STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315387	A. BUILDING _____ B. WING _____	11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLAIRE REHAB & NURSING	115 DUTCH LANE ROAD FREEHOLD, NJ 07728

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Survey Date: 11/30/22 Census: 142 Sample: 30 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		12/30/22

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

Electronically Signed | 12/23/2022

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F 550	Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to maintain a [redacted] in a manner to promote dignity as per facility policy for 1 of 4 Residents (Resident # 16) reviewed for EX Order 26 § 4b1. This deficient practice was evidenced by the following: During the initial tour of the facility on 11/15/22 at 11:11 AM, the surveyor observed Resident #16's EX Order 26 § 4b1 that was attached to the bed frame. The drainage bag contained [redacted] and was	F 550	• All residents are at risk to be affected by the deficient practice • Resident #16 prefers [redacted] catheter bag to be uncovered and care plan was updated accordingly. • All residents who have foley catheter bags were checked to ensure that a dignity bag is in place. • All nursing staff re-educated on facility Resident Rights policy and he importance	

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F 550	Continued From page 2 not covered to maintain privacy. The surveyor made the same observations on 11/18/22 at 12:17 AM, 11/21/22 at 10:31 AM and 11/22/22 at 11:37 AM. During an interview with the surveyor on 11/22/22 at 12:17 AM, Resident #16 stated [redacted] Resident #16 further stated " I don't like it; if a family or friend comes in for a visit and they have to look [redacted] According to the Admission Record, Resident #16 was admitted with diagnoses that included, but were not limited to, EX Order 26 § 4b1 [redacted] Review of Resident #16's Quarterly Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care, dated 09/27/22, revealed that Resident #16 was EX Order 26 § 4b1 and had an EX Order 26 § 4b1 . . Review of the Care Plan (plan that provides direction on an individual's care) revealed Resident #16 had a EX Order 26 § 4b1 . During an interview with the surveyor on 11/22/22 at 12:02 PM, the Certified Nursing Assistant (CNA) #1 stated that the resident's EX Order 26 § 4b [redacted] should have a privacy cover on it. During an interview with the surveyor on 11/22/22 at 11:35 AM, LPN #2 stated that the resident's Ex.Order 26.4(b)(1) should have a privacy cover on it, so people don't see the [redacted]. During an interview with the surveyor on 11/29/22	F 550	of keeping a resident's foley catheter bag covered. • DON/Designee will audit 5 residents with foley catheter bags weekly X4 weeks and then monthly x3 months to ensure proper resident rights-dignity standards of foley catheter bags are being met. • Findings will be submitted to the monthly QAPI (quality assurance performance improvement) committee for 3 months who will determine further interventions as needed.	

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F 550	Continued From page 3 at 10:22 AM, the Registered Nurse Unit Manager (RN/UM) stated all EX Order 26 § 4b1 should have a privacy cover. During an interview with the survey team on 11/30/22 at 12:23 PM, the Director of Nursing (DON) stated that the EX Order 26 § 4b1 should be attached to the bed and in a privacy bag. The DON further stated it was important for the EX Order 26 § 4b1 EX Order to be covered with a privacy bag for the resident's dignity. Review of the facility's policy titled "Quality of Life-Dignity," reviewed/revised 01/2022, reflected that staff shall promote dignity and assist residents as needed by helping the resident to keep EX Order 26 § 4b1 covered. NJAC 8:39-4.1, 12	F 550		
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	F 656		12/30/22

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F 656	Continued From page 4 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to implement care plan interventions for 1 of 4 residents (Resident #22) reviewed for EX Order 26 § 4b1 . This deficient practice was evidenced by the following:	F 656	• All residents are at risk to be affected by the deficient practice • Staff immediately corrected the deficient practice and reposition Resident # 22 EX Order 26 § 4b1 . • All residents' [redacted] were checked to ensure that a bag	

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F 656	Continued From page 5 According to the Admission Record, Resident #22 had diagnoses that included, but were not limited to, EX Order 26 § 4b1 [redacted] Review of Resident #22's Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 10/02/2022, included the resident had a Brief Interview for Mental Status of [redacted], which indicated that the resident was EX Order 26 § 4b1. Further review of the MDS revealed the resident had a EX Order 26 § 4b1 and had EX Order 26 § 4b1 [redacted] Review of Resident #22's Care Plan (CP) revealed a "Focus" initiated on 05/20/17, for the resident's use of a EX Order 26 § 4b1 [redacted] The CP included an intervention, initiated on 05/20/17, to EX Order 26 § 4b1 [redacted] During tour of the [redacted] unit on 11/15/22 at 11:16 AM, the surveyor observed Resident #22 in bed with the head of bed slightly elevated. The surveyor observed that the resident's [redacted] drainage bag was not in a privacy bag, positioned facing the entrance room door and the [redacted] inside was visible from the hallway. The surveyor made the same observations on 11/18/22 at 10:58 AM, 11/21/22 at 10:26 AM, 11/21/22 at 1:59 PM, and 11/23/22 at 11: 45 AM.	F 656	placement is in accordance with their care plan. • All nursing staff re-educated on facility Resident Rights policy and he importance of keeping a resident's foley catheter bag covered. • DON/Designee will audit 5 resident [redacted] weekly X4 weeks and then monthly X3 months to ensure residents plan of care is being followed. • Findings will be submitted to the monthly qapi committee for 3 months who will determine further interventions as needed.	

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F 656	Continued From page 6 During an interview with the surveyor on 11/29/22 at 12:27 PM, the Registered Nurse/Nursing Supervisor (RNS) stated the team met quarterly to discuss the resident's plan of care. The RNS added that CP interventions showed how to care for the resident. When questioned about the care of Resident #22's Ex.Order 26.4(b)(1), the RNS stated the resident's EX Order 26 § 4b1 should be in a [redacted] bag, off floor and positioned away from the entrance room door. During an interview with the surveyor on 11/30/22 at 12:26 PM, the Director of Nursing (DON)stated that the resident's EX Order 26 § 4b1 should have been in a [redacted] bag and not facing the entrance room door. Review of the facility's "Urinary Catheter Care" policy, revised 01/2022, indicated to "Review the resident's care plan to assess for any special needs of the resident." Review of the facility's "Care Plans, Comprehensive, Person-Centered" policy, dated 01/2022, indicated that "10. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process."	F 656		
F 658 SS=E	NJAC 8:39-11.2 (e)(2) 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,	F 658		12/30/22

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F 658	Continued From page 7 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to a.) clarify a duplicate oxygen order for one resident, b.) consistently document in the Medication Administration Record (MAR) for 2 residents, and c.) consistently document a prn (as needed) controlled substance medication in the MAR for one resident, in accordance with professional standards. This deficient practice was identified for one resident (Resident #6) reviewed for Ex.Order 26.4(b), 3 of 5 residents reviewed for unnecessary medications (Resident #10, Resident #67, and Resident #136) and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states:	F 658	• All residents are at risk to be affected by the deficient practice • Resident #6 duplicate [redacted] order immediately corrected and verified with MD . Staff nurse(s) that did not document medication administration for residents #10, #67 and #136 were identified and educated on facility policy for Documentation of Medication Administration. • All residents' with Oxygen orders charts reviewed to ensure orders were correctly in place. • All nursing staff re-educated on facility policy and procedure for Medication Administration and Documentation. • DON/Designee will audit 5 resident MAR (medication administration record) per unit weekly X4 weeks and then monthly X3 months to ensure proper documentation is in place . • Findings will be submitted to the monthly qapi committee for 3 months who will determine further interventions as needed.	

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"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."

1.) On 11/15/22 at 1:45 PM, 11/18/22 at 9:30 AM and 11/21/22 at 12:06 PM, the surveyor observed Resident #6 in bed using EX Order 26 § 4b1 [redacted]

According to the Admission Record, Resident #6 was admitted to the facility with a diagnosis of EX Order 26 § 4b1 [redacted]

Review of the Annual Minimum Data Set (MDS), dated 08/16/22, an assessment tool utilized to facilitate the management of care, reflected that the resident was EX Order 26 § 4b1, had an active diagnosis of EX Order 26 § 4b1 [redacted].

Review of Resident #6's current Care Plan, created and revised on 02/11/22, reflected that Resident #6 had EX Order 26 § [redacted] and EX Order 26 § 4b1 [redacted]. The Care Plan further reflected that Resident #6 utilized EX Order 26 § 4b [redacted] as needed and at night.

Review of the Electronic Medical Record (EMR) reflected an as needed order dated [redacted] for EX Order 26 § 4b1 [redacted]

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order dated 11/08/22 for EX Order 26 § 4b1 as needed for a [redacted]

During an interview with the surveyor on 11/29/22 at 10:20 AM, the Licensed Practical Nurse (LPN) #3 stated that if she saw a duplicate order, she would call the physician to clarify the order. LPN #3 stated that it was important to clarify the order so that the nurses know which order to give, and the resident does not receive duplicate treatments.

During an interview with the surveyor on 11/29/22 at 10:48 AM, the LPN/Unit Manager (LPN/UM) reviewed the orders with the surveyor and confirmed there were two Ex.Order 26.4(b) orders, one dated 09/10/21 and one dated 11/08/22. The LPN/UM stated there should not be two orders for Ex.Order 26.4(b); and that the nurse that wrote the 11/08/22 order, should have checked to see if there was an original order for Ex.Order 26.4(b). The LPN/UM further stated that she expected her nurses to clarify duplicate orders with the physician so that it was not confusing.

During an interview with the surveyor on 11/30/22 at 12:24 PM, in the presence of the Administrator and Director of Nursing (DON), the Registered Nurse/UM stated that if there was a duplicate order, she would expect her nurses to clarify the order with the physician.

2 a.) According to the Admission Record, Resident #10 was admitted with diagnoses that included, but were not limited to, unspecified EX Order 26 § 4b1 [redacted]

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EX Order 26 § 4b1 [redacted]

Review of the current Physician Orders and the November 2022 MAR for Resident #10 revealed there was no documentation to indicate that the physician orders were administered as ordered on the following dates and times:

Ordered Daily:
- EX Order 26 § 4b1 [redacted] give one tab by mouth in the evening for EX Order 26 § 4b1 [redacted], ordered 07/19/22. The nurse did not document on 11/24/22.

- Bowel Routine as per policy one time a day for constipation and every 48 hours as needed for constipation, ordered 7/19/22. The nurse did not document on 11/02/22, 11/05/22, and 11/24/22.

- EX Order 26 § 4b1 [redacted] EX Order 26 § 4b1 EX Order 26 § 4b1 [redacted], ordered 07/26/22. The nurse did not document on 11/02/22, 11/05/22, and 11/24/22.

- EX Order 26 § 4b1 [redacted], ordered 7/19/22. The nurse did not document on 11/03/22 and 11/24/22.

- EX Order 26 § 4b1 [redacted] ordered 07/19/22. The nurse did not document on 11/02/22, 11/05/22, and 11/24/22.

- EX Order 26 § 4b1 [redacted]

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mouth in the evening for supplement, ordered 07/19/22. The nurse did not document on 11/24/22.

- EX Order 26 § 4b1 , ordered 10/20/22. The nurse did not document on 11/02/22, 11/05/22 and 11/24/22.

Ordered two times daily:
- EX Order 26 § 4b1 ordered 07/26/22. The nurse did not document at 9:00 AM 11/02/22, 11/05/22 and 11/24/22 and at 9:00 PM 11/03/22, 11/11/22, 11/12/22, and 11/24/22.

- EX Order 26 § 4b1 ordered 7/19/22. The nurse did not document at 9:00 AM on 11/02/22, 11/05/22, and 11/24/22 and at 9:00 PM on 11/03/22, 11/11/22, 11/12/22, and 11/24/22.

- EX Order 26 § 4b1 ordered 07/20/22. The nurse did not document at 9:00 AM on 11/02/22, 11/05/22, and 11/24/22 and at 6:00 PM on 11/24/22.

- EX Order 26 § 4b1 ordered 10/19/22. The nurse did not document at 9:00 AM on 11/02/22, 11/05/22, and 11/24/22 and at 9:00 PM on 11/03/22, 11/11/22, 11/12/22, and 11/24/22.

- EX Order 26 § 4b1

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EX Order 26 § 4b1 ordered 7/19/22. The nurse did not document at 2:00 PM on 11/02/22, 11/05/22, 11/24/22, and 11/28/22 and at 10:00 PM on 11/03/22, 11/11/22, 11/12/22, and 11/24/22.

Ordered three times daily:
- EX Order 26 § 4b1 , ordered 07/19/22. The nurse did not document at 9:00 AM on 11/02/22, 11/05/22, and 11/24/22 and at 2:00 PM on 11/02/22, 11/05/22, 11/24/22, and 11/28/22 and at 9:00 PM on 11/03/22, 11/11/22, 11/12/22, and 11/24/22.

Ordered four times daily:
- EX Order 26 § 4b1 as per sliding scale: if 151-200=5; 201-250=7; 251-300=9;301-350=11; 351-400=13; 401-450=15 under 60 or over 400 call MD, subcutaneously before meals and at bedtime for EX Order 26 § 4b1, ordered 10/12/22. The nurse did not document at 7:30 AM on 11/02/22, 11/05/22, and 11/24/22 and at 11:00 AM on 11/02/22, 11/05/22, and 11/24/22 and at 4:00 PM on 11/03/22, 11/12/22, 11/24/22 and at 9:00 PM on 11/03/22, 11/11/22, 11/12/22, and 11/24/22.

Ordered each shift:
- Pain assessment every shift for pain management 1-3=mild pain, 4-6= moderate pain, 7-10=severe pain 0=no pain, ordered 07/19/22. The nurse did not document on Day shift on 11/02/22, 11/05/22, 11/24/22, and 11/28/22 and on Evening shift on 11/03/22, 11/12/22, and 11/24/22.

- Vital Signs every shift for monitoring, ordered

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8/31/22. The nurse did not document on Day shift on 11/02/22, 11/05/22, 11/24/22, and 11/28/22 and on Evening Shift on 11/03/22, 11/12/22, and 11/24/22.

2 b.) According to the Admission Record, Resident #67 was admitted with diagnoses that included, but were not limited to, EX Order 26 § 4b1 [redacted]

Review of the current and discontinued Physician Orders and the October 2022 MAR for Resident #67 revealed there was no documentation to indicate that the physician orders were administered as ordered on the following dates and times:

Ordered Daily. The nurse did not document at 9:00 AM on 10/03/22 and 10/22/22 for the following medications:

- EX Order 26 § 4b1 [redacted] ordered 07/05/19.

- EX Order 26 § 4b1 [redacted] ordered 08/19/19.

- EX Order 26 § 4b1 [redacted] ordered 07/20/20.

- EX Order 26 § 4b1 [redacted] ordered 07/21/21.

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F 658	Continued From page 14 -EX Order 26 § 4b1 [redacted] ordered 01/21/22. - EX Order 26 § 4b1 [redacted] ordered 08/18/20 Ordered two times daily: - EX Order 26 § 4b1 [redacted] ordered 07/06/19. The nurse did not document at 9:00 AM on 10/03/22 and 10/22/22. - EX Order 26 § 4b1 [redacted] ordered 07/06/19. The nurse did not document at 9:00 AM on 10/03/22 and 10/22/22. - EX Order 26 § 4b1 [redacted] ordered 01/17/22. The nurse did not document at 9:00 AM on 10/03/22 and 10/22/22 and at 2:00 PM on 10/02/22 and 10/22/22. Ordered Each Shift: - Monitor for signs/symptoms of EX Order 26 § 4b1 [redacted] every shift for	F 658		

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control. Notify MD and document in progress notes if resident presents with any symptoms, ordered 08/23/21. The nurse did not document on Day Shift on 10/03/22 and 10/22/22 and on Evening Shift on 10/04/22 and 10/20/22.

- Pain assessment every shift for pain management 1-3 = mild pain, 4-6=moderate pain, 7-10=severe pain, 0= pain ordered 07/05/19. The nurse did not document on Day Shift on 10/03/22 and 10/22/22 and on Evening shift on 10/20/22.

- Vital Signs every shift for monitoring, ordered 08/31/22. The nurse did not document on Day shift on 10/03/22 and 10/22/22 and on Evening shift 10/20/22.

During an interview with the surveyor on 11/29/22 at 10:20 AM, LPN #3 stated that there should not be blanks on the MAR because that means if it's not documented, it is not done.

During an interview with the surveyor on 11/30/22 at 10:48 AM, the DON stated, in the presence of the Administrator, that she expected there would be no blanks in the MARs.

3.) According to the Admission Record, Resident #136 was admitted with diagnoses that included, but were not limited to, EX Order 26 § 4b1 [redacted]

Review of Resident #136's active Physician's Order Summary (POS) revealed an order for EX Order 26 § 4b1 [redacted]

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EX Order 26 § 4b1 , with a start date of 08/29/22.

Review of Resident #136's September, October and November 2022 MARs reflected an order for EX Order 26 § 4b1 with a start date of 08/29/22.

Review of Resident #136's September, October, and November 2022 Individual Patient Controlled Drug Record (declining inventory sheet), and the corresponding MARs, revealed that the number of doses of EX Order 26 § signed on the declining inventory sheet did not match the number of doses administered on the MARs.

The EX Order 26 § 4b1 was signed out (as administered) on the declining inventory sheet but not on the corresponding MAR on the following dates:
09/17/22 at 10:30 PM, 09/08/22 at 8:00 PM, 09/11/22 at 8:00 PM, 09/12/22 at 3:00 PM, 10/05/22 at 10:30 PM, 10/06/22 at 2:00 PM, 10/09/22 at 9:00 PM, 10/22/22 at 8:00 PM, 10/23/22 at 2:00 PM, 10/23/22 at 10:00 PM and 11/6/22 at 7:00 PM.

During an interview with the surveyor on 11/29/22 at 1:00 PM, the Registered Nurse (RN) stated that when administering a PRN controlled substance medication, the nurse must sign that the medication was administered in the declining inventory sheet and in the MAR. The RN added that it was important to sign both the declining inventory sheet and the MAR to indicate that the medication was administered to the right person,

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right time, and right dose. If the nurse only signed the declining inventory sheet and not the MAR, then it would be considered that the medication was omitted.

During an interview with the surveyor on 11/29/22 at 1:10 PM, the Registered Nurse Unit Manager (RN/UM) stated that when a PRN controlled substance was administered, the nurse needed to sign out both the declining inventory sheet and the MAR. The time and signature on the declining inventory sheet must correlate with the MAR when a PRN controlled substance was administered. The RN/UM added that it was important for the nurse to sign out the MAR and the declining inventory sheet at the time the medication was administered because the nurse and doctor needed to see in the MAR when the last dose was administered to avoid an overdose, a medication error and to evaluate if the medication was effective.

During an interview with the surveyor on 11/30/22 at 12:23 PM, the Director of Nursing (DON) stated the process for medication administration was to follow the five rights of medication administration. The nurses needed to document the PRN controlled substance medication in both the MAR and the declining inventory sheet at the time the medication was administered. The DON added that it was important to sign both the MAR and declining inventory sheet at the time the medication was administered because [redacted] was a controlled substance and needed to be accounted for.

The DON and RN/UM provided the surveyor a completed investigation which concluded there was no medication diversion.

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F 658	Continued From page 18 Review of the facility's "Oxygen Administration" policy, revised 01/2022, reflected that the purpose of this procedure was to provide guidelines for safe oxygen administration. The policy did not address duplicate orders. Review of the facility's "Medication and Treatment Orders" policy, revised 01/2022, did not address duplicate orders. Review of the facility's "Administering Medications" policy, revised 01/2022, reflected that the individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones . Review of the facility's "Documentation of Medication Administration" policy, revised 01/2022, revealed a nurse shall document all medications administered to each resident on the resident's MAR. Administration of medication must be documented immediately after (never before) it is given. Documentation must include, as a minimum: (a) name and strength of the drug,(b) dosage,(c) method of administration, (d) date and time of administration, (e) reason(s)why a medication was withheld, not administered, or refused , (f) signature and title of the person administering the medication and (g) resident response to the medication, if applicable (e.g., PRN, pain medications, etc.). NJAC 8:39-29.2(d), 29.3(a)	F 658		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		12/30/22

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F 690	Continued From page 19 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to consistently	F 690	• All residents are at risk to be affected by the deficient practice	

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F 690	Continued From page 20 monitor [redacted] output in accordance with the physician's order and professional standards of care for 3 of 3 residents (Residents #16, #22 and #137) reviewed for [redacted]. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1.) According to the Admission Record, Resident #137 was admitted with diagnoses that included, but were not limited to, [redacted] EX Order 26 § 4b1 .	F 690	• Nurse(s) that did not document [redacted] in the TAR (Treatment Administration Record) for Residents #137, #22 and #16 were identified and re-educated on the facility policy for [redacted] Care. • All residents with order to “Monitor superpubic foley output amounts” were reviewed to ensure proper output is being recorded. • All nursing staff re-educated on facility policy for [redacted] care and importance of documenting the and output. • DON/Designee with audit 5 resident TARs who have an order to “Monitor superpubic foley output amounts” weekly X4 weeks and then monthly X3 months to ensure proper documentation of [redacted] output is in place. • Findings will be discussed at daily clinical meetings and submitted to the monthly qapi committee for 3 months who will determine further interventions as needed.	

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F 690	Continued From page 21 Review of the Admission MDS, dated 06/26/22, revealed that Resident #137 was EX Order 26 § 4b1 and had an EX Order 26 § 4b1 . Review of Resident #137's CP initiated on 06/20/22, revealed that Resident 137 had a EX Order 2 . The CP further revealed an intervention initiated on 06/20/22, to monitor and document intake and output as per facility policy. Review of Resident #137's electronic medical record orders revealed the following: - An order dated 06/20/22 to record EX Order 26 § 4b1 every shift for monitoring. This order was discontinued on 11/06/22. - An order dated 11/07/22 to record EX Order 26 § 4b1 every shift for monitoring. Review of Resident #137's September, October and November 2022 MARs reflected the nurses did not record the each shift on the following dates: Day Shift: 09/07/22, 09/21/22, 09/25/22, 09/27/22, 10/03/22, 10/13/22, 10/22/22, and 11/21/22. Evening Shift: 09/12/22, 09/13/22, 09/16/22, 10/01/22, 10/03/22, 10/04/22, 11/01/22, 11/05/22, 11/06/22, 11/09/22, 11/16/22, and 11/18/22. Night Shift: 09/02/22, 10/16/22, 10/25/22, 10/29/22, and 11/03/22 2.) According to the Admission Record, Resident #22 had diagnoses that included, but were not limited to, EX Order 26 § 4b1	F 690		

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EX Order 26 § 4b1 [redacted]

Review of Resident #22's Quarterly Minimum Data Set (MDS), dated 10/02/2022, included the resident had a Brief Interview for Mental Status of [redacted], which indicated that the resident was EX Order 26 § 4b1. Further review of the MDS revealed the resident had an Ex.Order 26.4(b)(1) and had impairment to EX Order 26 § 4b1 [redacted]

Review of Resident #22's Care Plan (CP) revealed a "Focus" initiated on 05/20/17, for the resident's use of a EX Order 26 § 4b1 [redacted] The CP included an intervention, initiated on 05/20/17, to EX Order 26 § 4b1 [redacted]

Review of Resident #22's Order Summary Report (OSR,) for the order date range: 08/01/22 to 11/30/22, revealed a physician order (order), dated 08/25/22, to "EX Order 26 § 4b1 [redacted]

Review of Resident #22's August, September, and October 2022 TARs revealed the aforementioned 08/25/22 order, with the administration time of day, evening, and night shifts. The TAR reflected no documentation for the EX Order 26 § 4b1 output amount on the following dates and times:

Day shift: 08/26/22, 08/27/22, 08/28/22, 08/29/22, 08/30/22, 08/31/22, 09/01/22, 09/02/22, 09/03/22,

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09/04/22, 09/05/22, 09/06/22, 09/07/22, 09/08/22, 09/11/22, 09/16/22, 09/25/22 and 10/13/22.

Evening shift: 08/25/22, 08/26/22, 08/27/22, 08/28/22, 08/29/22, 08/30/22, 08/31/22, 09/01/22, 09/02/22, 09/03/22, 09/04/22, 09/05/22, 09/06/22, 09/07/22, 09/29/22 and 10/03/22.

Night shift: 08/25/22, 08/26/22, 08/27/22, 08/28/22, 08/29/22, 08/30/22, 08/31/22, 09/01/22, 09/02/22, 09/03/22, 09/04/22, 09/05/22, 09/06/22, 09/07/22 and 10/01/22.

Further review of Resident #22's OSR, for the order date range: 08/01/22 to 11/30/22, revealed a second order, dated 10/13/22, to '[redacted]

Review of Resident #22's October 2022 and November 2022 TARs revealed the aforementioned 10/13/22 order, with the administration time of day, evening, and night shifts. The TAR reflected no documentation for the [redacted] amount on the following dates and times:

Day shift: 10/22/22, 11/07/22 and 11/24/22.

Evening shift: 11/26/22.

Night shift: 10/20/22, 10/22/22, 10/28/22, 11/03/22 and 11/27/22.

3.) According to the Admission Record, Resident #16 was admitted with diagnoses that included, but were not limited to, [redacted]

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F 690	Continued From page 24 Review of Resident #16's Quarterly Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care, dated [redacted] revealed that Resident #16 was [redacted] and had an [redacted]. Review of Resident #16's "Order Summary Sheet" revealed a Physician's Order (PO) dated 03/11/22 to monitor [redacted] every shift. . Review of Resident #16's August, September, October, and November 2022 Treatment Administration Records (TARs) revealed the aforementioned 03/11/22 order, with the administration time of day, evening, and night shifts. The TAR reflected no documentation for the [redacted] amount on the following dates and times: Day Shift: 08/05/22, 08/06/22, 08/07/22, 08/22/22, 08/20.22,08/21/22, 08/26/22, 09/04/22, 09/09/22, 09/19/22, 09/23/22, 09/30/22,10/02/22, 10/10/22, and 10/30/22. Evening Shift: 08/12/22, 08/16/22, 08/18/22, 08/20/22, 08/30/22, 09/08/22, 09/16/22, 09/30/22, 10/09/22, 11/03/22, 11/09/22, 11/24/22, and 11/25/22. Night Shift: 08/02/22, 08/06/22, 08/13/22, 08/17/22, 08/19/22, 08/21/22, 08/26/22, 08/31/22, 09/04/22, 09/05/22, 09/06/22, 09/07/22, 09/08/22, 09/10/22, 09/11/22, 09/12/22, 09/17/22, 10/02/22, 10/21/22, 11/19/22, and 11/22/22. During an interview with the surveyor on 11/22/22 at 12:02 PM, the Certified Nursing Assistant	F 690		

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F 690	Continued From page 25 (CNA) #1 stated that the CNA would empty the EX Order 26 § 4b1, measure it, and give the amount to the nurse to document in the TAR. During an interview with the surveyor on 11/23/22 at 11:35 AM, LPN #2 stated that the CNA would empty the EX Order 26 § 4b1 EX Orde and the nurse would document the output in the TAR. During an interview with the surveyor on 11/29/22 at 10:22 AM, the Registered Nurse/Unit Manager stated all EX Order 26 § 4b1 would have a physician order to measure and document the output. The nurse or the CNA would empty the EX Order 26 § 4b1 and the nurse would document the amount in the TAR. During an interview with the survey team on 11/30/22 at 12:23 PM, the Director of Nursing stated that the CNA would EX Order 26 § 4b1 and give the amount to the nurse who would then document the amount in the EX Order . Review of the facility's "Urinary Catheter Care" policy, revised 01/2022, indicated to "Maintain an accurate record of the resident's daily output, per facility policy and procedure." NJAC 8:39-27.1(a)	F 690		
F 756 SS=E	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.	F 756		12/30/22

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F 756	Continued From page 26 §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 resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to ensure recommendations made by the Consultant Pharmacist were acted upon in a timely manner and documented for 5 of	F 756	• All residents are at risk to be affected by the deficient practice • Consultants Pharmacists Comments Report for residents #10 ,#44 ,#50 ,#67 and #139 that were not followed up in a	

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F 756	Continued From page 27 5 residents (Residents #10, #44, #50, #67, and #139) reviewed for unnecessary medications. This deficient practice was evidenced by: 1.) According to the Admission Record, Resident #10 was admitted with diagnoses that included, but were not limited to, EX Order 26 § 4b1 [redacted] Review of the Consultant Pharmacist's (CP) "Comments Report" (CPCR) form included the following recommendations dated 02/04/22: - "Please advise if there is a recent Ex.Order 26.4 [redacted] for this resident as the most recent is from 8/2021." - "Regarding the comment made on 01/08/22: Please consider monitoring Ex.Order 26.4(b)(1) test that measures the average Ex.Order 26.4(b)(1) over the past 3 months] every three months. The Pharmacy Consult was not addressed." - "Regarding the comment made on 01/08/22: Please consider monitoring Ex.Order 26.4(b)(1 every three months. The physician signed the "agreed" portion of the Pharmacy Consult Sheet. Please obtain lab values as there is no recent results for Ex.Order 2 in PCC. [electronic medical record]" Review of Resident #10's Electronic Medical Record (EMR) orders did not include an order for a EX Order 26 § 4b1 or lab order for EX Order 26 § 4 every three months. Review of the Medical Doctor/Nurse Practitioner	F 756	timely manner were reviewed and documented by DON. • DON was re-educated on facility Pharmacy Consultant Policy and Procedure by Regional Director of Nursing. • Unit Nurse Managers were re-educated facility Pharmacy Consultant Policy and Procedure and the importance of documentation of review in a timely manner. • Regional DON will audit 5 residents CPCR per unit X 3 months and then quarterly X2 quarters to ensure documentation of timely response is in place. • Findings will be submitted to the monthly qapi committee for 3 months who will determine further interventions as needed.	

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(MD/NP) Long Term Care (LTC) Routine Visit progress notes dated 02/09/22, 02/10/22 and 02/16/22 did not include a nurse practitioner's response to the CP's recommendations of 02/04/22.

Review of the MD Admission History & Physical (H&P) progress note dated 03/01/22 did not include a physician's response to the CP's recommendations of 02/04/22.

Review of the Physician's Progress Note dated 03/31/22 did not include a physician's response to the CP's recommendations of 02/04/22.

Review of the nurses' progress notes for the month of February did not address the CP's recommendations of 02/04/22.

Review of the CPCR form included the following recommendations dated 04/11/22:
- "Recent labs indicate A1C 11.1. Please evaluate current EX Order 26 § 4b regimen."
- "Regarding the comment made on 02/04/22: Please advise if there is a recent EX Order 26 § 4b1 for this resident as the most recent is from 8/2021. The Pharmacy Consult was not addressed".

Review of the Physician's Progress Notes dated 04/30/22 did not include a physician's response to address the CP's 04/11/22 recommendations.

Review of the nurses' progress notes for the month of April 2022 did not address the CP's recommendations of 04/11/22.

Review of the CPCR form included a recommendation dated 09/08/22 "There are PRN

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[as needed] orders with the same or overlapping indications for use. Please sequence or differentiate the indications for PRN: Ex.Order 26.4(b)(1) an [and] Ex.Order 26.4(b)."

Review of Resident #10's EMR included the following orders:
- An order dated 07/30/22 for EX Order 26 § 4b1 [redacted]
- An order dated 07/22/22 for EX Order 26 § 4b1 [redacted]
- An order dated 07/21/22 fo EX Order 26 § 4b1 [redacted]

Review of the MD/NP LTC Acute Visit progress notes dated 09/12/22, 09/16/22, and 09/26/22 did not include the NP's response to address the CP's 09/08/22 recommendations.

Review of the Physician's Progress note dated 09/30/22 did not include a physician's response to address the CP's 09/08/22 recommendations.

Review of the September 2022 nurses' notes did not address the CP's 09/08/22 recommendations.

Review of the CPCR form included the following recommendations dated 10/07/22:
- "Please note that there are duplicate orders for [redacted] protocol. Please update."
- "Regarding the comment made on 09/08/22: There are PRN orders with the same or overlapping indications for use. Please sequence or differentiate the indications for PRN: EX Order 26 § 4b1 [redacted]. The Pharmacy

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Consult was not addressed."

Review of Resident #10's EMR included the following orders:
- An order dated 07/19/22 for EX Order 26 § Routine as per policy every 48 hours for EX Order 26 § 4b1 if no EX Order 26 § 4b1 in 48 hours give EX Order 26 § daily as needed, then if no EX Order 26 § 4b1 in 12 hours, see EX Order 26 § 4b1
- An order dated 07/19/22 for EX Order 26 § 4b1 as per policy every 24 hours as needed for Ex.Order 26.4(b)(1) Give one EX Order 26 § 4b1 EX Order 26 § 4b, then if no results in 12 hours, see EX Order 26 order.
- An order dated 07/19/22 for EX Order 26 § Routine as per policy every 24 hours as needed for EX Order 26 § 4b1 One EX Order 26 § 4b1 EX Order 26 § 4 and notify attending physician or medical director if no results.
- An order dated 07/20/22 for EX Order 26 § Routine as per policy one time a day for EX Order 26 § 4b1

Review of Resident #10's EMR orders reflected the following:
- The EX Order 26 § 4b1 order dated 07/30/22 was discontinued on 10/19/22. The facility clarified the order on 10/19/22 to read EX Order 26 § 4b1
- The as needed EX Order 26 § 4b1 order dated 07/22/22 was discontinued on 10/19/22. The facility clarified the order on 10/19/22 to read EX Order 26 § 4b1
- The as needed EX Order 26 § 4b1 mg order dated 07/21/22 was discontinued on

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10/19/22. The facility clarified the order on 10/19/22 to read EX Order 26 § 4b1 , EX Order 26 § 4b1

Review of the MD/NP LTC Acute Visit progress note dated 10/12/22 and 10/27/22 did not include a NP's response to address the CP's 10/07/22 recommendations.

Review of the Physician's Progress note dated 10/30/22 did not include a physician's response to address the CP's 10/07/22 recommendations.

Review of the October 2022 nurses' notes did not address the CP's 10/07/22 recommendations.

Review of the CPCR Form dated 11/06/22 included a recommendation "Regarding the comment made on 10/07/22: Please note that there are duplicate orders for [redacted] protocol. Please update. The Pharmacy Consult was not addressed."

Review of Resident #10's electronic medical records orders reflected that the facility discontinued the EX Order 26 § 4b1 order dated 07/26/22 on 11/07/22.

Review of the Physician's Progress Note dated 11/25/22 did not include a physician's response to address the CP's 11/06/22 recommendations.

Review of the November 2022 nurses' progress notes did not address the C's 10/06/22 recommendations.

2.) According to the Admission Record, Resident

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#67 was admitted with diagnoses that included, but were not limited to, EX Order 26 § 4b1 [redacted]

Review of the CPCR form included the following recommendations dated 01/08/22:
- "As per CMS guidelines, for those receiving EX Order 26 § 4b1 [redacted]

Review of Resident #67's EMR included the following order:
- An order for EX Order 26 § 4b1 [redacted] dated 01/17/22.

Review of Resident #67's January 2022 through November 2022, MARs revealed the following:
- The 01/17/22 EX Order 26 § 4b1 order was scheduled to be given at 9:00 AM, 2:00 PM and 9:00 PM daily.

Review of the 02/08/22 Physician's Progress Note did not include a physician's response to the CP's recommendations of 01/08/22.

Review of the Health Status Note dated 07/06/22 reflected the nurse practitioner ordered the following labs, "CBC with Diff [a measure of the number of red blood cells, white blood cells and platelets in the blood including the different types of white blood cells], Ex.Order 26 and Ex.Order 26.4(b)(1) level

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[measures the level of Ex.Order 26.4(b)(1) in a person's blood]."

Review of the ordered labs reflected the physician did not order a CMP lab until 07/06/22.

Review of the CPCR form included a recommendation dated 03/04/22 "Please send a reminder to the MD regarding the comment made on 10/06/2021: Please consider monitoring Ex.Order 26.4(b) Lab (a simple blood test that measures your average Ex.Order 26.4(b)(1) over the past 3 months) every three months. The Pharmacy Consult was not addressed."

Review of Resident #67's EMR included a lab order dated 01/15/22 for an EX Order 26 § 4b1 every 3 months.

Review of the lab results provided by the facility reflected that an EX Order 26 § 4b1 on 09/07/22. The facility could not provide further EX Order 26 § 4b1 results during the months of January 2022 through November 2022.

Review of the Health Status Note dated 01/25/22 reflected lab orders that the "MD visited and ordered EX Order 26 § 4b1

Review of the Health Status Note dated 09/03/22 reflected "writer received a call from residents MD asking for the following labs to be done and faxed when results are received. following labs TO BE DONE 9/7 are EX Order 26 § 4b1 ."

Review of the lab printout provided by the facility reflected Resident #67 " the 01/25/22 lab

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order to be collected on 03/25/22 at 8:36 AM. The lab printout further reflected that the 09/03/22 lab order was collected and processed on 09/07/22 at 12:37 PM. The lab printout did not reflect the 01/15/22 order for the EX Order 26 § 4b1 every 3 months.

Review of the Physician's Progress notes dated 05/23/22, did not include a physician's response to address the CP's 03/04/22 recommendations.

Review of the CPCR form included a recommendation dated 08/01/22 "It was noted on the psych consult to decrease the morning EX Order 26 § 4b1

Review of Resident #67's EMR included an order dated 01/21/22 for EX Order 26 § 4b1 "

Review of the August 2022 through November 2022 MARs reflected that the aforementioned 01/21/22 EX Order 26 § 4b1 order was not addressed until 11/22/22 after surveyor inquiry.

Review of the Physician's Progress note dated 09/29/22 did not include a physician's response to address the CP's 08/01/22 recommendations.

Review of the MD/NP LTC Routine Visit progress note dated 10/03/22 did not include a NP's response to address the CP's 08/01/22 recommendations.

Review of the Nurse's Notes included a Health

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Status Note dated 07/06/22 which reflected the Nurse Practitioner reviewed the resident's target behaviors and will reduce the [redacted] dose of [redacted]EX Order 26 § 4b1[redacted]. Primary physician is aware of the changes and in agreement with the gradual dose reduction.

Review of the 07/05/22 [redacted] Note reflected to discontinue [redacted]EX Order 26 § 4b1[redacted] in the [redacted] order.

3). According to the Admission Record, Resident #44 had diagnoses that included, but were not limited to: [redacted]EX Order 26 § 4b1[redacted]

Review of Resident #44's CPCR revealed a CP recommendation, dated 02/03/22, that "For those with a[redacted]EX Order 26 § 4b1[redacted] receiving [redacted]EX Order 26 § 4b1[redacted] should be reviewed for gradual dose reduction. If a dose reduction is clinically contraindicated, remember to provide a short progress note. Please evaluate the use of [redacted]EX Order 26 § 4b1[redacted] [redacted]EX Order 26 § 4b1[redacted]). The CPCR reflected that the CP made the same recommendation on 03/07/22, 06/06/22, 07/07/22 and documented that "The Pharmacy Consult was not addressed."

The CPCR revealed a second CP recommendation, dated 02/03/22, that "As per CMS guidelines, is a taper of [redacted]EX Order 26 § 4b1[redacted] If a taper of this medication is contraindicated, include the rationale in your

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response to this request." The CPCR reflected that the CP made the same recommendation on 03/07/22, 06/06/22, 07/07/22 and documented that "The Pharmacy Consult was not addressed."

The CPCR revealed a third CP recommendation, dated 04/06/22, that "The most recent TSH level was 6.65 (2/22); consider adjusting the dosage of Ex.Order 26.4(b)(1)." The CPCR reflected that the CP made the same recommendation on 06/06/22, 07/07/22, 08/01/22 and documented that "The Pharmacy Consult was not addressed."

Review of Resident #42's Order Summary Report (OSR) for active orders as of 02/03/22 revealed the following 08/21/21 physician orders:

1 EX Order 26 § 4b1 [redacted]

Review of the February 2022, March 2022, April 2022, May 2022, and June 2022 Medication Administration Reports (MARs) reflected that the

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aforementioned orders doses remained the same.

On 11/21/22 at 12:08 PM, the surveyor reviewed Resident #44's "Progress Notes" (PN) from 02/06/22 to 07/15/22. The PN revealed no documentation that the CP recommendation was discussed or addressed with the physician or psychiatrist. The PN further revealed no documented rationale or response to the CP's recommendations.

Review of the 02/03/22, 03/07/22, and 07/07/22 Pharmacy [redacted] Sheets (consult sheet) provided by the DON on 11/30/22, included the aforementioned CP's recommendations with handwritten notations. The 02/07/22 and 03/07/22 consult sheets had handwritten notations of "1/25/22 assessed by psych for [redacted] The 02/07/22 and 03/07/22 consult sheets did not include a rationale or reason for not accepting the CP recommendation. The 07/07/22 consult sheet revealed a handwritten notation that Ex.Order 26.4(b note 07/18/22, increase Ex.Order 26.4(b)(1)], decrease Ex.Order 26.4(b)(1 and Ex.Order 26.4(b)(1) ."

Review of the [redacted] Notes [redacted]), provided by the Director of Nursing (DON) on 11/30/22, reflected that the resident was seen by the psych on 01/25/22, 7/18/22, and 9/21/22.

Review of Resident #44's PN on 11/30/22, revealed a 04/11/22 late entry [redacted], initiated on 11/29/22, which was after surveyor inquiry.

4.) According to the Admission Record, Resident

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F 756	Continued From page 38 #50 had diagnoses that included, but were not limited to EX Order 26 § 4b1 [redacted] Review of Resident #50's CPCR revealed a CP's recommendation, dated 11/09/21, to "Please specify the quantity for administration for the order for EX Order 26 § 4b1 " (a medication used to treat or prevent Ex.Order 26.4(b)(1) .) The CPCR reflected that the CP made the same recommendation on 02/03/22 and documented that the "The [redacted] Consult was not addressed." Review of the Resident #50's "Consultant Pharmacist's Monthly Report" (CPMR), provided by the DON, included the aforementioned 11/09/21 CP's recommendation, and revealed a handwritten notation that the order was updated to administer EX Order 26 § 4b1 [redacted] Review of Resident #50's OSR for active orders as of 02/22/22 revealed a 07/09/21 order for EX Order 26 § 4b1 [redacted] The order did not specify the quantity for administration. Review of the November 2021, December 2021, January 2022,and February 2022 MARs reflected that the aforementioned order remained the same until 02/22/22. Further Review of Resident #50's OSR for active orders as of 02/22/22 revealed a second order, dated 02/22/22, for EX Order 26 § 4b1 [redacted]	F 756		

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	315387	A. BUILDING _____ B. WING _____	11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 756		F 756		

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supplement."

5.) According to the Admission Record, Resident #139 was admitted with diagnoses that included, but were not limited to, EX Order 26 § 4b1 [redacted]

Review of Resident # 139's Electronic Pharmacist Information Consultant (EPIC) report, dated 10/03/22, and the CPCR dated 10/03/22 and 10/06/22, revealed the following nursing recommendations:

1. Do Not Crush EX Order 26 § 4b1 [redacted]
2. The use of [redacted] EX Order 26 § 4b1 may increase the risk for EX Order 26 § 4b1 . EX Order 26 § 4b1 [redacted]
3. The resident should rinse their mouth after the use of EX Order 26 § 4b1 [redacted]
4. Refrigerate EX Order 26 § 4b1 before opening. [redacted] must be stored at room temperature ONCE OPENED.
5. Missing documentation of EX Order 26 § 4b1 and EX Order 26 § 4b1 [redacted] Please update order(s) to include supplementary documentation on the Medication Administration Record.
6. Identify and monitor the behavior being exhibited for EX Order 26 § 4b1 and EX Order 26 § 4b1
7. Please date EX Order 26 § 4b1 [redacted] when opened and discard after 90 days per the manufacturer.
8. EX Order 26 § 4b1 [redacted] must be

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swallowed whole. Do not crush, chew or open. If the medication cannot be changed, please obtain a physician's order of "may open capsule."
9. Do not exceed the use of 3 (three) grams of EX Order 26 § 4b1 per day from all sources, or as per facility policy.
10. EX Order 26 § 4b1
11. The EX Order 26 § 4b1 should be checked every shift for placement and proper adherence to the skin, The nurse checking the patch should record and document such observations on the current medication administration record.
12. After removal of the EX Order 26 § 4b1, documentation must reflect disposal by two licensed nurses.
13. Please clarify the order for EX Order 26 § 4b1 and EX Order 26 § 4b1. An order EX Order 26 § 4b1 is not noted.
14. EX Order 26 § 4b1 should be separated from all other medications by 2 hours.

Review of Resident# 139's October 2022 and November 2022 Physician's Order Sheet (POS), MARs and Treatment Administration Sheets (TAR) revealed that the above recommendations were not addressed until 11/21/22 and 11/22/22 after surveyor inquiry.

Review of Resident# 139's Physician's and Nurse Practitioner's (NP) progress notes, dated 09/30/22 through 11/22/22, did not include a physician's or NP's response to the CP's recommendations.

Review of Resident# 139's Nurse's Notes, dated 09/30/22 through 11/21/2022, did not include a nurse's note related to the CP's

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recommendations.

During an interview with the surveyor on 11/21/22 at 1:25 PM, the DON stated that she received the CP's recommendations from the CP which she then passed on to the Unit Managers (UM). The DON further stated that it was the responsibility of the UMs to make sure the CP's recommendations were completed by the 15th of the month. The DON added that recommendations for the physicians are completed and placed in the resident's chart and that she would go back and recheck that all the recommendations were completed.

During an interview with the surveyor on 11/21/22 at 1:45 PM, the Registered Nurse/Nursing Supervisor (RNS) stated the DON passed out the CP's recommendations to the UMs monthly. The RNS further stated the UMs would follow up with the physician for any new orders and document in the electronic medical record.

During an interview with the surveyor on 11/29/22 at 10:18 AM, the Registered Nurse Unit Manager (RN/UM) stated that the CP's recommendations were emailed to the DON and then she would forward the recommendations to the UMs. The UM would review the nursing recommendations and the physician's orders would be updated as recommended. The doctor's recommendations would be given to the nurse practitioner or to the doctor and any psych recommendations to the psychiatrist. The doctors would review the recommendations and check on the form either accepted or not accepted and the physician's orders would be changed if needed. The RN/UM stated the pharmacy recommendations should be completed within a week.

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F 756	Continued From page 42 During a follow-up interview with the surveyor on 11/29/22 at 12:30 PM, the RNS stated CP's recommendation for [redacted] are called into the physician for approval, if approved, a physician order wound then be transcribed into the EMR. During an interview with the survey team on 11/30/22 at 12:23 PM, the DON and the Administrator stated that the CP's recommendations should be addressed in a timely manner. Review of the facility's policy titled "Pharmacy Consultant Policy and Procedure", dated 01/01/22, revealed that the pharmacist will provide the DON with Pharmacy recommendations on an ongoing basis each month. The DON will act upon these recommendations by bringing them to the attention of the attending physician and ensuring any changes are implemented in a timely manner.	F 756		
F 759 SS=D	NJAC 8:39-29.3 Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review other facility documentation, it was	F 759	• All residents are at risk to be affected by the deficient practice	12/30/22

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F 759	Continued From page 43 determined that the facility failed to maintain a medication error rate of less than 5%. This deficient practice was identified for 1 of 2 nurses on 1 of 2 units (3rd Floor) administering medications to 2 of 4 residents (Resident #30 and #79) making 2 errors out of 25 medication opportunities which resulted in a medication error rate of 8%. This deficient practice was evidenced by the following: 1. On 11/22/22 at 8:21 AM, the surveyor observed Licensed Practical Nurse (LPN) #1 administer medications to Resident #79. LPN #1 dispensed six medications including EX Order 26 § 4b1 [redacted] LPN #1 handed Resident #79 the EX Order 26 § 4 [redacted], instructed the resident to administer the medication and stated to the surveyor that Resident #79 liked to administer the medication himself/herself. Resident #79 administered two EX Order 26 [redacted] and was about to administer a third EX Orde [redacted] when LPN#1 instructed the resident to stop and that the order was for only two puffs. After administering the medications, LPN #1 signed off the EX Order 26 § 4b1 [redacted] order as administered. Review of the Medication Review Report for November 2022 included a physician's order for "EX Order 26 § 4b1 [redacted] EX Order 26 § 4b1 [redacted] with a start date of 12/12/19. (Error #1)	F 759	• Nurse(s) that were found to have made an error for medication administration for residents # 79 and #30 were idented and immediately re-educated on facility policy on Medication Administration. Resident # 79 and #30 MD was immediately notified with no new orders. • All nursing staff re-educated on facility policy for Medication Administration and importance of following all steps. • DON/Designee will conduct Medication Pass review of 5 residents per week X4 weeks and then monthly X 3 months to ensure all medications are properly administered. • Findings will be mentioned at clinical meetings and submitted to the monthly qapi committee for 3 months who will determine further interventions as needed.	

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Review of the November 2022 electronic Medication Administration Record (eMAR) included the aforementioned order scheduled at 8:00 AM was signed out as administered on 11/22/22.

2. On 11/22/22 at 8:47 AM, the surveyor observed LPN#1 administer medications to Resident #30. LPN #1 dispensed six medications including two tablets of EX Order 26 § 4b1 [redacted] After administering the medications, LPN #1 signed off the EX Order 26 § 4b1 order as administered.

Review of the Medication Review Report for November 2022 included a physician's order for EX Order 26 § 4b1 [redacted] with a start date of 12/12/19. (Error #2)

Review of the November 2022 eMAR included the aforementioned order scheduled at 9:00 AM and was signed out as administered on 11/22/22.

During an interview with the surveyor on 11/22/22 at 1:07 PM, LPN #1 stated that she checked the eMAR against the label on the medication to make sure she was giving the correct dosage. When questioned about the EX Order 26 § 4b1 dosage amount administered to Resident #79, LPN #1 reviewed the physician order and stated the resident was supposed to get one puff. When questioned about the EX Order 26 § 4b1 dosage amount administered to Resident #30, LPN #1 stated she administered two EX Order 26 § 4b1 . LPN #1 inspected the medication cart, handed the surveyor a medication bottle and stated that she

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administered the medication from that particular bottle. Review of the medication label revealed that LPN #1 administered two tablets of [redacted]. LPN #1 added that there were no other Vitamin D3 medication bottles in her medication cart.

During an interview with the surveyor on 11/23/22 at 10:10 AM, the Director of Nursing stated she expected nurses to follow the five rights when administering medication which included: right resident, right dosage, right time, right route, and right medication.

Review of the facility's "Administering Medication" policy, revised 01/2022, indicated that "The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication."

NJAC 8:39-29.2(d)

New Jersey Department of Health

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H 000	Initials Comments The facility is not in compliance with N.J.A.C. Title 8 Chapter 43E- General Licensure Procedures and Standards Applicable To All Licensed Facilities.	H 000		
H5790	8:43E-13.4(d) UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM A licensed healthcare facility or program shall retain a completed copy of the Universal Transfer Form sent with a patient when a patient is transferred as part of the patient's medical record. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other facility documentation, it was determined that the facility failed to retain a completed copy of the Universal Transfer Form (UTF) sent with a patient when a patient was transferred as part of the patient's medical record for 2 of 2 residents (Residents #73 and #146) reviewed for EX Order 26 § 4b1. This deficient practice was evidenced by the following: 1.) According to the Admission Record, Resident #73 was admitted with diagnoses that included but not limited to, EX Order 26 § 4b1	H5790	• All residents are at risk to be affected by the deficient practice • The facility cannot retroactively create the Universal Transfer form for residents # 73 and #146 • All nursing staff were re-educated on the facility policy Transfer or Discharge for Emergency and the importance of keeping a copy of the UTF in the residents' medical records. • DON/Designee will review the previous days acute transfers to ensure that there is a copy of the UTF in the residents chart daily X2 weeks and then weekly X4 weeks.	12/30/22

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

Electronically Signed | 12/23/22

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H5790	Continued From page 1 EX Order 26 § 4b1 [redacted] Review of Resident #73's Census Sheet revealed the resident was transferred out to the [redacted] on the following dates: 05/10/21, 11/07/21, 12/27/21, 02/18/22, 05/18/22, 07/18/22, and 08/13/22. Review of Resident #73's Electronic Medical Record (EMR) and hard chart did not contain copies of the UTF forms for the above dates. On 11/21/22 at 02:00 PM the surveyor requested copies of Resident #73's UTFs from the Director of Nursing (DON) but the DON was unable to provide the requested UTFs. 2.) According to the Admission Record, Resident #146 was admitted with diagnoses that included but not limited to, EX Order 26 § 4b1 [redacted] Review of Resident #146's census sheet revealed the resident was transferred out to the [redacted] on the following dates: 12/30/21, 03/02/22, 03/09/22, 05/01/22 and 06/12/22. Review of Resident #146's EMR and hard chart did not contain copies of the UTFs for the above dates. During an interview with the surveyor on 11/22/22 at 9:40 AM, the Director of Nursing (DON) stated that the nurses completed the UTF, but did not keep a copy for the chart. The DON added that a copy of the UTF should have been kept in the medical record.	H5790	• Findings will be submitted to the monthly qapi committee for 3 months who will determine further interventions as needed.	

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H5790	Continued From page 2 Review of the facility's "Transfer or Discharge, Emergency" policy, revised 01/2022, indicated that facility staff would prepare a transfer form [UTF] to send with the resident. The policy did not address retaining a copy of the completed UTF as part of the resident's medical record.	H5790		
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews, and review of other facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the day shift. This was evident for 1 of 14 day shifts reviewed. Findings include:	S 560	" All residents are at risk to be affected by the deficient practice. " The facility will utilize internal and external resources to increase recruitment of direct staff and to ensure the availability of other staffing resources (e.g. contracted staff) in the event of staffing shortage.	12/30/22

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S 560	Continued From page 3 Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. "Direct care staff member" means any registered professional nurse, licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021: One CNA to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 10/30/22 to 11/05/22 and 11/06/22 to 11/12/22, the staffing-to-resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift are documented below: -11/06/22 had 15 CNAs for 144 residents on the	S 560	Contract and recruitment posts attached. " The facility will add an additional holiday bonus pay to ensure the holiday weeks are staffed appropriately. " For the next month, the administrator or designee will review the projected staffing hours daily to ensure staffing hours above state minimum. " Findings will be submitted for 3 months to the monthly QAPI committee who will determine further interventions as needed.	

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S 560	Continued From page 4 day shift, required 18 CNAs. During an interview with the surveyor on 11/29/22 at 12:18 PM, the Staffing Coordinator stated that she staffed the facility by the guidelines which were 1:8 on day shift, 1:13 on evening shift and 1:15 on night shift. She further indicated that sometimes she substitutes nurses for CNAs on the day shift, but not very often. NJAC 8:39-5.1(a)	S 560		

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
315387 Y1	A. Building B. Wing Y2	2/9/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLAIRE REHAB & NURSING	115 DUTCH LANE ROAD FREEHOLD, NJ 07728

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 F0550	Correction	ID Prefix F0656	Correction	ID Prefix F0658	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	12/30/2022	LSC	12/30/2022	LSC	12/30/2022
ID Prefix F0690	Correction	ID Prefix F0756	Correction	ID Prefix F0759	Correction
Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.45(f)(1)	Completed
LSC	12/30/2022	LSC	12/30/2022	LSC	12/30/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/30/2022	☐ YES ☐ NO

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315387	A. BUILDING **01** B. WING _____	**11/30/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLAIRE REHAB & NURSING	**115 DUTCH LANE ROAD** **FREEHOLD, NJ 07728**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 11/28/22 and 11/29/22 and Allaire Rehabilitation and Nursing Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Allaire Rehabilitation and Nursing Center is a four-story, Type I Fire Resistant Protected building that was built in June 1986. The facility is divided into 9 smoke zones.	K 000		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/28/22 and 11/29/22, in the presence of facility management, it was determined that the facility failed to maintain 2 of 46 illuminated exit signs in proper working condition to clearly identify the exit access path to reach an exit discharge door.	K 293	1. All residents are at risk by this deficient practice. 2. The exit signs were immediately fixed to ensure proper compliance with exit lighting requirements. The maintenance	1/15/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/23/2022

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 293	Continued From page 1 This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 On 11/28/22 during the survey entrance at approximately 9:10 AM, a request was made to the Corporate Compliance Officer (CCO) and Director of Maintenance (DOM) to provide a copy of the facility layout which identified the various rooms and smoke compartments. A review of the facility provided layout identified that there were four stories in the main building and an Annex building. Starting on 11/28/22 at approximately 9:42 AM and continued on 11/29/22, a tour of the building with the CCO and DOM was performed. Along the two-day tour of the facility, the surveyor observed 2 of 46 illuminated exit signs not functioning properly in the following locations: 1) On 11/29/22 at 10:11 AM, the surveyor observed one illuminated exit sign above the corridor double smoke doors next to resident room [redacted] that was not illuminated.	K 293	director and his staff were re-educated on the procedures for checking emergency exit lighting. 3. DOM/Designee shall audit 5 exit signs weekly for the next 3 months and submit the weekly logs to the facility administrator by the end of the week. 4. The audit findings shall be submitted to the monthly QA committee meeting for 3 months to review and determine if further interventions are needed.	

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ALLAIRE REHAB & NURSING	**115 DUTCH LANE ROAD** **FREEHOLD, NJ 07728**

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K 293	Continued From page 2 2) On 11/29/22 at approximately 11:08 AM, the surveyor observed inside the level one "FC" stairwell, one illuminated exit sign above the exit discharge door was not illuminated. The CCO and DOM confirmed the findings at the times of observations. The Administrator was informed of the deficiency at the survey exit on 11/29/22. Fire Safety Hazard. NJAC 8:39 -31.1 (c) NFPA Life Safety Code 101	K 293		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms	K 321		1/15/23

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K 321	Continued From page 3 b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/28/22 and 11/29/22, in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was evidenced by the following: On 11/28/22 during the survey entrance at approximately 9:10 AM, a request was made to the Corporate Compliance Officer (CCO) and Director of Maintenance (DOM) to provide a copy of the facility layout which identified the various rooms and smoke compartments. A review of the facility provided layout identified that there were four stories in the main building and an Annex building. Starting on 11/28/22 at approximately 9:42 AM and continued on 11/29/22, a tour of the building with the CCO and DOM was performed. Along the two-day tour of the facility, the surveyor observed the following:	K 321	1. A self-closure was immediately purchased and installed for the medical records room. Maintenance director and his staff were re-educated on the requirements for enclosures of hazardous areas. 2. All residents are at risk to be affected by the deficient practice. 3. DOM/Designee shall audit monthly x3 months all rooms which require self-closures to ensure proper standards are being met and submit findings to facility administrator. 4. Findings shall be submitted to the monthly QA committee meeting x3 months to review and determine if further interventions are needed.	

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K 321	Continued From page 4 1) On 11/29/22 at approximately 11:58 AM, an inspection on the lower level Medical Records room identified that the corridor door had no means to self-close the door into its frame. The surveyor observed inside the room eight (8) five-drawer filing cabinets and one (1) four-drawer filing cabinet filled with combustible medical records. The surveyor also observed multiple combustible medical records on top of the cabinets. The surveyor recorded the room to be 15 feet by 13 feet (195 square feet) which is larger than 50 square feet. The door failed to self-close into its frame as required by code. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. The CCO and DOM confirmed the findings at the times of observations. The Administrator was informed of the deficiency at the survey exit on 11/29/22. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection	K 351		1/15/23

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K 351	Continued From page 5 measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/28/22 and 11/29/22, it was determined that the facility failed to properly install sprinklers, as required by Centers for Medicare & Medicaid Services' regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition, and as required by the New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. The deficient practice is evidenced by the following, On 11/28/22 during the survey entrance at approximately 9:10 AM, a request was made to the Corporate Compliance Officer (CCO) and Director of Maintenance (DOM) to provide a copy of the facility layout which identified the various rooms and smoke compartments. A review of the facility provided layout identified that there were four stories in the main building and an Annex building.	K 351	1. The masking tape was immediately removed from the two sprinkler heads inside the maintenance shop closets. A fire sprinkler was installed to provide coverage on the top landing area of stairwell A-3. An escutcheon cap was installed inside the first-floor housekeeping closet. The ceiling tile was removed to locate the fire sprinkler inside the ground floor Dining Room's closet. The ceiling tile was removed to locate the fire sprinkler inside the ground floor utility/electrical closet. The maintenance director and his staff were re-educated on the requirements and procedures for installation and checking for coverage of sprinkler systems. 2. All residents are at risk by this deficient practice. 3. DOM/Designee shall audit monthly x3 months all sprinklers and areas that require fire sprinkler coverage and submit	

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K 351	Continued From page 6 Starting on 11/28/22 at approximately 9:42 AM and continued on 11/29/22, a tour of the building with the CCO and DOM was performed. Along the two-day tour of the facility, the surveyor observed the following locations that failed to provide proper fire sprinkler coverage: On 11/28/22 - 1) At approximately 10:22 AM, the surveyor observed, inside the maintenance shop, two (2) closets had masking tape covering the fire sprinklers inside the closets. 2) At approximately 10:35 AM, the surveyor observed no evidence of fire sprinkler coverage on the top landing area of stairwell A-3. At this time the surveyor asked the DOM, "Do you have a sprinkler on this level." The DOM said, "No." On 11/29/22 - 3) At approximately 11:22 AM, the surveyor observed, inside the first floor housekeeping closet, one (1) sprinkler had no escheon cap. This left a 1/2 inch gap in the ceiling tile. With the opening in the ceiling, in the event of a fire, the heat would bypass the fire sprinkler in the area and not activate the fire sprinkler system. 4) At approximately 11:50 AM, the surveyor observed no evidence of a fire sprinkler inside the ground floor Green Dining Room's two feet deep by four feet eight inch wide closet. 5) At approximately 11:55 AM, the surveyor observed no evidence of a fire sprinkler inside the ground floor utility/electrical closet. The surveyor recorded the closet to be two feet deep by six feet wide.	K 351	the report to the facility administrator. 4. The audit findings shall be submitted to the monthly QA committee meeting x3 months to review and determine if further interventions are needed.	

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K 351	Continued From page 7 The CCO and DOM confirmed the findings at the times of observations. The Administrator was informed of the deficiency at the survey exit on 11/29/22. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of other facility documentation on 11/28/22 and 11/29/22, in the presence of facility management, it was determined that the facility failed to failed a.) to inspect 1 of 32 portable fire extinguishers annually, and b.) perform a monthly examination for 1 of 31 portable fire extinguishers, as required by the National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 7.3 Maintenance. - 7.3.1.1 All Fire Extinguishers.	K 355	1. All residents are at risk to be affected by the deficient practice 2. A new fire extinguisher was immediately purchased for the facility vehicle and the fire extinguisher in the basement elevator mechanical room was replaced. The list of fire extinguisher locations was updated to include the fire extinguisher on the facility vehicle and the updated list shall be used as a reference during monthly checking of fire extinguishers. The Maintenance director and his staff were re-educated on the procedures for checking portable fire extinguishers.	1/15/23

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K 355	Continued From page 8 - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than one year at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. According to NFPA 10- 4-3.4, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. During the building tour on 11/28/22 and 11/29/22, in the presence of the facility Corporate Compliance Officer (CCO) and Director of Maintenance (DOM), the surveyor observed and inspected thirty-two (32) portable fire extinguishers in various locations as follows: 1) On 11/28/22 at 9:45, the surveyor observed, inside the basement-level Elevator Mechanical room one (1) "ABC-Type" fire extinguisher that was last annually inspected January 2022. There was no evidence of a monthly visual examination being performed and document on the inspection tag attached to the extinguisher for June, July, August, September and October 2022. 2) On 11/29/22 at 9:26 AM, the surveyor observed, inside the facility transportation bus (license plate 02-7459), one (1) "ABC-Type" fire extinguisher that had been last annually inspected 2019. The CCO and DOM confirmed the findings at the times of observations. The Administrator was informed of the deficiency	K 355	3. DOM/Designee shall audit 5 fire extinguishers monthly for next 3 months and submit findings to the facility administrator. 4. Audit findings shall be submitted to the monthly QA Committee meeting for 3 months to review and determine if further interventions are needed.	

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K 355	Continued From page 9 at the survey exit on 11/29/22.	K 355		
	NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).			
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or	K 363		1/15/23

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K 363	Continued From page 10 frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation on 11/28/22 and 11/29/22, in the presence of facility management, it was determined that the facility failed to ensure that 2 of 18 corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. The evidence includes the following: On 11/28/22 during the survey entrance at approximately 9:10 AM, a request was made to the Corporate Compliance Officer (CCO) and Director of Maintenance (DOM) to provide a copy of the facility layout which identified the various rooms and smoke compartments. A review of the facility provided layout identified that there were four stories in the main building and an Annex building. Starting on 11/28/22 at approximately 9:42 AM and continued on 11/29/22, a tour of the building with the CCO and DOM was performed. Along the two-day tour of the facility, the surveyor observed the following: 1) On 11/28/22 at approximately 11:29 AM, the surveyor observed the Third Floor Soiled Linen room corridor door had a one (1) inch hole through the door with electrician's black electrical tape on one side of the door. In the event of a	K 363	1. The third-floor soiled linen room corridor door hole was covered and sealed with appropriate fire rated material. The first-floor soiled linen room corridor door hole was covered and sealed with appropriate fire-rated material. The maintenance director and his staff were re-educated on the requirement and procedures for checking smoke resistant passages. 2. All residents are at risk by this deficient practice. 3. DOM/Designee shall audit monthly x3 months all fire door assemblies for holes and submit the report to the facility administrator. 4. The audit findings shall be submitted to the monthly QA committee meeting x3 months to review and determine if further interventions are needed.	

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ALLAIRE REHAB & NURSING	**115 DUTCH LANE ROAD** **FREEHOLD, NJ 07728**

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K 363	Continued From page 11 fire, the tape would melt and leave a one-inch hole through the door. 2) On 11/29/22 at approximately 11:30 AM, the surveyor observed the First Floor Soiled Linen room corridor door had a one (1) inch hole through the door with electrician's black electrical tape on one side of the door. In the event of a fire, the tape would melt and leave a one-inch hole through the door. The CCO and DOM confirmed the findings at the times of observations. The Administrator was informed of the deficiency at the survey exit on 11/29/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363		
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 11/28/22 and 11/29/22, in the presence of facility management, it was determined that the facility failed to ensure that 2 of 14 electrical outlets located next to a water	K 911	1. The two duplex GFCI protected electrical outlets in the third-floor unit manager□s office were immediately replaced. The maintenance director and	1/15/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315387	A. BUILDING **01** B. WING _____	**11/30/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLAIRE REHAB & NURSING	**115 DUTCH LANE ROAD** **FREEHOLD, NJ 07728**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 911	Continued From page 12 source (within six feet) were equipped with Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: During the survey entrance on 11/28/22 at approximately 9:10 AM, a request was made to the Corporate Compliance Officer (CCO) and Director of Maintenance (DOM), to provide a copy of the facility layout which identified the various rooms and smoke compartments. A review of the facility provided layout identified that there were four stories in the main building and an Annex building. Starting on 11/28/22 at approximately 9:42 AM and continued on 11/29/22, a tour of the building with the CCO and DOM was performed. During the two-day tour of the facility, the surveyor observed and tested fourteen (14) electrical outlets (within six feet of a sink) in wet locations with a GFCI tester to de-energize the outlets. The surveyor observed the following: 1) On 11/28/22, the surveyor observed, inside the Third Floor Unit Manager's office, two (2) duplex electrical outlets: one duplex outlet was 22 inches (1'-10") to the left and one duplex outlet was 57 inches (4'-9") to the left of the sink. These two (2) duplex electrical outlets had labels that read "GFCI protected outlet". When the surveyor tested the two (2) duplex electrical outlet with a GFCI tester to de-energize, both duplex electrical outlets did not de-energize as required by code. The CCO and DOM confirmed the findings at the	K 911	his staff were re-educated on the requirements and procedures for GFCI testing and compliance. 2. All residents are at risk by this deficient practice. 3. The DOM/Designee shall audit monthly x3 months all electrical outlets that require GFCI testing and submit the report to the facility administrator. 4. The audit findings shall be submitted to the monthly QA committee meeting x3 months to review and determine if further interventions are needed.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315387	A. BUILDING **01** B. WING _____	**11/30/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLAIRE REHAB & NURSING	**115 DUTCH LANE ROAD** **FREEHOLD, NJ 07728**

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K 911	Continued From page 13 times of observations. The Administrator was informed of the deficiency at the survey exit on 11/29/22. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		

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
315387 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/9/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLAIRE REHAB & NURSING	115 DUTCH LANE ROAD FREEHOLD, NJ 07728

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0293	01/30/2023	LSC K0321	01/30/2023	LSC K0351	01/30/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0355	01/30/2023	LSC K0363	01/30/2023	LSC K0911	01/30/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
11/30/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO