STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING _____ B. WING _____	C 11/08/2023

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OAKS AT DENVILLE, THE	**21 POCONO ROAD DENVILLE, NJ 07834**

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F 000	INITIAL COMMENTS NJ00168293, NJ00168327, NJ00166485, NJ00162085, NJ00167488 Survey Date: 11/08/23 Census: 52 Sample: 15 + 3 + 5 = 25 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 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other pertinent documentation, it was determined that the facility failed to ensure a medication was administered to the manufacturer's cautionary specifications and in accordance with professional standards of clinical practice. The deficient practice was identified for one (1) of three (3) nurses administering medications to one (1) of four (4) residents during the medication administration observation and was evidence by the following. A review of the manufacturer's specifications for EX Order 26.4B1) under section 2.1	F 658	F658 1. The RN and the DON were in-serviced on looking at the cautionary that was on the bingo card of the medication which contained the cautionaries for the medications for resident #35. 2. The medication bingo cards of all residents were checked for cautionaries and noted that those with similar medications, i.e., EX Order 26.4B1, had Take with meal on the label. Other medications with cautionaries also had	12/8/23

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

Electronically Signed | 12/01/2023

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F 658	Continued From page 1 titled EX Order 26.4B1 Individualize the dosage of EX Order 26.4B1 tablets. EX Order 26.4B1 r tablets should be taken with or immediately following meals. On 11/02/23 at 8:31 AM, during the medication administration observation, the surveyor observed the Registered Nurse (RN) prepare medications for Resident #35. The RN prepared seven medications which included EX Order 26.4B1 At 8:42 AM, the surveyor observed the resident sleeping and the breakfast tray was not in the room. At 8:56 AM, the RN confirmed with the surveyor that she was ready to administer the medications to Resident #35, proceeded into the resident's room and attempted to awaken the resident. The surveyor requested to speak with the RN outside the room. At 9:01 AM, the surveyor and the RN reviewed the resident's bingo card (a multidose card containing individually packaged medications) for EX Order 26.4B1 The bingo card had an affixed cautionary label that indicated "Take with Meal." At that time, the surveyor and the RN reviewed the electronic Medication Record (eMAR) together. The eMAR included the order for EX Order 26.4B1 which did not reveal a cautionary to administer the medication with a meal. At that time the RN stated she should not have	F 658	the information on the label of the bingo cards. 3. In order for the deficient practice not to recur, the DON in-serviced staff to document the cautionaries in the Medication Administration Record and to make sure that the nurses read the instructions as they prepare to give the residents medication. 4. The DON and/or designee will monitor new medication orders to make sure that cautionaries are included in Medication Administration Record of the individual resident□s orders. The pharmacy consultant will review medication orders including cautionaries on a monthly basis. The DON, pharmacy consultant, and/ or designee will report the information in the daily meetings with the nurse managers and administrator and will also include the findings in QAPI meetings, monthly for three months, then two times quarterly. The QAPI committee will determine if it requires to be continued. 5. Completion Date: 12/8/23	

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F 658	Continued From page 2	F 658		

attempted to administer the medication without the resident having a meal. The RN stated that the medication could be better absorbed with a meal or decrease nausea when taken with a meal. The RN stated that she missed the cautionary on the bingo card.

At that time, the RN asked the RN/Charge Nurse (CN) for Resident #35's breakfast tray.

At that time, in the presence of the surveyor and the RN, the RN/CN confirmed that Resident #35's breakfast tray was not in the room, the hallway, or the dining room, but would speak with the other staff about it.

At 10:22 AM, during an interview with the surveyor, the Registered Nurse/Unit Manager stated the cautionary on the bingo card should have been followed.

On 11/03/23 at 11:17 AM, during a meeting with the survey team, the Director of Nursing (DON), the Licensed Nursing Home Administrator (LNHA), the Clinical Implementation Analyst (CIA), the Regional Nurse Consultant (RNC), and the Executive Director (ED), the surveyor discussed the concern regarding the nurse not following the proper administration of EX Order 26.4B1 by following the cautionary affixed to the resident's bingo card.

On 11/08/23 at 10:49 AM, during a meeting with the survey team, the LNHA, the CIA, the RNC #1, the RNC #2, the Vice President of Clinical Services, and the ED, the DON acknowledged the cautionary for the EX Order 26.4B1 should have been read and followed. The DON informed the

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F 658	Continued From page 3 survey team that the cautionary would be added to the Medication Administration Record to help the nurses with proper administration of medication. A review of the facility provided policy "Medication Administration and General Guideline dated 11/21/22 included the following: Policy; Medications are administered as prescribed in accordance with State Regulations, using good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication, monograph of all medications is available in [drug reference] otherwise authorized personnel should refer to Drug Reference material provided by facility. NJAC 8:39-29.2 (d)	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review and review of other pertinent facility provided documentation, the facility failed to a) ensure a root cause analysis conclusion was	F 689	F689 1. The incident of [redacted] of resident #35 was revisited by the charge nurse and the	12/1/23

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F 689	Continued From page 4 included in a resident's [EX Orde] investigation/incident report and b) implement and document in the resident's care plan a new intervention after a resident's [EX Orde] in order to prevent any additional [EX Order 2] [EX Order 26] for one (1) of two (2) residents reviewed for [EX Order 26] (Resident #35). This deficient practice was evidenced by the following: On 10/31/23 at 11:54 AM, the surveyor observed Resident #35 seated in a wheelchair at the end of the hall looking out the window. The surveyor reviewed Resident #2's medical record. The Admission Record (or face sheet; admission summary) indicated that the resident was admitted to the facility with medical diagnoses that included but were not limited to; [EX Order 26.4B1] EX Order 26.4B1) following EX Order 26.4B1 [redacted]. Resident #35's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [EX Order 26.4B1], indicated a Brief Interview for Mental Status (BIMS) score of [EX Orde] out of 15, which reflected that the resident's EX Order 26.4B1 [redacted]. Further review indicated the resident had a reentry into the facility from an [EX Order 26.4B1] and that the resident had a [EX Orde] with a [EX Order 26.4B1]. A review of the New Jersey Universal Transfer	F 689	DON. The incident report and an addendum were noted in the conclusion. Resident's care plan was also updated to include the interventions that were implemented after the incident occurred. 2. Other incident reports with falls since June were reviewed by the DON to assure that the root cause of the incident is noted in the conclusion of the report and that the individual care plans were updated to include interventions taken after the incident. 3. In order to ensure that the deficient practice does not recur, the DON in-serviced the nursing staff regarding the policy on incident reporting and the importance of updating the residents care plan to include the interventions after the incident occurred. 4. The DON, and/or designee will review Risk Watch Analysis daily as per policy and will continue to report incidents to the interdisciplinary team during the daily meeting to assure the completion of the investigation and trends of possible causative factors, and that the care plan is updated with current interventions. The DoN or designee will audit all incident reports weekly to ensure all incident reports are concluded with interventions in place. In addition, the DON will report the information during the QAPI meetings monthly x3, then quarterly x2. The QAPI committee will determine if it requires to be continued.	

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F 689	Continued From page 5 Form dated EX Order 26.4B1 indicated that Resident #35 was transferred to the hospital and the reason for transfer was EX Order 26.4B1 ." A review of the facility provided "Full Occurrence Report," an investigation/incident report, dated EX Order 26.4B1 revealed under the notes section that Resident #35 was EX Order 26.4B1 and that the resident had EX Order 26.4B1. The resident had EX Order 26.4B1 and was sent to the hospital. Under the Conclusion Statement section was "N/A" (not applicable). Under the Recommendations section was "None Noted." The investigation/incident report did not contain a root cause analysis conclusion or recommendations/interventions to prevent any additional EX Order 26 The EX Order Risk Assessment dated NJ Exec. Order 26:4.b.1, indicated Resident #35 was EX Order 26.4B1 A review of Resident #35's individualized comprehensive care plan (CP) reflected a problem, with a created date of NJ Exec. Order 26:4.b.1, of at risk for EX Order 26 which included actual dated EX Order 26.4B1 The EX Order 26.4B1 was not listed. The interventions listed included additional interventions that were added after each of the EX Order 26 on EX Order 26.4B1 and EX Order 26.4B1. There was no additional intervention added after the EX Order 26.4B1 or any documented evidence that the interventions already in place were reviewed in order to prevent any additional EX Order 26 On 11/02/23 at 10:53 AM, the surveyor interviewed Resident #35's assigned Certified Nursing Assistant who stated that the resident was a EX Order 26.4B1 and had a bed that was low to the	F 689	5. Completion Date: 12/1/23	

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F 689	Continued From page 6 ground. On 11/02/23 at 11:16 AM, the surveyor interviewed the Registered Nurse/Charge Nurse (RN/CN) of the [redacted] floor unit regarding the process after a resident had a [redacted] The RN/CN stated that the resident would be assessed, the family and physician would be notified and the resident would be sent to the hospital if warranted. She then stated that the [redacted] would be reported and that a risk watch (incident report) assessment and a [redacted] risk assessment would be done. The RN/CN stated that the unit manager would do an investigation which included a conclusion and that an intervention would be put in place if one was needed. On that same date and time, the surveyor asked the RN/CN if Resident #35 had a [redacted]. The RN/CN stated that the resident EX Order 26.4B1 on [redacted] and that he/she was evaluated at the hospital but was not admitted. The surveyor then asked who would update the CP and if the expectation was to have an added intervention after a [redacted] The RN/CN stated that the CP was done by the unit manager and that she would expect an intervention. The RN/CP then stated that Resident #35 received EX Order 26.4B1 after the [redacted] to improve transfers, frequently was reminded to ask for help, frequently checked, non slip socks or shoes worn and bed in the lowest position. She added that the resident got EX Order 26.4B1 to transfer self. On 11/02/23 at 11:26 AM, the surveyor interviewed the RN/Unit Manager (RN/UM) of the [redacted] floor unit regarding the process for CP and [redacted] The RN/UM stated that every three (3)	F 689		

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F 689	Continued From page 7	F 689		

months the CP was updated and if there were changes or an incident like [EX Order]. She added that if there was a [EX Order] then an intervention should be added near the date of [EX Order]. The RN/UM stated that at morning meeting the interdisciplinary team discussed the [EX Order] and interventions. She stated that the [EX Order] would be investigated, concluded and an intervention added.

At that same time, the surveyor asked the RN/UM to view Resident #35's CP and to confirm that the [NJ Exec. Order 26:4.5 EX Order] was not listed and that an additional intervention was not added. The RN/UM confirmed the CP was not updated and stated that during that time she was working the 3-11 shift and that there was a different UM. She stated that whoever was in charge at that time should have had the [EX Order] listed and then added an intervention. The surveyor asked what the importance of adding the [EX Order] and an additional intervention was. The RN/UM stated that the importance was so everyone would be alert to prevent the resident from [EX Order 26.4B] again. The RN/UM stated that she knew the resident was very [EX Order 26.4B1] but that they could try to stop the resident from [EX Order 26.4B] again.

Furthermore, the surveyor then showed the RN/UM the investigation/incident report that had no conclusion or recommendations. The RN/UM stated that there should have been a conclusion.

On 11/02/23 at 01:14 PM, in the presence of the survey team, the surveyor asked the Director of Nursing (DON) if the investigation/incident report provided was the full and complete investigation. The DON stated that it was the full investigation minus the [EX Order 26.4B1] which would be in the

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F 689	Continued From page 8	F 689		

computer. The surveyor asked where the conclusion and statements would be. The DON stated that the nurse would write it in the report.

On 11/03/23 at 10:28 AM, the surveyor interviewed the DON regarding the process of the CP and [redacted]. The DON stated that when a resident had a [redacted] then the CP should be updated with an intervention that pertained to the [redacted]. She added that hopefully the CP would be updated by the next morning but that sometimes the investigation may take longer. The DON stated that the conclusion should be done within 72 hours. The surveyor then showed the DON Resident #35's CP and investigation/incident report for the [redacted]. The DON confirmed that there was no conclusion listed on the investigation/incident report and that there was no update to the CP after the [redacted]. The DON stated that there should have been a conclusion and an added intervention to the CP unless all possible interventions were already in place and if that was the case then that should have been documented.

On 11/03/23 at 11:30 AM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA), DON, Regional Nurse Consultant #1 (RNC #1), Clinical Implementation Analyst (CIA) and Executive Director (ED) the concern that Resident #35's [redacted] investigation/incident report did not contain a root cause analysis conclusion and the CP was not updated to include an added intervention to prevent another [redacted]

On 11/08/23 at 11:25 AM, in the presence of the survey team, LNHA, CIA, RNC #1, RNC #2,

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F 689	Continued From page 9 ED and Vice President of Health Services (VPoHS), the DON confirmed that the Resident #35's investigation/incident report for the EX Order 26.4B1 EX Orde did not have a conclusion and that the CP was not updated. She added that she did not have an explanation for why it had not had a conclusion or why the CP was not updated. The DON confirmed that there should have been a conclusion and the CP should have been updated. A review of the facility provided policy titled, "Incident Reporting," with a revised date of 02/01/2021, included the following: Policy: It is the policy of the community that all incidents are properly reported, recorded and analyzed for causative factors and trends. Corrective and/or preventative measures shall be implemented as indicated ...3. Analyze all incidents for risk potential implementing corrective and/or preventative actions as required ... Incident Report Investigation Forms: 1. An investigation shall be initiated on all reported incidents. An Incident Investigations Report form shall be completed at the time of the incident. 2. Document in the "Comments/Conclusion" section if facts relating to the cause of the incident are actually known. Possible causes may be investigated but not documented until substantiated by facts ... Quality Monitoring and Management: 1. The Executive Director/Administrator, Director of Nurses/AL Nurse Manager will review all Incident Reports which have occurred in the community/facility, on a monthly basis. 2. A determination will be made as to what	F 689		

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F 689	Continued From page 10 corrective and/or preventative measures, if any, will be implemented by the facility staff. 3. Documentation of such determination will be submitted to the Quality Improvement Committee ... Risk Watch Reporting Process: ... 3. Administrator/DON or designee begins the Review stage a. Reviews Full Report ... c. Review for appropriate recommendations, add or modify as needed, and record whether they have been implemented ... 4. Unit Manager/Supervisor, DON, or designee generates Daily Safety Review or Occurrence Log in RiskWatch (Analysis menu) for discussion of recent occurrences at daily stand up meeting (Ongoing) a. Communicate relevant information to affected staff b. Update care plans as necessary ... 7. Risk Watch Incident Reports along with Medical Charts will be reviewed by the Administrator/DON or designee at the end of each month. a. All data entry will be reviewed i.e. recommendations, interventions, etc. for effectiveness and final outcomes. A review of the facility provided policy titled, "Falls Management Program," with a revised date of 12/22/2022, included the following: 11. Post fall a. The interdisciplinary team, at the daily report or Falls Committee, will review the post-fall assessment, incident report, any employee/elder statements, post-fall investigation, post-fall summary, and current interventions to evaluate if they were appropriately implemented, still	F 689		

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F 689	Continued From page 11 relevant, and effective. The ECP (elder care plan) will be modified accordingly. All changes to the ECO will be communicated to the direct caregivers ... 12. All falls are investigated and trended for possible causative factors utilizing the Risk Watch Analysis and reported to the community Quality Improvement Committee along with appropriate action plans. A review of the facility provided policy titled, "Resident care Plan (RCP)," with a revised date of 6/29/2023, included the following: Policy: It is the policy ...to ensure that the care planning process is systematic, comprehensive, interdisciplinary and timely and directed toward achieving and maintaining each resident's optimal physical, psychosocial and functional status. Procedure: ... 9. The effectiveness of the RCP must be regularly evaluated based on progress towards goals. The RCP will be modified as necessary based on the evaluation process ... 11. The RCP will be updated at the Resident Care Conference and as necessary to address the resident's needs.	F 689		
F 700 SS=D	N.J.A.C. 8:39-27.1 (a) Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following	F 700		12/1/23

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F 700	Continued From page 12 elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: NJ00168293 Based on observation, interview, record review, and review of other pertinent facility documents, it was determined that the facility staff failed to: a) properly assess bed rails (side rail/enabler) safety to prevent harm to a cognitively impaired resident by not screening the resident properly during admission, ensuring correct installation, usage, and maintenance, b) obtain a physician order, c) educate and obtain consents from the resident/responsible party regarding risk/benefit of using bed rails, and evaluating alternatives before using bed rails prior to installation, d) monitor, inspect, and supervise the usage of bed rails, and e) follow facility policy and procedures. This deficient practice was identified for one (1) of one (1) resident reviewed for bed rails and was evidenced by the following:	F 700	F 700 1. Resident #251 has been discharged from the facility. 2. Current residents in the facility who have side rails/enablers were reassessed by the DON and designee. Those who were noted to need or want the siderails on their respective beds have doctor□s orders put in place in their medical record, informed consent from residents or family representatives for those with BIM score is less than 12, and the care plans were updated to show the use of the siderails. 3. The DON in-serviced the licensed nursing staff regarding siderail assessment including need for physician□s orders for the use of the	

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F 700	Continued From page 13 A review of the reportable event record/report (FRE; Facility Reported Event) was called in on 10/09/23 at 11:48 AM, with an event date of 10/05/23 [unidentified time of event]. The event description included the following: On 10/05/23, the Power of Attorney (POA) spoke with Resident #251 who was told that he/she was [redacted] by a [redacted] nurse. The POA did not report to any staff as she did not believe that this had occurred. The POA mentioned to the Director of Nursing (DON) on 10/08/23 regarding Resident #251's statement regarding the young [redacted]. "The [redacted] Certified Nursing Assistant (CNA) on that resident's assignment was immediately removed from the schedule as a precaution but this description fits several staff members." The surveyor reviewed the closed medical records for Resident #251. A review of Resident # 251's admission record reflected the resident was admitted to the facility with a diagnosis that included unspecified [redacted] According to the admission Minimum Data Set, an assessment tool used to facilitate management of care dated, [redacted] Resident #251 was documented as having a Brief Interview for Mental Status score of [redacted] out of 15, indicating that the resident was [redacted]	F 700	siderail/enabler and indicate which type or side(s) are to be used, consent forms to be obtained from the resident and/or family representative which will include risk versus benefits and risk of injury, entrapment and bruising. This will also be included in educating new nurses who will work in the facility. 4. The DON, and/or designee, will review newly admitted or readmitted resident siderail assessment to assure completion and correct information. All newly admitted/readmitted residents will be audited weekly x 12 weeks. The DON will report the information during the QAPI meetings monthly x3. If the facility is in 100% compliance after the first quarter, 10 random admission charts will be audited monthly x 2 quarters. The QAPI committee will determine if it requires to be continued. 5. Completion Date: 12/1/23	

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F 700	Continued From page 14 NJ Exec. Order 26:4.b.1. The MDS also revealed that Resident #2 required EX Order 26.4B1 for Activities of Daily Living (ADLs). A review of the Side Rail Screen dated 9/14/23, under the question, Does the facility use side rail? The documented response was "No." Under, Comments/Recommendations/Additional Interventions: was blank, signed by Registered Nurse#1 (RN#1). A review of the Side Rail Screen dated 9/20/23, under the question, Does the facility use side rail? The documented response was "No." Under, Comments/Recommendations/Additional Interventions: Patient uses enablers while in bed for repositioning, signed by RN #2. The Physician Order Sheet for October 2023 did NJ Exec. Order 26:4.b.1 A review of the medical record did not reflect an education and a signed informed consent was obtained regarding the NJ Exec. Order 26:4.b.1 from the resident/resident representative prior to installation of the NJ Exec. Order 26:4.b.1. No additional document was provided. Further review of Resident #251's closed record did not reflect a copy of the maintenance department's inspection of the NJ Exec. Order 26:4.b. No additional information was provided. The Care Plan reflected interventions dated NJ Exec. Order 26:4.b.1, included, continue NJ Exec. Order 26:4.b.1 during care, and NJ Exec. Order 26:4.b.1	F 700		

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F 700	Continued From page 15	F 700		

with pillows for extra protection. An undated intervention was the use of an NJ Exec. Order 26:4.b.1 repositioning.

A review of the facility provided Full Occurrence Report dated 10/08/23 at 12:10 AM, reported by RN #3 documented that Resident #251 had EX Order 26.4B1 that EX Order 26.4B1 EX Order 26.4B1 was observed while the resident was being EX Order 26.4B1 The resident was NJ Exec. Order 26:4.b.1 how it happened.

The DON documented on 10/23/23 at 01:07 PM the following: A lengthy conversation with the POA occurred about the resident's EX Order 26.4B1 and EX Order 26.4B1. In a discussion of the risk versus benefit of side rails [bed rails], the resident used them to position self and the tendency of the resident top pull their body into them that caused NJ Exec. Order 26:4.b. The POA wished to continue the use of side rails and agreed to monitor the resident. The facility did not have padded side rails in stock, and they were ordered. The side rails were padded with pillows in the interim. The resident was observed removing the pillows and any other padding interventions tried. On 10/08/23, the resident sustained EX Order 26.4B1 EX Order 26.4B1 and NJ Exec. Order 26:4.b.1 area from his NJ Exec. Order 26:4.b.1 and attempting to get up unattended. The resident was sent out [to the hospital] and admitted with EX Order 26.4B1 EX Order 26.4B1

On 11/02/23 at 01:18 PM, during an interview with the surveyor, the DON stated that she had spoken with the POA and discussed the EX Order 26.4B1 from the side rails and documented the

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F 700	Continued From page 16 conversation regarding the resident who laid close to the bed rails, the interventions of ordering a Velcro side rail, change the bed to a raised perimeter mattress. The bed frame was EX Order 26.4B1 and thought the extra cushion would help. On 11/02/23 at 01:20 PM, during an interview with the surveyor, the Registered Nurse/ Unit Manager (RN/UM) stated she somewhat recalled the resident, but some time had passed. She recalled the resident was care planned to have two person assists during care. The two-person assist in the morning would either be two CNAs or a CNA with a Licensed Practical Nurse (LPN) or an RN, and the night shift would be a CNA and an LPN or an RN. The RN/UM further stated that this was our process to prevent abuse in our facility in the case of a resident who had behaviors of hitting staff. On 11/03/23 at 11:17 AM, during a meeting with the survey team, the Director of Nursing (DON), the Licensed Nursing Home Administrator (LNHA), the Clinical Implementation Analyst (CIA), the Regional Nurse Consultant (RNC), and the Executive Director (ED), the surveyor discussed the concern regarding the improper assessment of Resident#251's side rails/enabler prior to installation, the concerns regarding the failure to obtain a physician order, obtain a signed informed consent from the resident or resident's representative prior to installation, proof of inspection from the maintenance department, rehabilitation department as part of the interdisciplinary team, failure to follow facility policy and procedure.	F 700		

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F 700	Continued From page 17 At that time, the DON informed the surveyors that the bed rails were coded as enablers which caused the cascade of bed rails screens to not be performed. The DON also stated that the bed rails coded as enablers were discovered in September 2023 and a Quality Assurance and Performance for Improvement (QAPI; a data-driven and proactive approach to quality improvement that included QA and Performance Improvement to ensure services are meeting quality standards and assuring care reached a certain level) was also initiated. The incident for Resident #251 occurred on EX Order 26.4B1 On 11/8/23 at 10:49 AM, during a meeting with the survey team, the LNHA, the CIA, the RNC #1, the RNC #2, the Vice President of Clinical Services, and the ED, the DON acknowledged that on 9/15/23 and 9/20/23 an assessment was completed however was documented as an enabler which blocked the remainder of the assessment. At that time, the DON stated that she re-audited the entire building after the surveyor's inquiry for bed rails marked as enablers. On 11/08/23 at 12:43 PM, during an interview with the surveyor, the Physical Therapist (PT)/Rehabilitation Director (RD) stated that she did not receive any referral from nursing to evaluate the resident's ability to use or remove the side rail or what padding should be used. The PT/RD also stated that the resident was EX Order 26.4B1 and was NJ Exec. Order 26:4.b.1 to unlock or move the bed rail up or down. On 11/08/23 at 10:49 AM, during a meeting with	F 700		

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F 700	Continued From page 18 the survey team, the LNHA, the CIA, the RNC #1, the RNC #2, the Vice President of Clinical Services, and the ED, the DON stated that they stood behind their conclusion on the reportable from EX Order 26.4B1, that the EX Order 26.4B1 were related to the use of the side rail. "I have witnessed the resident use the side rail, the resident was EX Order 26.4B1 more functional." A review of the facility provided; Side Rail/Enabler Information/Instruction, undated, reflected the following: 1. Complete a Side Rail assessment on admission, quarterly or any time a rail will be used for the first time on a resident. All rails whether it is an enabler, or a side rail follows the same rule and same regulation. 2. Physician Order for the use of side rails/enabler. You must indicate which type is used and which sides ... 4. All rails/enabler usage needs consent ...If the resident has a BIMS less than 12, you must get consent from family representative. You must explain risk versus benefit of side rail use. This includes risk of injury, risk of entrapment, risk of bruising. A review of the facility policy Side Rails and Bed Safety, revised on 6/2023 included the following: Policy [facility name redacted] shall strive to provide a safe environment for residents while they are in bed. 1. The residence sleeping environment shall be assessed by the interdisciplinary team considering the resident's safety, medical conditions, comfort, and freedom of movement,	F 700		

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F 700	Continued From page 19 as well as input from the resident and family regarding previous sleeping habits and that environment. 2. To prevent death injuries from the bed and related equipment including the frame, mattress, side rails, headboard footboard and bed accessories the community shall promote the following approaches: a. Inspection by maintenance staff of all bed related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment. d. Ensure that side rails are properly installed using manufacturers instructions and other pertinent safety guidance to ensure proper fit ... e. Identify identify additional measures for residents who have been identified as having a higher than usual risk for injury including entrapment (e.g. altered mental status, restlessness ...) 3. The maintenance department shall provide a copy of inspections to the administrator and report results to the QA committee or appropriate action ... 4....Maintenance and monitoring of the bed, mattress, and accessories should be ongoing... 6. The staff shall obtain consent for the use of side rails from the resident or the resident's legal representative prior to use... 8. Side Rails may be used if assessment and consultation with the attending physician have determined that they are needed to help manage a medical symptom or condition or help the resident reposition or move in bed and transfer, and no other reasonable alternatives can be identified. NJAC 8:39-27.1(a)	F 700		

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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. §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	F 756		12/1/23

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F 756	Continued From page 21 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 interviews, record review, and review of the facility provided documents, it was determined that the facility failed to a) identify irregularity for a total of twelve months and b) act upon the recommendations made by the Consultant Pharmacist (CP) in a timely manner. This deficient practice was identified for one (1) of five (5) residents reviewed for unnecessary medications (Resident #17). This deficient practice was evidenced by the following: On 10/30/23 at 11:51 AM, the surveyor observed Resident #17 in bed asleep. The surveyor reviewed Resident #17's medical records. The resident's Admission Record (or face sheet; admission summary) reflected that the resident was admitted to the facility and had diagnoses EX Order 26.4B1 [redacted]	F 756	F756 1. The Medication Regimen Review of resident #17 was reviewed by the DON and Unit Manager with the EX Order 26.4B1 nurse. The medications and sequencing were added to the EX Order 26.4B1 for EX Order 26.4B1, EX Order 26.4B1 for NJ Exec. Order 26:4.b.1, and EX Order 26.4B1 for NJ Exec. Order 26:4.b.1. 2. The DON contacted the pharmacy consultant, who came to the facility to review the medical records of all residents to ensure that PRN sequencing was appropriately ordered. The pharmacy consultant sent the report of the findings to the DON, who then shared the list with the nurse managers. The nurse managers notified the physician/nurse practitioners about the recommendations and the appropriate sequencing of the medication orders were obtained and carried out. The Pharmacy Consultant reviewed all resident charts to ensure all other previously identified recommendations were carried out. The pharmacy consultant was educated to accurately complete the resident medication review flowsheet loacted in the resident chart to indicate their findings with the monthly review. 3. To ensure that the deficient practice does not recur the DON in-serviced all	

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F 756	Continued From page 22 EX Order 26.4B1 [redacted] A review of the resident's significant change Minimum Data Set (scMDS), an assessment tool used to facilitate the management of care with an assessment reference date (ARD) of EX Order 26.4B1, Section C Cognitive Patterns revealed a cognitive skills for daily decision making was coded as NJ Exec. Order 26:4.b.1 which reflected that the resident's EX Order 26.4B1 [redacted] The Order Status (OS) active orders as of EX Order 26.4B1 showed that the resident had an order of EX Order 26.4B1 [redacted] The OS also included an active order for EX Order 26.4B1 [redacted] The above order for EX Order 26.4B1 was transcribed to the electronic Medication Administration Record (eMARS) from EX Order 26.4B1 through EX Order 26.4B1. A review of the Consultant Pharmacist-Medication Regimen Review (or MRR) permanent record from EX Order 26.4B1 through	F 756	nurses in the facility in obtaining orders for medications with proper sequencing. New nurses to the facility will likewise be in-serviced as part of their orientation, about the proper sequencing of medications. Nurse managers were provided education on the new process for completing the pharmacy consultant reports. 4. The DON or designee will review all new orders and monitor for proper sequencing of medications. The DON and/or designee will report the information in the daily meetings with the nurse managers and administrator. The DON or designee will audit 5 charts weekly for 4 weeks then 5 charts monthly for proper sequencing and will report the findings in QAPI meeting monthly x3, then quarterly x2. The QAPI will determine if it needs to be continued. All Pharmacy Consultant reports will be completed by the nurse manager/designee and a copy provided to the DON for review and to ensure all recommendations were carried out. Pharmacy Consultant reccomendations will be audited on a monthly basis to ensure the reccomendations are being carrieed out. 10 reccomendations will be audited each month for 3 quaters and reported in Qapi. Qapi committee will determine if this auditing will need to continue at that time. 5. Completion Date: 12/1/23	

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F 756	Continued From page 23 NJ Exec. Order 26:4.b.1 [in the paper chart] showed that there were no recommendations identified regarding the order for EX Order 26.4B1 On 11/02/23 at 11:29 AM, the surveyor interviewed Licensed Practical Nurse #1 (LPN#1) and LPN #2. The surveyor asked the nurses who were responsible for consultant pharmacist reviews, and LPN #1 stated that it was the nurse. LPN #1 further stated that the nurse notified the physician of the CP's recommendations. On that same date and time, LPN #1 informed the surveyor that for residents with multiple PRN pain medications, the PRN medications should be sequenced to mild, moderate, and severe pain. On 11/02/23 at 01:36 PM, the surveyor asked the Director of Nursing (DON) for a copy of the facility's policy regarding MRR in the presence of another surveyor. On 11/03/23 at 9:57 AM, the surveyor interviewed the Consultant Pharmacist/Owner (CP/O) via phone conference in the presence of the survey team. The CP/O informed the surveyor that he and the other CP were both responsible for residents' monthly MRR. The CP/O stated that the monthly MRR was submitted via email to the DON, Licensed Nursing Home Administrator (LNHA), and other designated people in the facility [usually the Unit Manager]. He further stated that the reports were being submitted within 24 hours. On that same date and time, the CP/O informed the surveyor that part of his responsibility was to	F 756		

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F 756	Continued From page 24 check residents with multiple PRN pain medications, to make sure that they were properly sequenced. The surveyor then notified the CP/O of the above findings and concerns regarding the EX Order 26.4B1 order that was ordered on EX Order 26.4B1 and was not sequenced for EX Order 26.4B1 The CP/O acknowledged that it should have been identified as an irregularity for not being sequenced for EX Order 26.4B1 medication. He further stated that he will get back to the surveyor and that he will double check the order himself because the resident was in EX Order 26.4B1. On 11/03/23 at 11:17 AM, the survey team met with the LNHA, DON, Regional Nurse Consultant #1 (RNC#1), Clinical Implementation Analyst (CIA), and Executive Director (ED). The surveyor notified the facility management of the above findings and concerns regarding EX Order 26.4B1. On 11/03/23 at 12:11 PM, the CP/O called back in the presence of the survey team. The CP/O informed the surveyor that after checking his notes and records, he found out that on NJ Exec. Order 26:4.b there was a CP's recommendation to sequence the NJ Exec. Order 26.4.b.1 medications, and "it looks like that it was not addressed." At that same time, the surveyor asked the CP/O why the CP recommended it on EX Order 26.4B1 to sequence the EX Order 26.4B1 medications when the order for EX Order 26.4B1 was since EX Order 26.4B1. The CP/O responded, "We address what we see in our review." Furthermore, the surveyor asked the CP/O why the NJ Exec. Order 26:4.b recommendation to sequence the	F 756		

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F 756	Continued From page 25 [NJ Exec. Order 26:4.b.1] medications was not included in the medical records that the surveyor reviewed, and the CP/O had no response. Then, the CP/O stated that he would send the [NJ Exec. Order 26:4.b] CP MRR to the surveyor to show the CP's recommendation. On 11/03/23 at 12:27 PM, the CP/O sent via email the copy of the Consultant Pharmacist Medication Regimen Review for recommendations created between [NJ Exec. Order 26:4.b] and [NJ Exec. Order 26:4.b] includes routing for nursing dated [NJ Exec. Order 26:4.b] which included "Multiple PRN medications are noted for the same or overlapping indications. Please sequence the following medication: EX Order 26.4B1." The [NJ Exec. Order 26:4.b.1] recommendations follow-through and the nurse's signature were both blank, which indicated that the recommendations were not acted upon. On 11/08/23 at 9:51 AM, the surveyor interviewed the DON in the [EX Order]-floor nursing station. The surveyor showed the DON the Consultant Pharmacist-Medication Regimen Review in the resident's chart for the date [EX Order 26.4B1] "[EX Ord] day [EX Order 26]-." The surveyor also notified the DON of the provided copy of the CP/O for the date [EX Order 26.4B1] wherein there was a recommendation for nursing regarding [NJ Exec. Order] sequencing of medications EX Order 26.4B1. The DON stated that the [EX Ord] day [NJ Exec. Orde] did not specify for what medication and that usually it was for EX Order 26.4B1 medications not for EX Order 26.4B1. At that same time, the DON stated that the CP should have documented the recommendations of [NJ Exec. Order] sequencing of [EX Order 26] medications in the	F 756		

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F 756	Continued From page 26 sheet that was reviewed by the surveyor in the resident's medical chart for the nurse to be able to determine what to follow up with the physician. The DON further stated that she will check the records in her office to verify if the facility received the [NJ Exec. Order 26:4.b.] recommendations of the CP that were provided to the surveyor by the CP/O via email, and will get back to the surveyor. On 11/08/23 at 10:49 AM, the survey team met with the LNHA, DON, RNC#1, CIA, Vice President of Clinical Services (VPoCS), RNC#2, and ED [came at 11:15 AM]. The DON stated that it was an expectation that the CP would document in the chart where the sheet of MRR monthly recommendations located the CP's recommendations. The DON acknowledged that the [NJ Exec. Order 26:4.b.] visit and recommendations of the CP did not include the EX Order 26.4B1 sequencing for [NJ Exec. Ord] medication. On that same date and time, the surveyor asked the facility management why the provided copy of the facility and the CP/O for [NJ Exec. Order 26:4.b.] recommendations that were not in the chart of the resident at the time of review were not acted upon. The DON stated, "I do not have a good answer." A review of the facility provided Medication Regimen Reviews Policy with a revised date of 8/17/21 that was provided by RNC#2 included that the CP shall review the medication regimen of each resident at least monthly. The Procedure included: 1. The CP will perform an MRR for every resident in the facility. 2. Routine reviews will be done monthly ...	F 756		

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F 756	Continued From page 27 7. The CP will document his/her findings and recommendations on the monthly drug/medication record review report ... 9. The CP will provide to the DON and Medical Director with a written, signed, and dated copy of the report, listing the irregularities found and recommendations for their solutions. 10. Copies of drug/regimen review reports, including physician responses, will be maintained as part of the permanent medical record ... To Nursing: 1. The CP will provide a report within seven (7) working days of the review. 2. Nursing will provide a response within two (2) weeks of receipt of report. 3. Nursing will retain a copy of the report pending Nursing documentation review. On 11/08/23 at 02:33 PM, the survey team met for an Exit conference with LNHA, RNC#1 and #2, VPoCS, CIA, and ED. The facility management had no additional information about the concern above. NJAC 8:39- 29.3 (a)(1)	F 756		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		12/1/23

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F 761	Continued From page 28 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review of other facility documentation, it was determined that the facility failed to provide appropriate Pharmaceutical Services and ensure a) a biological was properly labeled with an expiration date, b) removal of a discontinued biological from active inventory for a discharged resident (Resident # 23), c) medications were secured within the medication cart, and d) a narcotic medication for Resident #38 was properly labeled with an expiration date. This deficient practice was observed in two (2) of two (2) refrigerators located in the medication storage room, and one (1) of two (2) medication carts inspected and was evidenced as follows. A review of the manufacturer's specifications for EX Order 26.4B1 under section 2.7 titled, Preparation and Administration of EX Order 26.4B1 In-Use Storage Conditions for EX Order 26.4B1 for	F 761	F761 1. The medications for Resident #23, who was discharged from the facility, were removed from active inventory and returned to the pharmacy provider. Resident #28□s medication, which was EX Order 26.4B1 was destroyed by two nurses and the physician was notified to send a new prescription to the pharmacy. The administrator called and spoke with the pharmacist and informed them of the mislabeling of used by dates on the medications, EX Order 26.4B1 and EX Order 26.4B1 A new EX Order 26.4B1 was then delivered to the facility for resident #38 and was properly labeled with the use by date clearly noted on the medication. The nurse who left the medication locked right after it was inspected by the	

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F 761	Continued From page 29 Injection Once Reconstituted in Acceptable Intravenous Diluents Stability studies have shown that the reconstituted solution is stable in the vial for 12 hours at room temperature and up to 48 hours if stored under refrigeration at 2°C to 8°C (36 to 46°F). The diluted solution is stable in the infusion bag for 12 hours at room temperature and 48 hours if stored under refrigeration. The combined storage time (reconstituted solution in vial and diluted solution in infusion bag) should not exceed 12 hours at room temperature or 48 hours under refrigeration. 1. On 11/01/23 at 11:08 AM, in the presence of Registered Nurse #1 (RN #1) the surveyor inspected the Medication Room refrigerator on the third floor. During the inspection, the surveyor observed an intravenous (IV) medication bag of EX Order 26.4B1 EX Order 26.4B1 with an affixed label for Resident #23 dated 10/16/23 with a use by date of 10/15/24. On the reverse side of the IV medication bag had another affixed label that revealed a prepared date of 10/17/23 at 4:00 PM and a use by date of 10/24/23 at 4:00 PM. The expiration dates on the affixed labels on the front and back of the bag were different. 2. At that time, RN #1 informed the surveyor that Resident #23 was discharged from the facility. RN #1 stated that the medication should not have been intermingled with the active inventory and should have been returned to the pharmacy for disposal.	F 761	surveyor. 2. The DON and the nurse managers audited the residents with reconstituted and/or compounded medications to ensure proper labeling. No other issues were noted. The pharmacy consultant came to the facility and audited the medications of current residents, no issues were reported from the audit. The DON and nurse managers inspected the other medication and treatment carts in the facility and noted that all were locked when the nurse was away from the cart. 3. The DON inserviced the nurses to ensure that the medications received from the pharmacy are properly labeled and that the use by date and the expiration date match. In addition, the DON inserviced nurses to remove any medication and/or treatments of discharged residents from the active inventory and returned to the pharmacy or destroyed by the nurses. The DON educated all nurses to lock the medication and/or treatment carts when the nurse is away from either cart. 4. The DON, or designee, will audit delivered compounded or reconstituted medications to the facility to ensure that they are properly labeled with the date of expiration. The DON will also audit discharge residents to ensure that all medication and/or treatments have been properly removed from active inventory and have been returned to the pharmacy	

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F 761	Continued From page 30 At that time, the RN explained the process for discontinued medications. She stated that the discontinued medications were separated from the active inventory and kept locked in the medication room. All nurses on all shifts were responsible in ensuring discontinued and expired medications were removed from active inventory. She further stated that the discontinued medication should not be administered to another resident and went against the five (5) rights of medication administration. RN#1 stated that she would inform her supervisor and inform the pharmacy to pick up the IV for return. At 11:27 AM, during an interview with the surveyor, the Registered Nurse/Unit Manager (RN/UM) confirmed the discontinued medication for the discharged resident should have been removed from the active inventory. The surveyor reviewed the medical record for Resident #23. The electronic Medication Administration Record (eMAR) for EX Order 26.4B1, included orders for EX Order 26.4B1 started on EX Order 26.4B1, and discontinued on EX Order 26.4B1 A review of the transfer/discharge/expiration for Resident #23 revealed the resident was discharged on EX Order 26.4B1 at EX Order 26.4B1 3. On 11/01/23 at 11:31 AM, the surveyor observed the high side medication cart on the EX Order floor parked in front of the nurses' station, located across the elevators. There were two nurses in the station. The Licensed Practical Nurse	F 761	or destroyed appropriately. The DON, or designee, and pharmacy consultant will conduct 6 unit audits weekly on random shifts to ensure that medication and/or treatment carts are properly locked when not in use or when the nurse is not near the cart. The DON will report the findings in QAPI meetings monthly x3, then quarterly x2. The QAPI committee will determine if it requires to be continued. 5. Completion Date: 12/1/23	

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F 761	Continued From page 31 assigned to the cart was facing the computer located in front of the dining area. At that time, the surveyor greeted the nurses and requested to inspect the high side cart. The surveyor asked the nurse why the medication cart was unlocked, and the Licensed Practical Nurse #1 (LPN#1) assigned to the medication cart stated she did not mean to leave it unlocked. 4. On 11/01/23 at 11:45 AM, the surveyor began the inspection of the refrigerator located in the medication storage room on the [redacted] floor. At that time, in the presence of LPN#1, the surveyor observed a bag that contained a prefilled [redacted] with an affixed labeled for Resident #38, dated [redacted], and a use by date of [redacted]. The prefilled syringe had an affixed label with a date of [redacted] At that time, LPN #2 walked into the medication room. LPN #1 and LPN #2 inspected the syringe and could not explain the different dates on the bag against the [redacted] date on the syringe. At that time, LPN #2 stated she would call the pharmacy and inquire about the discrepancy between the dates. On 11/1/23 at 01:02 PM, during an interview with the surveyor, the Licensed Nursing Home Administrator (LNHA) informed the surveyor that he had contacted the pharmacy. The LNHA stated that he had learned from the provider pharmacy that the inscribed date on the affixed label of the prefilled syringe was the expiration	F 761		

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F 761	Continued From page 32	F 761		

date. The pharmacy provider had omitted the description, "use by date". The EX Order 26.4B1 gel EX Order 26.4B1 had expired.

The surveyor reviewed the Medical Record for Resident #38.

A review of the resident's Physician Order sheet for EX Order 26.4B1, included an order for EX Order 26.4B1, started on EX Order 26.4B1

A review of the Individual Patient's Controlled Drug Record reflected EX Order 26.4B1 of EX Order 26.4B1 were recorded as received on NJ Exec. Order 26:4.b.1 NJ Exec. Order 26:4.b.1 , one of which was administered on .

On 11/03/23 at 11:17 AM, during a meeting with the survey team, the Director of Nursing (DON), the LNHA, the Clinical Implementation Analyst (CIA), the Regional Nurse Consultant (RNC), and the Executive Director (ED), the surveyor discussed the storage and labeling concerns.

On 11/08/23 at 10:49 AM, during a meeting with the survey team, the DON, the LNHA, the CIA, the RNC #1, the RNC #2, the Vice President of Clinical Services, and the ED, the RNC #1 stated that they would follow the expiration date on the affixed label on the EX Order 26.4B1 with the Resident #23's name and not the reverse side. The same label that indicated the expiration was EX Order 26.4B1, almost a year from the EX Order 26.4B1 prescription order date.

At that time, RNC #1 stated that the medication was not expired based on the affixed label with the Resident's name. The expiration date on the

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F 761	Continued From page 33 EX Order 26.4B1 provided by the pharmacy was not consistent with the EX Order 26.4B1 manufacturer's specification for storage and stability. At that time, the DON confirmed the discontinued medication for the discharge resident should not have been with the active inventory since the resident was discharged at the time of the unit inspection. At that time, the RNC #1 stated the dating on the EX Order 26.4B1 prefilled syringe was not an error. At that time, the DON stated the pharmacy had informed the facility that the words "use by" was omitted. The expectation was the use by date would match the affixed label on the bag and the syringe. The provider pharmacy had sent a replenishment of prefilled EX Order 26.4B1 EX Order 26.4B1 for Resident #38. The facility provided documentation that the expired EX Order 26.4B1 was wasted and was not administered to the resident after surveyor inquiry. A review of the facility provided skilled nursing policies and procedures for storage medications revised 5/1/17 included the following: Policy: The facility shall store all drugs and biologicals in a safe, secure and orderly manner. Procedure 3. Drug containers that have missing, incomplete, improper or incorrect labels shall be returned to the pharmacy for proper labeling before storing. 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. 7. Compartments (including, but not limited to,	F 761		

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F 761	Continued From page 34 drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.	F 761		
F 812 SS=F	NJAC 8:39- 29.4(a) (d)(h), 29.7(a) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to store potentially hazardous foods in a manner to prevent food borne illness as evidenced by the following:	F 812	Food Procurement, Store/Prepare/Serve-Sanitary F812 The facility failed to properly date and label food being prepared and stored in	12/1/23

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F 812	Continued From page 35 On 10/30/2023 at 9:59 AM, in the presence of the Food Service Manager (FSM) the surveyor observed the following: 1. In the "tray line freezer, room service" the surveyor observed a pack of vegetable burgers undated and opened, and six (6) trays of pastries prepared by the baker, the FSM was unable to state when the package was received, opened, or expiration date. 2. In the "room service storage, cold prep, [soda brand] refrigerator" the surveyor observed shredded mozzarella cheese that was opened and undated. The FSM was unable to state when the package was received, opened, or expiration date. 3. In the "freezer walk in" the surveyor observed 10 trays with frozen cupcakes and cookies not labeled with a prepared date or a use by date. The FSM was unable to state when the trays were prepared or would expire. On 11/01/23 at 11:20 AM, the FSM provided the surveyor with the Food and Supply Storage Policy #B003, date issued 5/95, revised date 01/23 page 1 and 2 which included: Policies: All food, non -food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for the human consumption. Procedures: -Most, but not all, products contain an expiration date. The words "sell by," "best by," "enjoy-by" or	F 812	accordance with correct food handling practices. All food that was found to be undated was disposed of and not served to any residents. The rest of the food stored was audited to ensure that no other food items were undated. All residents could be affected. Food Service Manager will in-service staff on correct food storage, labeling, and dating and how it applies to when food items are received, opened, prepared, and expiring. Food Service Manager or designee will audit this weekly for four weeks and then monthly. The findings will be reported in the monthly QAPI meetings x 3 months and then quarterly x 2 months. The QAPI committee will dtermine if the QAPI will need to be continued at that time. Completion Date: 12/1/23	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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"use-by" should precede date. Foods past the "use by," "sell by," "best-by" or "enjoy by" date should be discarded.
- Cover, label and date unused portions and open packages. Complete all sections on an orange label or use the [name]/ Fresh date labeling system. Products are good through the close of business on the date noted on the label.
-Refer to the Food Storage Chart in this policy to determine discard dates for food items.
Freezer Storage:
Food prepared in house, and then stored frozen should be kept no longer than three months. Commercially produced foods may be held frozen until the manufacturer's expiration date, or for three months if no expirations date on the package. Once the packaging around the food has been opened, food must be used within three months.

At 11/06/23 at 10:23 AM, the surveyor discussed the kitchen concerns with the facility Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON).

On 11/08/2023 at 12:00 PM, the DON provided a written statement to the survey team which read ...
Concern: Kitchen; labeling of food, unsealed food, undated food.
Response: We do not have any supporting documents to defend this deficient practice. The kitchen is a third-party entity and cannot be part of our facility survey as they are not employed by the facility.

On 11/08/23 at 02:33 PM, the survey team met for an Exit conference with LNHA, Regional

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F 812	Continued From page 37 Nurse Consultant #1 and #2, and Vice President of Clinical. The facility management informed the survey team that there was no additional information.	F 812		
F 842 SS=D	NJAC 8:39-17.2(g) Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care	F 842		12/1/23

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F 842	Continued From page 38 operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:	F 842		

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F 842	Continued From page 39 Based on observation, interview, record review, and review of other pertinent documents, it was determined that the facility failed to maintain complete and readily accessible medical records. This deficient practice was identified for one (1) of two (2) residents reviewed for EX Order 26.4B1 (Resident #17). This deficient practice was evidenced by the following: On 10/30/23 at 11:30 AM, during the tour, Licensed Practical Nurse#1 (LPN#1) informed the surveyor that Resident #17 was EX Order 26.4B1 EX Order 26.4B1 On 10/30/23 at 11:51 AM, the surveyor observed Resident #17 in bed asleep. The surveyor reviewed Resident #17's medical records. The resident's Admission Record (or face sheet; admission summary) reflected that the resident was admitted to the facility and had diagnoses that were not limited to essential EX Order 26.4B1 [redacted]	F 842	F842 1. The DON obtained the printed copies of the medical record from the EX Order 26.4B1 company for resident #17 and place in resident #17 medical chart. 2. The DON audited other residents on hospice service to make sure that the communication forms are in place. The DON designated a hospice section in each resident□s medical record/chart. All hospice notes will be on each respective resident's medical chart. 3. The DON and hospice nurse inserviced staff about the new hospice record designation in each resident□s medical chart. The DON will also educate nurses that upon completion of the hospice nurse visit, the hospice nurse will discuss findings and recommendations from the visit with the nurse and will stay in the facility until all recommendations are carried out or declined by the physician. 4. The DON/designee will audit hospice notes and recommendations weekly x4 weeks, then monthly x3 months, then quarterly x2 with findings reported the QAPI committee, which will determine if it needed to be extended/ continued. 5. Completion Date: 12/1/23	

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F 842	Continued From page 40 unspecified [redacted], and [redacted] A review of the resident's significant change Minimum Data Set (scMDS), an assessment tool used to facilitate the management of care with an assessment reference date (ARD) of [redacted] Section C Cognitive Patterns revealed a cognitive skills for daily decision making was coded as [redacted] which reflected that the resident's [redacted]. The scMDS also showed that the resident was in [redacted] The personalized care plan revealed that the resident was admitted to [redacted] services on [redacted] On 11/02/23 at 11:29 AM, the surveyor interviewed LPN#1 in the presence of LPN#2. LPN#1 informed the surveyor that the [redacted] aide comes to the facility every Monday, Wednesday, and Friday. LPN#1 stated that the [redacted] nurse comes in at least once a week. On that same date and time, LPN#1 showed the binder for [redacted] Both nurses and the surveyor observed that the last [redacted] notes were dated [redacted] and there were no further notes after that. LPN#2 double-checked the physical chart and stated that she did not see other [redacted] notes. LPN#2 further stated that she knew that the [redacted] nurse comes once a week and writes notes on the paper [which will be left as a facility copy in the physical chart of the resident] and also on the [redacted] nurse's tablet (is a fully	F 842		

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functional personal computer geared for pen-enabled, handwriting-enabled, and speech-enabled applications). Then LPN#2 informed the surveyor that the hospice nurse was currently in the building and would have the hospice nurse talk to the surveyor about her notes.

At this time, the surveyor asked LPN#2 if she had access to the hospice nurse's notes on the hospice nurse's tablet, and LPN#2 responded "No." The surveyor then asked LPN#1 and LPN#2 if the hospice nurse's visit notes considered the resident's part of medical records and should be available and accessible to the facility, LPN#2 stated "I can't answer that."

Further review of the hospice binder revealed there were no hospice nurse visit notes after 9/13/23 through 11/02/23.

On 11/02/23 at 11:36 AM, the surveyor interviewed the Hospice Registered Nurse (HRN) in the 4th floor nursing station. The HRN informed the surveyor that she was the assigned nurse for the resident and visits once a week and that she had other residents in the facility other than the resident. The HRN stated that she documents on her tablet and in the paper carbonized (duplicate paper) visit notes [the one left in the facility]. The HRN further stated that the paper visit notes that were left at the facility were the facility requirement and the one she documented in her tablet was the hospice requirement that she had to comply with.

At that same time, the surveyor notified the HRN of the above findings and concerns regarding the

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F 842	Continued From page 42	F 842		

missing hospice visit notes in the hospice binder. The HRN stated that she did not know why her remaining September and October notes were not in the chart because she did leave them with the facility nurse.

On 11/03/23 at 11:17 AM, the survey team met with the Licensed Nursing Home (LNHA), Director of Nursing (DON), Regional Nurse Consultant #1 (RNC#1), Clinical Implementation Analyst (CIA), and Executive Director (ED). The surveyor notified the facility management of the above findings and concerns regarding the missing hospice visit notes.

On 11/08/23 at 9:46 AM, the surveyor reviewed the medical records [chart] of the resident and observed the missing EX Order 26.4B1 visit notes that were printed on NJ Exec. Order 26:4.b.1 [redacted]

On 11/08/23 at 9:51 AM, the surveyor interviewed the DON in the 4th-floor nursing station regarding the resident's EX Order 26.4B1 notes. The DON informed the surveyor that all residents in the EX Order 26.4B1 were audited after the surveyor's inquiry about Resident # 17's missing EX Order 26.4B1 visit notes from the EX Order 26.4B1 nurse. The DON stated that there were missing EX Order 26.4B1 visit notes and found out that there were a few EX Order 26.4B1 residents who did not have or had missing EX Order 26.4B1 notes. She further stated that it was Resident #17 who had the most missing EX Order 26.4B1 visit notes.

On that same date and time, the DON informed the surveyor that the HRN provided a copy of the missing notes after the surveyor's inquiry. The

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F 842	Continued From page 43 DON stated that either she or the HRN did not know where the hospice notes that were left at the facility were and it was not found [facility copies]. The DON acknowledged that the hospice notes should have been in the medical records of the resident. On 11/08/23 at 10:49 AM, the survey team met with the LNHA, DON, RNC#1 and RNC#2, CIA, Vice President of Clinical Services (VPoCS), and ED (came in after at 11:15 AM). The DON informed the surveyor that the facility acknowledged the findings of the surveyor about missing hospice notes in the medical records of the resident. A review of the facility provided Hospice Coordination of Care Policy with a revised date of 10/30/23 included that the facility and hospice will identify the specific services that will be provided by each entity, and this information will be communicated in the plan of care. The hospice and facility will communicate with each other when any changes are indicated or made to the plan of care. On 11/08/23 at 02:33 PM, the survey team met for an Exit conference with LNHA, RNC#1 and #2, VPoCS, CIA, and ED. The facility management had no additional information about the concern above.	F 842		
F 882 SS=E	NJAC 8:39-35.2 (d)(5) Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more	F 882		12/1/23

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F 882	Continued From page 44 individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on the interview and review of pertinent documentation, it was determined that the facility failed to ensure that the a) employed designated Infection Preventionist (IP) had at least part time position for one (1) of three (3) IP and b) had completed specialized training in infection prevention and control per Centers for Medicare & Medicaid Services (CMS) guidance prior to assuming the IP role for three (3) of three (3) employees reviewed for IP. This deficient practice was evidenced by the following: A review of CMS QSO-19-10-NH, dated 3/11/19, included but was not limited to Background: "Effective November 28, 2019, the final requirement includes specialized training in infection prevention and control for the individual(s) responsible for the facility's IPCP	F 882	F882 1. On 11/8/23, the current Unit Manager in the facility assumed the part-time role as IP in the facility. 2. The current IP and DON reviewed the antibiotic stewardship and infection rates in the facility to ensure that proper procedures are being followed. No deficient practice(s) were identified. 3. To ensure that the deficient practice does not recur, the policy and procedure and job description will be updated to include the requirements of an IP based on the IPs education, experience, training, and position according to CMS, NJDOH, and CDC guidelines.	

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F 882	Continued From page 45 (infection prevention and control program)." Specialized Training for Infection Prevention and Control: In order to receive ... a certificate of completion, learners must complete all modules and pass a post-course exam ... The "Nursing Home Infection Preventionist Training Course" is available on CDC's (Centers for Disease Control and Prevention) TRAIN website ...Completion of this course will provide specialized training in infection prevention and control. According to the CMS QSO-22-19-NH Memo dated 6/29/22 and Fact Sheet, Updated Guidance for Nursing Home Resident Health and Safety dated 6/29/22, effective date on October 24, 2022 Overview of New and Updated Guidance, Summary of Significant Changes, included that in Infection Control, requires the facilities to have a part-time IP. While the requirement is to have at least a part-time IP, the IP must meet the needs of the facility. The IP must physically work onsite and cannot be an off-site consultant or work at a separate location. IP's role is critical to mitigating infectious diseases through an effective infection prevention and control program. IP specialized training is required and available. On 10/30/23 at 9:08 AM, the survey team entered the facility and was welcomed by the Assistant Administrator (AA). The AA informed the survey team that there was a NJ Exec. Order 26:4.b.1 nurse last Friday ([redacted]), all residents were tested and they were negative. On 10/30/23 at 10:04 AM, the two surveyors met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) during	F 882	4. The DON and Administrator will ensure that the facility follows the revised policy and procedure and job description for any further change in IP. 5. Completion Date: 12/1/23	

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F 882	Continued From page 46	F 882		

an entrance conference. Both the LNHA and the DON informed the surveyors that the facility had a designated part-time IP (IP#1) and completed the required training and certificate of an IP. The surveyor asked the LNHA and the DON to provide a copy of the IP's resume, signed job description, and copy of the required training certificate.

A review of the designated IP#1 CDC Nursing Home Infection Preventionist Training Course (web-based) required training for IP revealed that it was completed on 6/27/23.

A review of the Job Description Acknowledgment for the position of an IP showed that IP#1 did not sign and it was not dated.

A review of IP#1's employee file revealed that he was hired on [redacted] as per diem IP.

On 11/02/23 at 9:46 AM, the surveyor interviewed the DON in the presence of the survey team about the requirement for an IP, and the DON stated that she would get back to the surveyor.

On 11/02/23 at 11:50 AM, the surveyor interviewed IP#1 in the presence of another surveyor regarding his job title and qualifications as an IP. IP#1 informed the surveyor that he started in the facility as a part-time IP first week of [redacted]. He further stated that his background was a graduate of Public Health.

On 11/03/23 at 11:17 AM, the survey team met with the LNHA, DON, Regional Nurse Consultant #1 (RNC#1), Clinical Implementation Analyst (CIA), and Executive Director (ED). The surveyor

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F 882	Continued From page 47 notified the facility management of the above findings and concern with regard to an IP requirement and that IP#1 was hired as per diem IP on [redacted] (according to the payroll authorization form) and assumed the position of an IP prior to completion of the CDC certificate as a requirement for an IP. On 11/03/23 at 01:01 PM, the DON in the presence of the survey team stated that IP#1 was a covering per diem IP because the full-time IP was on leave. The DON further stated that as a DON she also can cover as an IP and the Unit Manager (UM). Then the surveyor asked the DON if she knew that the UM could be the IP while covering for the designated IP#2 who was on leave, and why the facility management did not use the UM as an IP in order to comply with the IP requirement. At that same time, the DON stated that they [facility management] did not know before that it was a requirement to have a 5-year experience to be able to be an IP not until the surveyor's inquiry. The DON further stated that that was why "usually" the IPs are the nurses because they have the experience. The surveyor asked for a timeline of the facility's designated IP since the last recertification from [redacted] through [redacted], including their resume, signed job description, and copy of education training and certificate. The DON stated that she would get back to the surveyor. On 11/06/23 at 9:28 AM, the LNHA provided a copy of the Infection Preventionist timeline as follows: IP#1=from [redacted] through the present (hired as	F 882		

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F 882	Continued From page 48 PRN [as needed] to cover IP#2 while out on leave) [this was not previously provided to the surveyor and did not notify the surveyors during the entrance conference that IP#1 was a per diem IP covering for IP#2 not until surveyor's inquiry] IP#2=from [redacted] through present IP#3=from [redacted] through [redacted] On 11/08/23 at 10:14 AM, the LNHA provided a copy of IP#2's employee files and revealed that IP#2 was hired on [redacted] as a full-time IP of the facility. On 11/08/23 at 10:40 AM, IP#1 provided a copy of IP#2's CDC Nursing Home Infection Preventionist Training Course (web-based) for a total of 19.75 contact hours that was completed on [redacted] Further review of the above findings showed that IP#2 assumed the position of a full-time IP on [redacted] prior to obtaining a completed training course for an IP on [redacted] On 11/08/23 at 10:49 AM, the survey team met with the LNHA, DON, RNC#1 and RNC#2, CIA, Vice President of Clinical Services (VPoCS), and ED (joined the meeting at 11:15 AM). The VPoCS acknowledged that the CDC certification was part of the requirement of an IP. The surveyor notified the facility management of the above findings that IP#1 and IP#2 both assumed the position as an IP before completing the CDC web-based education and prior to obtaining the certificate. On that same date and time, the surveyor followed up on IP#3's resume, signed job	F 882		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD DENVILLE, NJ 07834**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 882	Continued From page 49 description, and certificate. On 11/08/23 at 12:59 PM, the DON in the presence of the survey team stated that IP#4 will be the IP as of today until we [facility] figure out with IP#1. The DON provided also a copy of IP#3's signed Job Description Acknowledgment for Infection Preventionist Coordinator dated [redacted]. On 11/08/23 at 01:50 PM, the DON provided a copy of IP#3's CDC Nursing Home Infection Preventionist Training Course (web-based) that showed that IP#3 completed the 19.3 contact hours on [redacted]. On 11/08/23 at 01:53 PM, the survey team met with the LNHA, VPoCS, CIA, DON, ED, and RNC#1 and #2. The surveyor notified the facility management of the concern regarding IP#3 assumed the position of an IP as shown in the signed Job Description acknowledgment on [redacted] prior to completing the CDC Nursing Home Infection Preventionist Training Course (web-based) on [redacted]. On that same date and time, the facility management confirmed that IP#3 assumed the position of an IP before completing the requirement of training in CDC after the surveyor showed to the facility management the provided documents of the DON. A review of the facility provided Infection Preventionist Policy that was provided by the DON with a revised date of 11/28/17 did not include the requirements of an IP based upon the IP's education, experience, training, and position	F 882		

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F 882	Continued From page 50 according to the CMS, NJDOH, and CDC guidelines. On 11/08/23 at 02:33 PM, the survey team met for an Exit Conference with LNHA, DON, VPoCS, CIA, ED, and RNC#1 and #2. The facility management had no additional information provided and did not refute the findings. NJAC 8:39-19.1(b)	F 882		
F 944 SS=E	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure facility staff had mandatory training that outlined and informed staff of the elements and goals of the facility's QAPI (quality assurance and performance improvement) program for five (5) of five (5) Certified Nurse Assistants (CNAs) reviewed for mandatory education. This deficient practice was evidenced by the following: The surveyor reviewed the annual in-service education hours for five randomly selected CNA files, which were provided by the facility. The "Training Hours" Transcripts showed the	F 944	F994 1. C.N.A. #1 is no longer employed at the facility. C.N.A.□s #2, 3, 4, and 5 were educated on QAPI. 2. On 11/9/23, QAPI education was initiated for all staff, and remains ongoing. 3. The list of in-service topics to be done annually was amended to include QAPI for all staff. 4. The Human Resource director, or designee, will audit staff education lists to make sure that staff are educated in QAPI. The HR director will report the	12/1/23

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F 944	Continued From page 51 following: CNA #1 had a hire date of [NJ Exec. Order 26:4.b]. The facility could not provide a "Training Hours" Transcripts. CNA #1 did not have QAPI training. CNA #2 had a hire date of [NJ Exec. Order 26:4.b]. According to the "Training Hours" Transcripts, CNA #2 did not have QAPI training. CNA #3 had a hire date of [NJ Exec. Order 26:4.b.1]. According to the "Training Hours" Transcripts, CNA #3 did not have QAPI training. CNA #4 had a hire date of [NJ Exec. Order 26:4.b.]. According to the "Training Hours" Transcripts, CNA #4 did not have QAPI training. CNA #5 had a hire date of [NJ Exec. Order 26:4.b.1]. According to the "Training Hours" Transcripts, CNA #5 did not have QAPI training. On 11/02/23 at 01:54 PM, during surveyor interview, the Licensed Nursing Home Administrator (LNHA) stated that CNA #1's last day of work at the facility was in [NJ Exec. Order 26:4.b.1] and that he did not come back yet because he was asked not to return to work until he finished his mandatory education. The LNHA further stated that CNA #2 was on a medical leave since [NJ Exec. Order 26:4.b.1]. On 11/03/23 at 9:57 AM, the surveyor interviewed the Director of Nursing (DON) regarding education. The DON stated that the facility did not have an educator right now that oversaw the process and that the facility was working on a better process for education. She stated that it was a collaborative process right now and that the Director of Human Resources was overseeing the computer system that contained education and the Infection Preventionist was overseeing nonclinical education. She added that	F 944	findings to the QAPI committee. The DON/designee will report the findings in QAPI meetings monthly x3, then quarterly x2. The QAPI committee will determine if it requires to be continued. 5. Cpmpletion Date: 12/1/23.	

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F 944	Continued From page 52 she was also working on some of the education. On 11/03/23 at 12:49 PM, in the presence of the survey team, the surveyor notified the LNHA, DON, Regional Nurse Consultant #1 (RNC #1), Clinical Implementation Analyst (CIA) and Executive Director (ED) the concern that the five CNAs did not have education on QAPI. On 11/08/23 at 11:07 AM, in the presence of the survey team, LNHA, CIA, RNC #1, RNC #2, ED and Vice President of Health Services (VPoHS), the DON stated that the QAPI education was not completed for the five CNAs. She added that the poster fair that was done did not contain the topic of QAPI. A review of the facility provided policy titled, "In Service Training," with a revised date of 6/20/23, included the following: Policy: It is the policy of this community to conduct in-service training programs for all personnel on a regularly scheduled basis. Procedure: 1. In-service training programs are planned and conducted for the development and improvement of skills of all personnel. It may include, but is not limited to: ... o. Others that become necessary or appropriate. The list did not include QAPI. A review of the facility provided policy titled, "Quality Assessment Performance Improvement Program," with a revised date of 8/23/17, included the following: Procedure: ... 20. Education and training will be provided to the QAPI Committee members on the quality process, QAPI improvement principles, data	F 944		

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F 944	Continued From page 53 collection and root cause analysis. QAPI Team members will receive training on group facilitation to support and assist in the QAPI and PIP (performance improvement projects) process. The policy did not include all facility staff. N.J.A.C. 8:39-33.1	F 944		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation, it was determined that the facility failed to ensure that Certified Nursing Assistants (CNAs) received 12 hours of mandatory annual in-service training/education that included specific topics for one (1) of five (5)	F 947	F947 1. The C.N.A.#1 is no longer employed in the facility. 2. The DON and Human Resources	12/12/23

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F 947	Continued From page 54 CNA files reviewed (CNA #1). The deficient practice was evidenced by the following: The surveyor reviewed the in-service education hours for five randomly selected CNA files, which were provided by the facility which included the following: The facility provided "Training Hours" transcripts (record of inservices that were done through a computer education program) for four (4) of the five (5) requested CNAs. The facility could not provide any documented evidence that CNA #1, with a date of hire of [NJ Exec. Order 26:4.b.] received any in-service training from [NJ Exec. Order 26:4.b.] to [NJ Exec. Order 26:4.b.] On 11/02/23 at 01:54 PM, during surveyor interview, the Licensed Nursing Home Administrator (LNHA) stated that CNA #1's last day of work at the facility was in [NJ Exec. Order 26:4.b.1] and that he did not come back yet because he was asked not to return to work until he finished his mandatory education. On 11/03/23 at 9:57 AM, the surveyor interviewed the Director of Nursing (DON) regarding education. The DON stated that the facility did not have an educator right now that oversaw the process and that the facility was working on a better process for education. She stated that it was a collaborative process right now and that the Director of Human Resources was overseeing the computer system that contained education and the Infection Preventionist was overseeing nonclinical education. She added that she was also working on some of the education.	F 947	Director will audit all C.N.A.□s education hours to ensure that they have completed the 12 hours education hours by their anniversary hire date. 3. The policy on in-service education for staff has been amended to include mandatory annual education for all staff and C.N.A.□s that will include QAPI. The DON will in-service the staff regarding the amendment of the policy, completing the education material as schedule and attending mandatory in-service training to ensure that the deficient does not recur. 4. The HR director will utilize Relias in order to track the education hours of all C.N.A.□s employed by the facility based on their date of hire. The reports will be generated monthly and the HR Director/Designee will report the findings in QAPI meetings monthly x3, then quarterly x2. The QAPI committee will determine if it requires to be continued. 5. Completion Date: 12/12/23	

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F 947	Continued From page 55 On 11/03/23 at 11:32 PM, in the presence of the survey team, the surveyor notified the LNHA, DON, Regional Nurse Consultant #1 (RNC #1), Clinical Implementation Analyst (CIA) and Executive Director (ED) the concern that CNA #1 did not have the annual mandatory 12 hours of inservice/education. On 11/08/23 at 10:59 AM, in the presence of the survey team, LNHA, CIA, RNC #1, RNC #2, ED and Vice President of Health Services (VPoHS), the DON stated that CNA #1 did not have any education for the time frame requested and that CNA #1 worked per diem (as needed) for the facility and worked less than 180 hours. She added that he was not allowed to work until his education was completed. On that same date and time, the surveyor asked what the expectation was for when the education was to be done. The RNC #1 stated that the education could be by the end of year. He added that the expectation was as long as the education was complete before the compliance date. The RNC #1 stated that ideally the education would be staggered [throughout the year] but that per diem staff may not be able to come in for the education. The surveyor then asked the facility to provide CNA #1's "Training Hours" transcripts for the previous year, the timeframe of [redacted] to [redacted]. On 11/08/23 at 01:18 PM, in the presence of the survey team, LNHA and RNC #2, the DON stated that she could not locate any in-service training/education for the timeframe of [redacted] to [redacted] for CNA #1.	F 947		

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F 947	Continued From page 56 On 11/08/23 at 01:53 PM, in the presence of the survey team, the facility administration team confirmed that they could not provide any documented evidence that CNA #1 had any in-service training for either timeframe of [NJ Exec. Order 26:4.b] to [NJ Exec. Order 26:4.b] or [NJ Exec. Order 26:4.b] to [NJ Exec. Order 26:4.b]. On 11/08/23 at 02:20 PM, in the presence of the survey team, the DON stated that she had found in a file a test that CNA #1 had completed which was dated [NJ Exec. Order 26:4.b.i] which was for a poster education fair. The surveyor asked the DON to provide the employee sign in sheet that would correspond to the inservice/education which would include the length of time the education took. There was no documented evidence of how long the poster education fair or the poster sign test would have taken. On 11/08/23 02:33 PM, in presence of survey team, LNHA, CIA, RNC #1, RNC #2, ED and Vice President of Health Services (VPoHS), the DON confirmed that the facility could not provide documented evidence of how many hours the poster fair and test took to complete. The facility could not provide documented evidence that CNA #1 had the annual mandatory 12 hour inservice/education from [NJ Exec. Order 26:4.b] to [NJ Exec. Order 26:4.b.i] or from [NJ Exec. Order 26:4.b] to [NJ Exec. Order 26:4.b]. A review of the facility provided policy titled, "In Service Training," with a revised date of 6/20/23, included the following: Policy: It is the policy of this community to conduct in-service training programs for all personnel on a regularly scheduled basis. Procedure: 1. In-service training programs are	F 947		

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F 947	Continued From page 57 planned and conducted for the development and improvement of skills of all personnel. It may include, but is not limited to: ... The policy did not address mandatory annual education for CNAs. N.J.A.C. 8:39-43.17 (b)	F 947		

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	061424	A. BUILDING: _____ B. WING _____	C 11/08/2023

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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 the interviews, and record review, it was determined that the facility failed to ensure that a) the facility complied with applicable state rules and regulations by ensuring that the facility designated Infection Preventionist (IP) met the requirement to hire a part-time employee in the infection control prevention role for one (1) of three (3) IP and b) the IP was qualified by at least five years of experience for two (2) of three (3) designated IP reviewed. The deficient practice was evidenced by the following: According to the N.J. Stat. § 26:2H-12.87, current through L. 2023, c. 103; amended by L. 2021, c.	S 560	S560 1. On 11/8/23, the current Unit Manager in the facility assumed the part-time role as IP in the facility. 2. The current IP and DON reviewed the antibiotic stewardship and infection rates in the facility to ensure that proper procedures are being followed. No deficient practice(s) were identified. 3. To ensure that the deficient practice does not recur, the policy and procedure and job description was updated to	12/1/23

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

Electronically Signed | 12/01/23

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S 560	Continued From page 1 190, s.1, effective 8/05/21, included that (b) an individual designated as the infection preventionist who; (i) has primary professional training in medicine, nursing, medical technology, microbiology, epidemiology, or a related field; (ii) is qualified by education, training, and at least five years of infection control experience, or by certification in infection control by the Certification Board of Infection Control and Epidemiology; (iii) is employed by the facility consistent with the requirements of subsection f. of this section; and (iv) has completed specialized training in infection prevention and control ..... (1) An infection preventionist assigned to a long-term care facility's infection prevention and control committee pursuant to subsection e. of this section shall be a managerial employee and shall be employed: (a) in the case of a long-term care facility with a licensed bed capacity equal to 100 or fewer beds, on at least a part time basis;.. On 10/30/23 at 10:04 AM, the two surveyors met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) during an entrance conference. Both the LNHA and the DON informed the surveyors that the facility had a designated part-time IP (IP#1) and completed the required training and certificate of an IP. The surveyor asked the LNHA and the DON to provide a copy of the IP's resume, signed job description, and copy of the required training certificate. IP#1's employee file revealed that he was hired on [redacted] as per diem IP.	S 560	include the requirements of an IP based on the IPs education, experience, training, and position according to CMS, NJDOH, and CDC guidelines. 4. The DON and Administrator will ensure that the facility follows the revised policy and procedure and job description for any further change in IP. 5. Completion Date: 12/1/23	

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S 560	Continued From page 2 A review of the IP#1 employee file showed that his resume reflected the following: Work Experience: NJ Exec. Order 26:4.b.1 [redacted] [total of six months of experience] which included evaluating and monitoring cases, providing education and isolation/quarantine parameters based on CDC (Centers for Disease Control and Prevention) NJ Exec. Order 26:4.b.1 [redacted] [total of 10 months of experience] which included interviewing positive cases for COVID-19 eliciting names and contact information and providing guidance and resources to support positive cases. NJ Exec. Order 26:4.b.1 [redacted] [total of four months] which included aiding the health officer with the recodification of all ordinances; worked collaboratively with the health officer, public health nurse, and communicable disease investigator on various tasks including the outbreak of measles in the NJ Exec. Order 26:4.b.1 [redacted] of [redacted] Further review of the above IP#1 employee files revealed that IP#1 did not have at least five years of infection control experience, or by certification in infection control by the Certification Board of Infection Control and Epidemiology. On 11/02/23 at 9:46 AM, the surveyor interviewed the DON in the presence of the survey team about the requirement for an IP, and the DON stated that she would get back to the surveyor. On 11/02/23 at 11:50 AM, the surveyor interviewed IP#1 in the presence of another surveyor regarding his job title and qualifications as an IP. IP#1 informed the surveyor that he started in the facility as a part-time IP first week	S 560		

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S 560	Continued From page 3 of [NJ Exec. Order 26:4.b.1]. He further stated that his background was a graduate of Public Health. On 11/03/23 at 11:17 AM, the survey team met with the LNHA, DON, Regional Nurse Consultant #1 (RNC#1), Clinical Implementation Analyst (CIA), and Executive Director (ED). The surveyor notified the facility management of the above findings and concern with regard to an IP requirement and that IP#1 was hired as per diem IP on [EX Order 26.4B1] (according to the payroll authorization form). On 11/03/23 at 01:01 PM, the DON in the presence of the survey team stated that IP#1 was a covering per diem IP because the full-time IP was on leave. The DON further stated that as a DON she also can cover as an IP and the Unit Manager (UM). Then the surveyor asked the DON if she knew that the UM could be the IP while covering for the designated IP#2 who was on leave, and why the facility management did not use the UM as an IP in order to comply with the IP requirement. At that same time, the DON stated that they [facility management] did not know before that it was a requirement to have a five year experience to be able to be an IP not until the surveyor's inquiry. The DON further stated that was why "usually" the IPs are the nurses because they have the experience. The surveyor asked for a timeline of the facility's designated IP since the last recertification from [NJ Exec. Order 26:4.b.1] through [NJ Exec. Order 26:4.b.1], including their resume, signed job description, and copy of education training and certificate. The DON stated that she would get back to the surveyor.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061424	A. BUILDING: _____ B. WING _____	C 11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	21 POCONO ROAD DENVILLE, NJ 07834

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S 560	Continued From page 4 On 11/06/23 at 9:28 AM, the LNHA provided a copy of the Infection Preventionist timeline as follows: IP#1=from [redacted] through the present (hired as PRN [as needed] to cover IP#2 while out on leave) [this was not previously provided to the surveyor and did not notify the surveyors during the entrance conference that IP#1 was a per diem IP covering for IP#2 not until surveyor's inquiry] IP#2=from [redacted] through present IP#3=from [redacted] through [redacted] On 11/08/23 at 10:14 AM, the LNHA provided a copy of IP#2's employee files and revealed that IP#2 was hired on [redacted] as a full-time IP of the facility. A review of the IP#2 employee file showed that her resume reflected the following: Work Experience: NJ Exec. Order 26:4.b.1 [total of 11 months] NJ Exec. Order 26:4.b.1 total of six months] NJ Exec. Order 26:4.b.1 [total of 11 months] IP#2 graduated in NJ Exec. Order 26:4.b.1 with the title of Master of Public Health and Epidemiology. IP#2 graduated in [redacted] with a Bachelor of Science, in Biological Sciences. Further review of the above IP#2 employee files revealed that IP#2 did not have at least five years of infection control experience, or by certification in infection control by the Certification Board of Infection Control and Epidemiology.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061424	A. BUILDING: _____ B. WING _____	C 11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	21 POCONO ROAD DENVILLE, NJ 07834

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S 560	Continued From page 5 On 11/08/23 at 10:49 AM, the survey team met with the LNHA, DON, RNC#1 and RNC#2, CIA, Vice President of Clinical Services (VPoCS), and ED (joined the meeting at 11:15 AM). The surveyor notified the facility management of the above findings about IP#1 and IP#2. On 11/08/23 at 12:59 PM, the DON in the presence of the survey team stated that IP#3 will be the IP as of today "until we [facility] figure out with IP#1." A review of the facility provided Infection Preventionist Policy that was provided by the DON with a revised date of 11/28/17 did not include the requirements of an IP based upon the IP's education, experience, training, and position according to the CMS, NJDOH (New Jersey Department of Health), and CDC guidelines. On 11/08/23 at 02:33 PM, the survey team met for an Exit Conference with LNHA, DON, VPoSCP, CIA, ED, and RNC#1 and #2. The facility management had no additional information provided and did not refute the findings.	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
315329 Y1	A. Building B. Wing Y2	1/2/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	21 POCONO ROAD DENVILLE, NJ 07834

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 F0658	Correction	ID Prefix F0689	Correction	ID Prefix F0700	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(n)(1)-(4)	Completed
LSC	12/08/2023	LSC	12/01/2023	LSC	12/01/2023
ID Prefix F0756	Correction	ID Prefix F0761	Correction	ID Prefix F0812	Correction
Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	12/01/2023	LSC	12/01/2023	LSC	12/01/2023
ID Prefix F0842	Correction	ID Prefix F0882	Correction	ID Prefix F0944	Correction
Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed	Reg. # 483.80(b)(1)-(4)	Completed	Reg. # 483.95(d)	Completed
LSC	12/01/2023	LSC	12/01/2023	LSC	12/01/2023
ID Prefix F0947	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.95(g)(1)-(4)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/12/2023	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?
11/8/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 061424 (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT 1/2/2024 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	21 POCONO ROAD DENVILLE, NJ 07834

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 12/01/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
11/8/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: C9B312

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING **01** B. WING _____	**11/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD** **DENVILLE, NJ 07834**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 10/30/2023. The facility was found to be in compliance with 42 CFR 483.73	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/30/23 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 Occupancy. The Oaks at Denville is a Four-story building that was built in 1993. It is composed of Type II protected construction. The facility is divided into eight - smoke zones. The generator does approximately 80 % of the building per Maintenance Director. The current occupied beds are 52 of 84.	K 000		
K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5	K 161		12/31/23

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

Electronically Signed | 12/01/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING **01** B. WING _____	**11/08/2023**

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K 161	Continued From page 1 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure fireproofing was applied to the steel beams in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.1.6.1.	K 161	Building Construction Type and Height K161 The facility failed to maintain the	

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K 161	Continued From page 2 This deficient practice had the potential to affect all 52 residents who resided at the facility. Findings include: An observation on 10/30/23 at 12:43 PM revealed the fireproofing was removed from three steel beams approximately 24" x 8" in the electrical room when electrical conduit was installed. An observation on 10/30/23 at 12:54 PM revealed the fireproofing was missing from one steel beam approximately 36" x 8" in stairway 2 on the third floor near room 321. The Maintenance Director and Administrator were present at the time of the observations and confirmed the fireproofing was missing from the steel beams in the electrical room and in stairway 2. NJAC 8:39-31.1(c), 31.2(e)	K 161	fireproofing applied to the steel beams in accordance with NFPA 101 Life Safety Code Section 19.1.6.1. The facility had a vendor repair and reapply fireproofing to the steel beams found in the electrical room and the steel beams in stairway 2 on the third floor near room 321. The maintenance team has auditted different parts building in order to find any other steel beams that may have lost fire proofing. The vendor repaired and reapplied fireproofing as necessary. All residents, staff, and visitors could be affected. Administrator and Maintenance Director will received in-service training from vendor on life expectancy of the fireproofing of steel beams. Random spot checks will be conducted throughout the facility looking for other steel beams that have lost fireproofing. This will be conducted once a month for 3 months. Findings will be reported to QAPI monthly for review. Completion Date 12/31/23.	
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by:	K 291		12/1/23

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K 291	Continued From page 3 Based on observation and interview, the facility failed to ensure emergency lighting was provided at the emergency generator transfer switch in accordance with NFPA 110, Standard for Emergency and Standby Power Systems (2010 Edition) Section 7.3. This deficient practice had the potential to affect all 52 residents who resided at the facility. Findings include: An observation on 10/30/23 at 12:40 PM revealed emergency lighting was not present at the emergency generator transfer switch located in the electrical room. The Maintenance Director and Administrator were present at the time of the observation and confirmed the emergency lighting was not present. NJAC 8:39-31.2(e) NFPA 110	K 291	Emergency Lighting K291 The facility failed to ensure emergency lighting was provided at the emergency generator transfer switch in accordance with NFPA 110. The emergency light for the emergency generator transfer switch has been installed to ensure lighting for the needed area. All staff, residents, and visitors can be affected. The emergency light is battery operated in order to be independent from other electrical systems. The battery for the emergency lighting will be changed annually by the maintenance department or designee. This will be monitored by testing the light quarterly to ensure the battery has the lifespan of one year. Should the light's battery still function after one year, it will be replaced regardless to ensure its functionality. Results will be reported to the Administrator and reported to Qapi for one year. This will be completed by 12/1/23.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance	K 353		12/12/23

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K 353	Continued From page 4 with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure sprinkler gauges were calibrated or replaced every five years in accordance with NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems (2011 edition) sections 26.1. This deficient practice had the potential to affect all 52 residents who resided at the facility. Findings include: An observation on 10/30/23 at 1:18 PM revealed the sprinkler gauge above the ceiling in the telephone room on the first floor across from the elevator was not calibrated or replaced. There was no tag or sticker which indicated when the last time the sprinkler gauge was calibrated. The Maintenance Director and Administrator were present at the time of the observation and	K 353	Sprinkler System Maintenance and Testing K353 The facility failed to ensure that all sprinkler gauges were calibrated or replaced every five years in accordance with NFPA 25. The sprinkler gauge above the ceiling in the telephone room on the first floor across from the elevator that was observed by the inspector will be replaced. It will be tagged and logged accordingly. The facility will audit all sprinkler gauges in the building to ensure all gauges are either properly calibrated or have been replaced within five years. All residents, staff and visitors can be affected.	

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K 353	Continued From page 5 confirmed that the sprinkler gauge was not calibrated or replaced. Neither the Maintenance Director nor the Administrator could identify when the last time the sprinkler gauge above the ceiling was last calibrated. NJAC 8:39-31.2(e) NFPA 13, 25	K 353	The Maintenance Director will audit and update the list of all sprinkler gauges in the building to ensure no gauges are missed by the vendor who inspects all the gauges. This will be reviewed by the Administrator after each inspection. This will be discussed in the next QAPI for further discussion and possible recommendations. Completion Date 12/12/23.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, the facility failed to ensure the fire and smoke dampers were inspected and tested every four years in accordance with NFPA 80 Standard for Fire Doors and Other Opening Protectives (2010 edition) 19.4.1.1 and NFPA 105 Standard for Smoke Door Assemblies and Other Protective	K 372	Subdivision of Building Spaces – Smoke Barriers K372 The facility did not complete smoke dampener inspections every 4 years as is required by NFPA 80. Since the last inspection was completed	12/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 372	Continued From page 6 Openings (2010 edition) 8.5.5. This deficient practice had the potential to affect all 52 residents who resided at the facility. Findings include: A review of the facility's "Fire and Smoke Damper" binder provided by the Maintenance Director revealed the fire and smoke dampers were inspected and tested every five years and not the required four years. The reports showed the fire and Smoke dampers were inspected and tested in 2015 and 2021 and should have been inspected and tested in 2015, 2019, and 2023. During an interview on 10/30/23 at 3:40 PM, the Maintenance Director and the Administrator confirmed the fire and smoke dampers were not inspected and tested in accordance with NFPA 80 and 105. NJAC 8:39-31.2(e) NFPA 80, 105	K 372	in 2021, the next smoke damper inspection will be scheduled in 2025. All residents, staff and visitors can be affected. The log for smoke damper inspections will note that inspections will be conducted every 4 years as a reminder to the Administrator and Maintenance Director. Inservice education has been provided for the Maintenance Director and Administrator so they are aware that smoke dampeners must be inspected every 4 years and not every 5 years. The Maintenance Director will submit the log to the Administrator each time the four-year inspection occurs; ensuring the inspection is properly documented. This will be reviewed in the next QAPI for further discussion and possible recommendations. This will be completed by 12/1/23.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of	K 712		12/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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OAKS AT DENVILLE, THE	**21 POCONO ROAD** **DENVILLE, NJ 07834**

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K 712	Continued From page 7 audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure fire drills were conducted quarterly in accordance with NFPA 101 Life Safety Code (2012 Edition) section 19.7.1.6. This deficient practice had the potential to affect all 52 residents who resided at the facility. Findings include: A review of the facility's "Fire Drill" logs revealed no documented evidence a fire drill was conducted during the first quarter of 2023 (January, February, March). During an interview on 10/30/23 at 3:40 PM, the Security Director and the Administrator confirmed the fire drill was not conducted for the first quarter of 2023. The Security Director stated that the individual from the company that conducted fire drills was out on medical leave. NJAC 8:39-31.2(e)	K 712	Fire Drills K712 The facility failed to conduct fire drills for each shift at unexpected times. The facility will correct the deficient practice by having fire drills on each shift at unexpected, non-patterned times once per shift each quarter. All residents, staff and visitors can be affected. Quarterly fire drills will be conducted at various, non-patterned intervals on all shifts by Administrator, Security Director or designee. The fire drills will be tracked and monitored by the Administrator, Security Director or designee to ensure that all drills are done at unexpected times. Monthly audits will be Administrator, Security Director or designee and reported in QAPI. Data will be submitted to the QAPI committee to ensure compliance. This will be monitored for two quarters. If not compliant, additional two quarters will be monitored until two consecutive quarters are met. This will be completed by 12/1/23.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K 761		12/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING **01** B. WING _____	**11/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD** **DENVILLE, NJ 07834**

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K 761	Continued From page 8 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure the fire doors were inspected annually by an individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. This deficient practice had the potential to affect all 52 residents who resided at the facility. Findings include: Observations of the facility's fire doors on 10/30/23 from 12:30 PM to 2:30 PM revealed the doors lacked the required inspection tags to be placed on the doors after completed inspections. During an interview at the time of the observations, the Maintenance Director and the Administrator confirmed the fire doors were not inspected annually.	K 761	Maintenance, Inspection and Testing - Doors K761 The facility did not complete annual door inspections in accordance with NFPA80. All fire doors in the facility will be inspected by the Maintenance Director and will continue to be inspected annually as required to ensure the safety of all residents and staff. Inspection tags and doors will be replaced as needed. All residents, staff and visitors can be affected. A log has been developed to ensure there will be proper documentation of annual inspection conducted on every fire door in the facility. Maintenance Director or	

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	315329	A. BUILDING **01** B. WING _____	**11/08/2023**

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K 761	Continued From page 9 NJAC 8:39-31.2(e) NFPA 80	K 761	designee will replace door tags or doors as needed. The Maintenance Director will submit the log to the Administrator each time the annual inspection occurs; ensuring the testing of all facility fire doors is conducted and ensuring the inspection is properly documented. This will be reviewed in the next QAPI for further discussion and possible recommendations. This will be completed 12/1/23.	

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
315329 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	1/10/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	21 POCONO ROAD DENVILLE, NJ 07834

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 K0161	12/31/2023	LSC K0291	12/01/2023	LSC K0353	12/12/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0372	12/01/2023	LSC K0712	12/01/2023	LSC K0761	12/01/2023
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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/8/2023	☐ YES ☐ NO