was identified during 1 of 1 NJ Exec. Order 26:4.b.1 observation for Resident # 14. This deficient practice was evidenced by the following: On 6/19/23 at 12:27 PM, the surveyor observed Resident #14 in their room seated in a wheelchair. The resident was alert and verbally responsive. The surveyor further observed that the resident had NJ Exec. Order 26:4.b.1 . The surveyor reviewed Resident #14's medical record on 6/1/23 at 12:29 PM. The Admission Record reflected that Resident #14 was admitted to the facility with medical diagnoses, which included but not limited to NJ Exec. Order 26:4.b.1 A review of the Admission Minimum Data Set, an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident had a Brief Interview for Mental Status of [redacted] indicating that the resident was NJ Exec. Order 26:4.b.1 A review of the June 2023 Physician Order Summary revealed a physician's order dated [redacted] for NJ Exec. Order 26:4.b.1	F 880	Deficiency F880 1.Immediate action(s) taken for the resident(s) found to have been affected include: Bed side table was immediately disinfected for resident #14.The identified licensed practical nurse was immediately in-serviced on the proper procedures for staging area disinfection on 6/21/23 by the DNS. 2.Identification of other residents having the potential to be affected was accomplished by: Observe nurses to determine they are following the correct procedure for disinfection of staged surface during wound care. 3.Actions taken/systems put into place to reduce the risk of future occurrence include: Beginning on 7/21/23 the Infection Preventionist (IP) will in-service all nurses on the need to clean staged areas during wound care. IP will meet with one (1) nurse per week for the next three (3) months for observation of cleaning procedure during wound treatment. 4.How the corrective action(s) will be	

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F 880	Continued From page 50 On 6/21/23 at 9:45 AM, the surveyor observed the Licensed Practical Nurse (LPN) gather all the needed supplies for NJ Exec. Order 26:4.b.1 of Resident #14 and placed it on top of the resident's bedside table without using a clean drape or any barrier in between. At the conclusion of NJ Exec. Order 26:4.b.1, the LPN discarded the supplies she used for NJ Exec. Order 26:4.b.1 and placed the bedside table next to the resident without disinfecting the table. The surveyor interviewed the LPN, who acknowledged that she did not sanitize the bedside table where she placed all the supplies for NJ Exec. Order 26:4.b.1. On 6/21/23 at 2:05 PM, the surveyor met with the facility's Licensed Nursing Home Administrator, Director of Nursing, Senior Director of Nursing Services, and Associate Executive Director to discuss the above concerns. There was no additional information provided. A review of the facility's Policy and Procedure titled "Skin Care & Pressure Ulcer Management Program" did not specifically indicate the procedures for wound dressing changes. NJAC 8-39-19.4 (a)	F 880	monitored to ensure the practice will not recur: The Infection Preventionist (IP) or designee, will complete once weekly wound care observation for next three (3) months to verify that staged areas are cleaned properly during wound care. Starting on 7/21/2023 and for the next 3 months, to confirm that the processes outlined above are sustained, the Administrator and/or designee will report the findings of the above observations and audits to the QAPI Committee. During and at the conclusion of the 3- month period, the Committee will reevaluate and initiate any necessary action or extend the review period. The administrator is responsible for ensuring implementation and ongoing compliance of this POC and addressing and resolving any variances that may occur.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315351 Y1	A. Building B. Wing Y2	8/11/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF EDISON	1801 OAKTREE ROAD EDISON, NJ 08820

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0557	Correction	ID Prefix F0600	Correction	ID Prefix F0609	Correction
Reg. # 483.10(e)(2)	Completed	Reg. # 483.12(a)(1)	Completed	Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed
LSC	07/21/2023	LSC	08/03/2023	LSC	08/02/2023
ID Prefix F0610	Correction	ID Prefix F0641	Correction	ID Prefix F0656	Correction
Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	08/02/2023	LSC	07/21/2023	LSC	07/28/2023
ID Prefix F0657	Correction	ID Prefix F0658	Correction	ID Prefix F0755	Correction
Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	07/28/2023	LSC	07/21/2023	LSC	08/02/2023
ID Prefix F0756	Correction	ID Prefix F0812	Correction	ID Prefix F0880	Correction
Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	07/21/2023	LSC	07/21/2023	LSC	07/21/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
6/27/2023	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315351	A. BUILDING **01** B. WING _____	**06/27/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF EDISON	**1801 OAKTREE ROAD** **EDISON, NJ 08820**

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E 000	Initial Comments . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 06/22/2023. The facility was found to be in compliance with 42 CFR 483.73. .	E 000		
K 000	INITIAL COMMENTS . A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 06/22/23 and was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Brighton Garden of Edison is a one-story building that was built in 1995. Acute care is in the West Wing. It is composed of Type II protected construction. The facility is divided into two - smoke zones. The generator does approximately 100 % of the building as per the Maintenance Director. The current occupied beds are 29 of 30. .	K 000		

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

Electronically Signed | 07/13/2023

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.