STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315115	A. BUILDING _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC COAST REHAB & HEALTH	485 RIVER AVE LAKEWOOD, NJ 08701

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F 000	INITIAL COMMENTS Standard Survey Census: 124 Sample Size: 26 + 2 closed records The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the	F 582		2/24/23

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

Electronically Signed | 02/02/2023

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F 582	Continued From page 1 Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to issue the required beneficiary notices for 1 of 3 residents reviewed for Beneficiary Protection Notification, (Resident # 118). This deficient practice was evidenced by the following: On 1/5/2023 at 10:09 AM, the surveyor reviewed the SNF Beneficiary Protection Notification Review (SNFBPNR) completed by the facility for Resident #118. The SNFBPNR indicated Resident # 118 last covered Medicare day was [redacted] and Resident # 118 remained in the	F 582	F582 B Resident #118 remains in the facility for long-term care placement under Horizon NJ Health-Medicaid. Resident #118 had no negative effects from this practice. Resident #118 is currently receiving non-skilled services for speech therapy under Medicare Part B. Physical and Occupational Therapy evaluations were conducted in [redacted]. No skilled services were required as there were no significant changes noted in the	

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F 582	Continued From page 2 facility. The SNFBPNR further revealed that a "Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage Form CMS-10055" was not given to Resident #118. There was no documentation to indicate why the form was not given to Resident #118. During an interview with the Director of Social Services (DSS) on 1/5/2023 at 10:13 AM, the DSS said, "I just started doing these forms in October." The DSS went on to say the forms were being done by the admission department. During an interview with the surveyor on 1/5/2023 at 11:05 AM, the Director of Admissions told the surveyor that per an email from their corporate offices in an October 2022 update regarding notifications that they no longer provide a SNF ABN unless a resident is appealing and therefore Resident # 118 did not get one (CMS-10055). During a follow up interview with the surveyor on 1/5/2023 at 1:50 PM, the Director of Admissions reviewed the SNFABN requirements per the regulation and said we should have given a SNFABN to Resident #118. She went on to say that she will let the DSS know moving forward the DSS will be responsible for providing the SNFBPNR forms. NJAC 8:39-4.1(a)(7)	F 582	resident□s functional status. A ABN was issued for the discharge of [redacted] A review of SNF Beneficiary Protection Notifications was complete at the time of the survey. No other residents were found to be affected by this practice. The Social Worker of the facility has been issuing both forms as applicable since notification during survey. In-services were conducted by the Administrator to re-educate pertinent staff that the SNF ABN and NOMNC must be issued when a resident has skilled benefit days remaining and is being discharged from Part A services and will continue living in the facility. This will not apply to NOMNC if the beneficiary initiated the discharge. The Administrator and Social Worker updated the facility Medicare Notice Guide policy to reflect the scenarios issued to Surveyors. The Administrator will conduct weekly audits of beneficiary notices x 4 weeks, then monthly x 2 months on residents with skilled benefit days remaining who are being discharged from Part A services and will continue living in the facility to ensure both the SNF ABN and NOMNC forms were issued appropriately by Social Services. Discrepancies will be reviewed with the Social Worker and re-education will be provided as needed. The Administrator will report the results of the weekly/monthly beneficiary notice audits and any corrective actions required	

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F 582	Continued From page 3	F 582	to the Quality Assessment and Assurance (QAA) Committee for quarter 1 2023 and quarter 2 2023. The QAA Committee will determine the need for any additional monitoring of beneficiary notices at the quarter 2 2023 meeting. Date of compliance: February 24, 2023	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690		2/24/23

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F 690	Continued From page 4 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to a) maintain an EX. Order 26.(4) B1 off the floor to prevent the spread of infection, b) failed to position the EX. Order 26.(4) B1 and EX. Orde below EX. Order 26.(4) B1 and c) failed to maintain resident dignity when the EX. Order 26.(4) B1 was visible from the hallway. This deficient practice was identified for 1 of 3 residents (Resident #177) reviewed for EX. Order 26.(4) B1 and was evidenced by the following: During the initial tour of the unit on 1/3/2023 at 11:14 AM, Resident # 177 was observed lying in bed with the head of the bed elevated and pillow under both knees. The EX. Order 26.(4) B1 was observed lying on the floor with EX. Q. Orde in the EX. Orde, uncovered and visible from the hallway. At 11:16 AM, the assigned nurse, Registered Nurse (RN #1) was observed entering the residents' room with a EX. Order 26.(4) B1 and when she left the room the EX. Order 26 was in the EX. Order 26.(4) B1 On 1/4/2023 at 9:59 AM, Resident # 177's catheter bag was observed to be in a EX. Order 26.(4) B1 hanging behind the EX. Order 26.(4) B1. Resident #177 was observed to be holding the EX. Order 26.(4) B1 in his/her EX. Order 26.(4) B1 and the EX. Order 26 was up and over the EX. Orde of the chair. The Unit Manager/Licensed Practical	F 690	F690 D Resident #177 remains free from any signs/symptoms of a EX. Order 26.(4) B1 infection. The EX. Order 26.(4) B1 has been maintained below the level of the EX. Order 26.(4) and out of reach of the resident. The resident□s dignity has been maintained with use of a EX. Order 26.(4) B1 Residents who have an EX. Order 26.(4) B1 EX. Order 26.(4) B1 had the potential to be affected. An audit was conducted and found that no other residents with EX. Order 26.(4) B1 were affected by this practice. Privacy and infection control measures were maintained with use of EX. Order 26.(4) B1. EX. Order 26.(4) B1 were found hanging appropriately below the level of the EX. Order 26.(4) and out of reach of residents during the facility audit. The policy for the Standards of Care for the Resident with an EX. Order 26.(4) B1 EX. Order 26.(4) B1 was reviewed. No changes or updates were required for this policy. In-services were conducted to re-educate licensed and certified nursing staff on the facility policy for Standards of Care for the Resident with an EX. Order 26.(4) B1 EX. Order 26.(4) B1 Education focused on management of catheters to reduce the potential of EX. Order 26.(4) B1 infections in	

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F 690	Continued From page 5 Nurse (UM/LPN #1) entered the resident's room and removed the residents' hand from the EX. Order 26.(4) B1 UM/LPN #1 did not reposition the EX. Order 26.(4) B1 and left it up and over the arm rest and above bladder level. A review of the Admission Record revealed Resident #177 was admitted to the facility with diagnoses including but not limited to; EX. Order 26.(4) B1 [redacted]. A review of the most recent comprehensive Minimum Data Set (MDS) an assessment tool used to facilitate care, dated EX. Order 26.(4) B1, revealed a Brief Interview for a Mental Status score of EX. Order 2 indicating Resident #177 had EX. Order 26.(4) B1. The MDS further reflected Resident #177 had an EX. Order 26.(4) B1 EX. Order 26.(4) B1 A review of the Order Summary Report (OSR) with active orders as of EX. Order 26.(4) B1 revealed a physician's order to POS Maintain EX. Order 26.(4) B1 EX. Order 26.(4) B1 DX (diagnosis): EX. Order 26.(4) B1 every shift. The OSR also included maintain EX. Order 26.(4) B1 at all times check placement Q shift (every shift). A review of the care plan with an initiated date of EX. Order 26.(4) B1 revealed a of Focus area of Resident # 177 is at high risk for EX. Order 26.(4) B1 EX. O (related/to) EX. Order 26.(4) B1 use for EX. O. Order 26.(4) B1 EX. Order 26.(4) B1 to EX. Order 26.(4) B1 EX. Order 26.(4) B1). The	F 690	residents with EX. Order 26.(4) B1 and to maintain dignity and privacy for these residents. The Director of Nursing or Designee will conduct weekly audits x 4 weeks, then monthly x 2 months on residents with EX. Order 26.(4) B1 to assure privacy and infection control measures are maintained. Discrepancies will be reviewed with staff assigned to maintaining the EX. Order 26.(4) B1 and re-education will be provided as needed. The Director of Nursing will report the results of the weekly/monthly EX. Order 26.(4) B1 EX. Order 26.(4) B1 audits and any corrective actions to the Quality Assessment and Assurance (QAA) Committee for quarter 1 2023 and quarter 2 2023. The QAA Committee will determine the need for any additional monitoring of EX. Order 26.(4) B1 at the quarter 2 2023 meeting. Date of compliance: February 24, 2023	

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F 690	Continued From page 6	F 690		

goals indicated resident will remain free from complications r/t Cath use evidenced by remaining free from s/s (signs/symptoms) EX. Order
The Interventions included but were not limited to; Keep EX. Order 26.(4) B1 placed below level of EX. Order 26.(4) B EX. Order 26.(4) B1 as warranted to maintain dignity/privacy.

During an interview with the surveyor on 1/5/2023 at 10:29 AM, the assigned Registered Nurse (RN #1) confirmed she worked on the unit EX. Order 26.(4) and EX. Order 26.(4) B1. RN #1 also said the EX. Order 26.(4) B1 should not be touching the floor. She confirmed she came into the room and put the EX. Order 26.(4) B1 EX. Order when the surveyor was outside the door. RN #1 said the EX. Order 26.(4) has a EX. Order 26.(4) B1 and that should be on the resident and the EX. Order hooked to a non-moveable part of the chair and off the floor. RN #1 also said the EX. Order 26.(should be down to gravity as much as possible so the EX. Order 26.(4) B1. RN #1 confirmed that it would not have been proper placement of the EX. Order 26.(4 to be up and over the chairs EX. Order 26.(4) B.

During an interview with the surveyor on 1/10/2023 at 12:39 PM, the Director of Nursing (DON), Assistant Director of Nursing (ADON) and Infection Preventionist Licensed Practical Nurse (IPLPN), said "Yes, the EX. Order 26. should have been in the EX. Order 26.(4) B1 and not on the floor." The surveyor also reviewed how the EX. Order 26.(was observed on 1/4/2023 over the EX. Order 26.(4) B and the EX. Order positioned behind the chair. When asked how the EX. Order 26.(4) B1 should be positioned the IP responded, "The EX. Order 26.(should have been below the EX. Order 26.(4) B."

A review of a facility policy titled EX. Order 26.(4) B1 with review date of September 6, 2022, revealed

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F 690	Continued From page 7 under the Standards of Care for the Resident with an EX. Order 26.(4) B1 ; Unobstructed EX. Order 26.(4) B1 should be maintained at all times. The catheter and collection EX. Order 26.(4) should be kept from kinking and the EX. Order 26.(4) B1 should always be kept below the level of the EX. Order 26.(4) (and not touching the floor). The policy further revealed a EX. Order 26.(4) B1 or EX. Order 26.(4) should be used when out of bed to maintain resident dignity. A EX. Order 26.(4) B1 cover should be utilized to maintain resident dignity when in bed. NJAC 8:39-27.1(a)	F 690		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 757		2/24/23

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F 757	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to adequately monitor the use of an EX. Order 26.(4) B1 by administering 28 doses instead of the prescribed 30 doses. The deficient practice was identified for 1 of 2 residents (Resident #45) reviewed for EX. Order 26.(4) B1 The deficient practice was evidenced by the following: A review of Resident #45's physician orders located in the electronic medical record (EMR), revealed that he/she was prescribed EX. Order 26.(4) B1 [redacted] to be given three times a day for ten days. The EX. Order 26.(4) B1 EX. Order 26.(4) B1 was to begin being administered on EX. Order 26.(4) B1 at 2:00 PM. A review of Resident #45's EX. Order 26.(4) B1 medication administration record (MAR) revealed that on EX. Order 26.(4) B1, no doses were given at 2:00 PM and 9:00 PM. On 1/9/2023 at 12:07 PM, during an interview with the surveyor, the Infection Prevention/Licensed Practical Nurse (IP/LPN) stated that Resident #45 did not get two doses of EX. Order 26.(4) B1 on the first day of the order because it had not been delivered to the facility yet. On 1/10/2023 at 12:33 PM, during a follow-up interview with the surveyor, the IP/LPN said Resident #45 should have had his/her doses extended to complete all 30 doses.	F 757	757 D The attending physician for Resident #45 was contacted regarding the order for EX. Order 26.(4) B1 [redacted] milligrams/5 milliliters and the number of doses administered. The attending physician updated the completion order from 30 to 28 doses and confirmed that the full course of EX. Order 26.(4) B1 therapy had been complete. Resident #45 remains in the facility without signs/symptoms of EX. Order 26.(4) B1 as the course of antibiotic administered was effective. Residents with EX. Order 26.(4) B1 medications ordered with a specified number of doses had the potential to be affected. An audit of active and recently completed EX. Order 26.(4) B1 medications ordered with specified administration durations were reviewed electronically. Five out of 5 residents were found not to be affected by this practice. In-services were conducted to re-educate licensed nursing staff on the importance of scheduling physician orders with specified durations to ensure the correct number of doses are administered. Licensed staff were re-educated how to update an order in Point Click Care after notifying the physician to extend the date for medication administration. Licensed staff are to utilize the update tab in the residents chart under orders to adjust the duration of the medication when ordered by the physician to ensure the total amount of doses are administered. The Director of Nursing or Designee will	

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F 757	Continued From page 9 The facility was unable to provide a policy regarding the [redacted] administration. NJAC 8:39-29.2(d)	F 757	conduct weekly audits x 4 weeks, then monthly x 2 months on residents with antibiotic orders that specify the number of doses to be administered to assure compliance. Discrepancies will be reviewed with staff assigned and re-education will be provided as needed. The Director of Nursing will report the results of the weekly/monthly medication audits and any corrective actions required to the Quality Assessment and Assurance (QAA) Committee for quarter 1 2023 and quarter 2 2023. The QAA Committee will determine the need for any additional monitoring of [redacted] orders at the quarter 2 2023 meeting. Date of compliance: February 24, 2023	
F 812 SS=E	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	F 812		2/24/23

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F 812	Continued From page 10 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 handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 1/9/2023 from 10:04 AM to 11:37 AM, the surveyor, accompanied by the Food Serviced Director (FSD) and Regional Food Service Director (RFSD) observed the following in the kitchen: 1. The surveyor entered the kitchen on 1/9/2023 to observe the dish machine in operation after the breakfast meal. The surveyor observed (3) dietary staff actively washing dishes upon entering the kitchen. The surveyor asked the FSD to provide a copy of the dish machine temperature log for the surveyor to review. The FSD revealed that, "In the end of December the dish machine was not hitting the temperatures necessary for high temperature operation. The machine was converted to low temperature operation with chemical sanitizing." The FSD revealed that the sanitizing chemical agent being used was Santec Resolve 3 (a concentrated liquid chlorine sanitizer/destainer solution). The surveyor reviewed the January 2023 dish machine temperature log. The log revealed that the sanitizer level was recorded for the breakfast, lunch, and dinner meals for the period 1/1-1/9/2023 however, no wash or rinse temperatures were recorded. The log revealed that the low temperature dish machine minimum operational temperatures were Wash: 120 F	F 812	F812 E The china, glassware, and silverware that had run through the dish machine was rewashed to ensure sanitation was maintained in a safe and consistent manner to prevent food borne illnesses. No residents were affected by this practice. All facility residents had the potential to be effected by this practice. The facility policy titled Dish Washing was reviewed by the Food Service Director (FSD). No changes or updates were required for this policy. In-services were conducted by the Food Service Director and Regional Food Service Director to re-educate the dietary staff on the operation of the dish machine. Staff were re-educated on running the dish machine at high temperatures and when converted to low temperature operation with chemical sanitization. Education focused on the requirement for chemical sanitizing with chlorine, checking and recording machine temperatures prior to the initiation of dish washing each meal, and the process of notifying the supervisor immediately when temperatures do not meet the standard. The dish machine was repaired on 1/10/2022 in the presence of the surveyor. The repairman stated that the squeeze tube may have had a small air leak that would not allow the chlorine sanitizing solution to reach the machine water. An audit tool was created by the Food	

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	315115	A. BUILDING _____ B. WING _____	01/11/2023

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F 812	Continued From page 11 (Fahrenheit) and Rinse 140 F. At 10:19 AM the surveyor watched the FSD utilize a chlorine test strip twice to assess the level of chlorine for the low temp dish machine while in operation for the breakfast meal. The FSD removed a chlorine test strip from its plastic container and dipped the strip into a substantial amount of dish water with white bubbles floating on the surface that had gone through the wash and rinse cycle of the dish machine. The test strip after being dipped into the dish water was white when removed from the water and examined. The white indicated that the dish machine water had less than 50 parts per million of chlorine in the water. The requirement for chemical sanitizing with chlorine is a minimum of 50 ppm (parts per million). The surveyor then gave the FSD another opportunity to test the sanitizer level of the low temperature dish machine. The FSD followed the same procedure and after dipping the chlorine test strip into the remaining dish water of the plastic pellet lid the test strip remained white and indicated that the chlorine level was less than 50 ppm. When interviewed as to who had conducted the sanitizer test at approximately 7 AM the FSD stated, "I tested the sanitizer and got 50 ppm." The FSD went on to say, "When I checked again at probably about 10 AM it was reading around 200 ppm, it was dark purple." The FSD agreed that when the surveyor observed her test the sanitizer, "It had nothing. I don't know why." At 10:25 AM the repairman (who had already been previously scheduled to do repairs that day) replaced the squeeze tube (tubing attached to the external chemical sanitizer pump) to the sanitizer pump on the dish machine. The repair man revealed that the squeeze tube may have had a small air leak that would not allow the chlorine sanitizing solution to reach the machine water. The	F 812	Service Director for monitoring the dish machine to assure that temperatures are recorded three times per day for each cycle by the pot washer. The FSD/Designee will audit the temperature log daily x 4 weeks, then monthly x 2 months to ensure compliance with the dish machine temperature logs. The Food Service Director will report the results of the weekly/monthly dish machine/temperature audits and any corrective actions required to the Quality Assessment and Assurance (QAA) Committee for quarter 1 2023 and quarter 2 2023. The QAA Committee will determine the need for any additional monitoring of the dish machine at the quarter 2 2023 meeting. Date of compliance: February 24, 2023	

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F 812	Continued From page 12	F 812		

repairman then ran a rack of plates through the dish machine in the presence of the surveyor and FSD. The FSD then tested the water with the same chlorine test strip utilized in previous attempts once the rack of dishes exited the machine. The FSD dipped the test strip, and the surveyor observed a deep purple color on the test strip after immediately removing the strip from the dish machine water that had accumulated on the plate. The strip revealed a chlorine concentration of greater than 50 ppm. The surveyor then reviewed the January 2023 dish machine temperature log again. The log revealed that in the "Wash" column staff were documenting "ppm" and were not documenting the wash temperature of the dish machine, which must be a minimum of 120 F, according to the temperature log. Further review revealed that no wash or rinse temperatures were recorded for breakfast, lunch, or dinner for the period of 1/1 through 1/9/2023 at breakfast. The surveyor then reviewed the December 2023 dish machine temperature log. The log revealed that dish machine temperatures were not recorded for the following dates and meals: 12/29/2022 lunch, 12/30/2022 breakfast, 12/30/2022 lunch, 12/31/2022 breakfast, and 12/31/2022 lunch. On interview with the FSD at 10:50 AM the FSD stated that machine temperatures should be recorded and checked prior to the initiation of dish washing to ensure the machine is running at proper temperature. The FSD further stated, "Whoever is the hot washer position is responsible for recording the temperature and ensuring that the machine is operating appropriately before initiating dishwashing. If the machine is not operating effectively then the hot washer should notify the supervisor so we can call for repairs. All temperatures should be documented before

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F 812	Continued From page 13	F 812		

initiating dishwashing." The FSD agreed that the dish machine was not operating properly prior to the surveyor making observation and that the facility did not follow their policy and procedure.

2. On 1/9/2023 at 11:09 AM, the surveyor completed an interview with the RFSD. The RFSD agreed that staff "must check and assure the dish machine is operating effectively before initiating dish washing, that is our policy."

3. On 1/9/2023 at 11:14 AM, the surveyor interviewed the dietary aide (DA) who was the designated "hot washer" position during operation of the low temperature dish machine for the breakfast meal. On interview the DA agreed that he did not record the wash or rinse temperature and did not test the chlorine sanitizer level in the dish machine prior to initiating the breakfast dish washing. The DA stated that the FSD checked the sanitizer level around 7 AM and he did not have to check again before doing the breakfast dishes.

The surveyor reviewed the facility policy titled Dish Washing, with Revised dates of 2017, 2018, 2019, 2020, 2021, 2022. The policy revealed the following under the heading POLICY: The facility will follow established methods for the safe and effective use of dish washer in the kitchen. The following was revealed under the heading PURPOSE: The Dining Services department will clean and sanitize the china, glassware, and silverware following established procedures and in a manner that is safe to all residents. In addition, the policy stated under the heading PROCEDURE:

Dish machine will be monitored for established

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F 812	Continued From page 14 proper temperature for dish washers. A temperature log will be maintained for the machine for recording wash and final rinse temperatures. The dietary staff will record the temperatures on the temperature log for breakfast, lunch, and dinner. The dishwasher will be drained and cleaned at the completion of each meal service. Temperatures that do not meet standard will be reported immediately to the supervisor on duty. The surveyor reviewed an undated facility policy titled Cleaning of Dish Machine. The following was revealed under the heading PROCEDURE: 1. Prior to use, run the machine until verification of proper temperatures and machine function is made. Verify that soap and rinse dispensers are filled and have enough cleaning product for the shift. The policy also revealed the following under the heading Note: Staff should check the dish machine gauges in the beginning and throughout the cycle to assure proper temperatures for sanitation.	F 812		
F 814 SS=D	NJAC 8:39-17.2(g) Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by:	F 814		2/24/23

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F 814	Continued From page 15 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to keep the garbage container area free of garbage and debris. This deficient practice was evidenced by the following" On 1/3/2023 between 9:34 AM and 10:30 AM, the surveyor, accompanied by the Dietary Aide (DA) observed the following in the designated facility garbage area: 1. The area directly behind the facility trash compactor was littered with trash, which included rubber gloves, plastic wrappers, cardboard boxes, plastic spoons, empty milk containers, paper, and other unidentifiable objects. On interview the DA stated, "We clean the area when they come to pick the dumpster up. We share it with housekeeping. It gets picked up once a week on Wednesday." The surveyor then questioned the DA whether garbage would be picked up if it was observed on the ground and it was not a Wednesday. The DA replied, "We should pick up the trash if we see it lying around before pick-up day." 2. The surveyor reviewed the 4 WEEK DUMPSTER AREA CLEAN UP SCHEDULE for the weeks of 12/5/22, 12/12/22, 12/19/22, and 12/26/22. The schedule revealed that the last time the dumpster area was inspected was 12/30/2022. The schedule further revealed: "The dumpster area will be maintained free and clear of debris and leakage on a daily basis. Housekeeping and dietary shall share the responsibility of maintaining the dumpster area on	F 814	F814 D The debris and garbage noted around the area directly behind the trash compactor/garbage container was picked up and disposed of accordingly to maintain a sanitary environment. No residents were affected by this practice. All facility residents had the potential to be effected by this practice. The Administrator reviewed with the Directors of Dietary and Housekeeping the 4-week dumpster area clean up schedule and the expectation of daily oversight of the area around and behind the trash compactor/garbage container to maintain a sanitary environment. In-services were conducted by the Food Service Director and Director of Housekeeping for their assigned staff to ensure the area behind and around the trash compactor/garbage container is maintained so that the area is free from debris and garbage. The department heads reviewed the 4-week dumpster area clean up schedule to ensure staff understand the importance of cleaning these areas and maintaining a sanitary environment. The Administrator/Designee will audit the trash compactor/garbage container area clean up schedule weekly x 4 weeks then monthly x 2 months to assure compliance. The Administrator/designee will conduct walking rounds around the area of the trash compactor/garbage container twice weekly to assure a sanitary environment. Any discrepancies will be addressed with the Directors of Dietary and	

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F 814	Continued From page 16 a rotating schedule basis." NJAC 8:38-19.3(c)	F 814	Housekeeping for compliance. The Administrator/Designee will report the results of the trash compactor/garbage container clean up schedule and environmental rounds near and around the trash compactor/garbage container to the Quality Assessment and Assurance (QAA) Committee for quarter 1 2023 and quarter 2 2023. The QAA Committee will determine the need for any additional monitoring of these areas at the quarter 2 2023 meeting. Date of compliance: February 24, 2023	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		2/24/23

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F 880	Continued From page 17 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 18 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to perform adequate handwashing to prevent the spread of infection as well as failed to follow their own Hand Hygiene policy. This deficient practice was identified for 1 of 2 nurses observed during medication administration. This deficient practice was evidenced by the following: On 1/5/2023 at 8:05 AM, the surveyor observed Registered Nurse (RN #2) administer an injectable medication to an unsampled resident. At 8:11 AM, the surveyor observed RN #2 enter the resident's bathroom. At that time, RN #2 turned on the faucet, wet hands her hands, applied soap, lathered outside the stream of water for 7 seconds, rinsed her hands, dried her hands, and turned off the faucet. RN #2 did not use alcohol-based hand sanitizer. The time was counted on the New Jersey Department of Health computer clock. RN #2 returned to the medication cart and retrieved a blood pressure cuff and then took the resident's blood pressure. At 8:14 AM, the surveyor observed RN #2 enter the resident's bathroom. At that time, RN #2 turned on the faucet, wet her hands, applied soap, lathered outside the stream of water for 8	F 880	F880 D Registered Nurse #2 was able to verbalize the correct amount of time for lathering her hands during handwashing upon interview with the surveyor. Registered Nurse #2 self-reported her error to nursing leadership post medication pass observation with the surveyor. The IP Nurse re-educated Registered Nurse #2 on hand-hygiene with a return demonstration completed the day of this medication pass observation. Registered Nurse #2 was determined competent with hand-hygiene by the Infection Practitioner (IP) Nurse. The unsampled resident was not identified for follow-up in this 2567. No residents were identified as having negative effects from this practice. The IP Nurse conducted observations and competency of staff upon notification for proper hand-hygiene techniques to ensure compliance with the facility Hand Hygiene policy. The facility Hand Hygiene Policy was reviewed by nursing leadership. No changes or updates were required for this policy. In-services were conducted to re-educate licensed staff on the importance of proper hand-hygiene techniques during medication administration. The IP Nurse/Designee will conduct weekly audits x 4 weeks, then monthly x 2 months with licensed nursing staff for	

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F 880	Continued From page 19 seconds, rinsed her hands, dried her hands, and turned off the faucet. RN #2 did not use alcohol-based hand sanitizer. The time was counted on the New Jersey Department of Health computer clock. RN #2 returned to the medication cart and gathered the resident's medications. RN #2 entered the resident's room and administered the oral medications. At 8:21 AM, the surveyor observed RN #2 enter the resident's bathroom again. At that time, RN #2 turned on the faucet, wet her hands, applied soap, lathered outside the stream of water for 7 seconds, rinsed her hands, dried her hands, and turned off the faucet. RN #2 did not use alcohol-based hand sanitizer. The time was counted on the New Jersey Department of Health computer clock. On the same date at 8:41 AM, during an interview with the surveyor, RN #2 replied, "20 seconds" when asked how long she should lather her hands during hand hygiene. On 1/10/2023 at 11:46 AM, during an interview with the surveyor, the Infection Prevention/ Licensed Practical Nurse (IP/LPN) replied, "Absolutely not." when asked if lathering soap and water for 7 seconds was sufficient. During the same interview, the IPLPN replied, "No." when asked if lathering soap and water for 8 seconds was sufficient. A review of the facility policy titled, "Hand Hygiene" dated January 2022, revealed under, "Hand Hygiene Technique" letter "B.", "Total time no less than 20 Sec."	F 880	hand-hygiene during medication administration to assure proper technique. Discrepancies will be reviewed with staff performing hand-hygiene and re-education will be provided as needed. The IP Nurse will report the results of the weekly/monthly hand-hygiene audits and any corrective actions implemented to the Quality Assessment and Assurance (QAA) Committee for quarter 1 2023 and quarter 2 2023. The QAA Committee will determine the need for any additional monitoring of hand-hygiene at the quarter 2 2023 meeting. Date of compliance: February 24, 2023	

EX. Order 26.(4) B1

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	061504	A. BUILDING: _____ B. WING _____	01/11/2023

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to: 1.) maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This was evident for 5 of 14-day shifts reviewed and 2.) follow facility policy to obtain medical exemption forms for 14 of 14 employees who signed an Employee Declination of Influenza Vaccination form for the 2022/2023 flu season. These deficient practices were evidenced by the following: 1. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance	S 560	S560 #1. No residents were identified to have had negative impact from the current staffing ratios. #2. No residents were affected by this practice. #1. This practice had the potential to affect all residents residing at the facility. #2. Residents who have contact with staff who are not up to date with their Influenza Vaccine had the potential to be affected. #1. The current Staffing Policy and Procedure was reviewed. No additional updates were required at this time. Education was provided on the current Staffing Policy and Procedure to licensed and certified nursing staff by the Director	2/24/23

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

Electronically Signed | 02/02/23

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S 560	Continued From page 1 with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nursing Staffing Report" completed by the facility for the weeks of 12/18/22 and 12/25/22, the staffing to residents' ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as documented below: The facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows: -12/20/22 had 14 CNAs for 121 residents on the day shift, required 15 CNAs. -12/24/22 had 14 CNAs for 125 residents on the day shift, required 16 CNAs. -12/25/22 had 15 CNAs for 125 residents on the day shift, required 16 CNAs. -12/26/22 had 15 CNAs for 124 residents on the day shift, required 16 CNAs. -12/30/22 had 14 CNAs for 124 residents on the day shift, required 15 CNAs	S 560	of Human Resources/Designee. The Director of Human Resources/Designee will conduct weekly audits of Certified Nurse Aide (CNA) staffing reports to ensure the facility maintained the required minimum of direct care staff-to-resident ratios for the day shift. Audits will continue until substantial compliance is met. The Director of Human Resources/Designee will conduct weekly meetings with the Administrator and Director of Nursing as feasible to review daily CNA ratios. This will be continued until substantial compliance is met to analyze and trend the information. Facility administration has been actively working on increasing staff ratios. The facility currently has the following in place to help increase staffing: " The facility has contracted an in-house recruiter that helps the facility recruit and retain the highest quality care staff. The recruiter is assisting the facility with advertising, scheduling interviews, providing follow-up to the candidate and facility, and helps the facility maintain a real-time status of where recruits are in the process. " Adds have been sponsored on Indeed and Apploi for open position recruiting and onboarding. " Referral bonus and sign-on bonus structures have been implemented. " Multiple staffing agencies have been contracted with to provide additional support staff for licensed and certified nursing staff. " Certified Nurse Aide rates have been increased.	

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	061504	A. BUILDING: _____ B. WING _____	01/11/2023

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S 560	Continued From page 2 During an interview with the Staffing Coordinator (SC) on 1/9/2023 at 12:55 PM, the SC stated that it was her responsibility to staff the facility. The SC stated that the facility was meeting the staffing requirements. A review of a revised facility policy dated 12/13/22, titled "Staffing Policy and Procedure," under Procedure, specifies the following ratios: - One certified nurse aide to every eight residents for the day shift - One direct care staff member to every 10 residents for the evening shift -One direct care staff member to every 14 residents for night shift. During a team meeting with the facility Administration on 1/10/2023 at 12:23 PM, the Director of Nursing acknowledge that call outs resulted in staffing shortages. 2. Findings include: According to the N.J. Stat. 26:2H-18.79 - Influenza vaccination in health care facilities, effective 1/13/2020, healthcare facilities are required to: c. For the purposes of its annual influenza vaccination program, each health care facility shall:(1) annually provide an on-site or off-site influenza vaccination to each of its employees;(2) require that each employee at the facility receive an influenza vaccination annually, no later than December 31 of the current influenza season as determined by the federal Centers for Disease	S 560	" The Baylor Program (12-hour shifts) is offered to licensed nursing staff. " The call-out policy has been reinforced for staff who call out on their assigned shifts. #2. The Influenza Vaccination policy was reviewed. No updates were required for the current policy. The Infection Practitioner Nurse (IP) spoke with staff who declined the influenza vaccination by December 31 of this current season and offered the influenza vaccination. Education on the mandatory requirement for influenza vaccination and the process for submitting a medical exemption was provided. Education was provided to facility staff (including contracted staff) on the current Influenza Vaccination policy. Staff were educated that a medical exemption form must be submitted using the form designated by the Department of Health, stating that the influenza vaccination for that employee is medically contraindicated, as enumerated by the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention if they wish to submit a medical exemption for the next influenza season. An attestation of a medical exemption will be subject to approval by this facility following review to confirm the medical exemption is consistent with standards enumerated by the Advisory Committee on Immunization Practices. The IP Nurse will continue to provide	

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S 560	Continued From page 3 Control and Prevention, which vaccination shall be provided by the health care facility, except that an employee may, in lieu of receiving the influenza vaccination at the facility, present acceptable proof, comprising:(a) an attestation from the employee, which shall be submitted in a form and manner designated by the facility, of a current influenza vaccination if the employee receives the vaccination from another vaccination source, which attestation shall include the lot number of the vaccination the employee received or;(b) a medical exemption, which shall be submitted using a form designated by the Department of Health, stating that the influenza vaccination for that employee is medically contraindicated, as enumerated by the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention. An attestation of a medical exemption shall be subject to approval by the facility following a review by the facility to confirm the medical exemption is consistent with standards enumerated by the Advisory Committee on Immunization Practices;(3) maintain a record or attestation, as applicable, of influenza vaccinations and medical exemptions for each employee and report to the Department of Health, in a manner and according to a schedule prescribed by the commissioner, the vaccination percentage rate of its workforce in receiving influenza vaccinations as part of the facility's annual vaccination program or by other means as attested to by the workforce, as applicable. The report may also include other information that the facility deems relevant to its vaccination percentage rate, including, but not limited to, the number of employees who received medical exemptions. On 1/3/2023 during the entrance conference with	S 560	education to staff on the requirement for annual influenza vaccination. Staff have been educated that annual vaccination will be received at the facility except when an employee presents acceptable proof, including attestation, of a current influenza vaccination received from another vaccination source. This will be required no later than December 31 of the current season as determined by the federal Centers for Disease Control and Prevention. The IP Nurse will maintain records of influenza vaccination for current and new facility staff, including contracted staff, and those who have declined vaccination with medical exemptions. Education records will be maintained by the IP nurse to include education on influenza vaccination, non-vaccine influenza control measures; and the symptoms, transmission, and potential impact of influenza. #1. The IP Nurse will Director of Human Resources will present the findings of the weekly staffing audits and any additional recruitment interventions to the Quality Assessment and Assurance (QAA) committee for quarter 1 2023 and quarter 2 2023. The QAA Committee will determine the need for any additional monitoring of staffing at the quarter 2 2023 meeting. #2. The IP Nurse will present staff influenza vaccination rates from current staff records to the Quality Assessment and Assurance (QAA) Committee each quarter for the next 4 quarters to assure compliance. Date of compliance: February 24, 2023	

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the facility administration, the surveyor requested evidence of the 2022/2023 facility influenza vaccination records for facility staff, including contracted staff. A review of the documentation revealed the following:

The facility provided evidence that 14 facility staff, including contracted staff, filled out an Employee Declination of Influenza Vaccination 2022/2023 form. 14 of 14 staff failed to provide medical documentation for exemption, as required by the Statute and facility policy and procedure.

On 1/5/2023 at 9:53 AM, the surveyor conducted an interview with the facility's designated Infection Preventionist Licensed Practical Nurse (IP/LPN). The surveyor asked the facility IP/LPN if she had obtained medical exemptions for the 14-facility staff who signed an Employee Declination of Influenza Vaccination 2022/2023 form. The IP/LPN responded, "My interpretation is that if a staff member declined the flu vaccination that they would have to work with a mask on all the time in the facility. We did not get medical exemptions for the employees who declined, we just had them sign the declination form." The surveyor requested that the IP/LPN, who was accompanied by the facility Director of Nursing (DON), review their facility policy and procedure regarding influenza vaccination.

During a follow up interview with the surveyor on 1/5/2023 at 1:50 PM, the facility IP/LPN explained, "As far as I can tell the flu vaccine is mandatory. I have done as much as I can to get everybody vaccinated and get their declinations. I have not got it all done and we have mandated masking for those who are non-compliant. Our facility policy does not require staff to have a medical exemption for the flu vaccine. Those who

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declined the vaccine have to be masked all the time. The statute does need a medical exemption and we did not enforce that. Going forward we are going to do it the right way and require staff to provide a medical exemption."

On 1/6/2023 at 11:17 AM the facility IP/LPN, accompanied by the DON, stated the following: "I wanted to clarify what I stated yesterday. I meant to say it is included in our facility policy that employees who declined to have the flu vaccine are required to provide medical documentation for their exemption. I messed it up yesterday, they do need to provide medical documentation and we did not follow our policy with the flu vaccine exemptions."

The surveyor reviewed the facility policy with Subject: Influenza Vaccination, review date: March 7, 2022. The policy revealed the following under the heading POLICY:

It is the policy of [facility name] to provide residents and staff protection from Influenza (flu), a contagious respiratory illness caused by influenza viruses that infect the nose, throat, and sometimes the lungs, unless the immunization is medically contraindicated, or the resident has already been immunized for the season.

Each employee, including employees who are not responsible for direct care, of this facility shall be required to receive an influenza vaccination annually, no later than December 31 of the current influenza season as determined by the federal Centers for Disease Control and Prevention, which vaccination shall be provided by the facility, except that an employee may, in lieu of receiving the influenza vaccination at this facility, present acceptable proof in the form and

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S 560	Continued From page 6 manner designated by this facility. Per diem and contracted employees are considered facility employees and are required to be vaccinated. A medical exemption form shall be submitted using a form designated by the Department of Health, stating that the influenza vaccination for that employee is medically contraindicated, as enumerated by the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention. An attestation of a medical exemption shell be subject to approval by the facility following a review by the facility to confirm the medical exemption is consistent with standards enumerated by the Advisory Committee on Immunization Practices.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061504 Y1	A. Building B. Wing Y2	3/16/2023 Y3

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 02/24/2023	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
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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 1/11/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ YES ☐ NO