STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315486	A. BUILDING _____ B. WING _____	09/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	100 HOLLINSHEAD SPRING ROAD SKILLMAN, NJ 08558

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Survey Date: 9/9/2021 Census: 31 Sample: 12+2 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 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609		10/16/21

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

Electronically Signed | 10/01/2021

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F 609	Continued From page 1 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to report three injuries of unknown origin to the New Jersey Department of Health (NJDOH) for 1 of 3 residents reviewed for accident and incidents (Resident #14). This deficient practice was evidenced by the following: On 9/01/21 at 10:11 AM, the surveyor observed Resident #14 seated in a wheelchair at the bedside. The resident had a fabric transfer sling (a device that is used in conjunction with a mechanical lift to transfer a patient between various surfaces such as a bed to chair) placed beneath his/her back and lower body in the wheelchair. The resident was Ex.Order 26.4(b)(1) and was unable to be interviewed. According to Resident #14's Face Sheet (an admission summary), the resident was initially admitted to the facility in Ex.Order 26.4(b)(and had diagnoses which included but were not limited to: Ex.Order 26.4(b)(1) According to the Significant Change in Status Minimum Data Set (MDS), an assessment tool dated Ex.Order 26.4(b)(, Resident #14 was readmitted to the facility on Ex.Order 26.4(b) from an acute hospital. Further review of the MDS revealed that the	F 609	This Plan of Correction constitutes Stonebridge at Montgomery□s written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Element One All residents have the potential to be affected by this practice: 1. The investigation and documentation for Resident #14□s incidents were reviewed and completed. 2. In-service nursing staff on the reporting requirements and abuse policy, reporting injuries of unknown origin. A schedule has been developed for continual education on reporting requirements and abuse education semi-annually for one year. Element Two 1. All residents admitted to the skilled	

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F 609	Continued From page 2 resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated that the resident was Ex.Order 26.4(b)(1) and had [redacted] which included Ex.Order 26.4(b)(1). Review of the "Functional Status" portion of the MDS indicated that the resident was totally dependent for transfers and required two-person assistance to transfer from the bed to wheelchair. A review of the Care Plan Report effective [redacted] to present, revealed that Resident #14 required help with activities of daily living (ADLs) due to Ex.Order 26.4(b)(1) related to Ex.Order 26.4(b)(1) diagnosis. An intervention was added to the entry on [redacted] for two-person assistance with transfers via Hoyer Lift. Further review of the Care Plan Report included another entry which specified that the resident was [redacted] secondary to needing assistance with ADLs, Ex.Order 26.4(b)(1) [redacted], and was on medications which may [redacted]. The entry included: Ex.Order 26.4(b)(1) [redacted]. Goals included: Ex.Order 26.4(b)(1) [redacted] will resolve without any complications and resident will not have a [redacted] 90 days through [redacted]. Interventions included: During the shower times the resident's CNA (Certified Nursing Assistant) would use 2 assist to move the resident with the Hoyer lift "to carry me from one place to another." The surveyor reviewed an incident investigation dated [redacted] at 8:00 AM, which detailed that it was related to a "[redacted]" that was described as a [redacted] on Resident #14's Ex.Order 26.4(b)(1) and further detailed that there was a [redacted] to the Ex.Order 26.4(b)(1) and [redacted]	F 609	unit have the potential to be affected by this practice. Element Three 1. In-service for all nursing staff on reporting requirements will be conducted on a semi-annually basis. a. This will be repeated twice a year for one year. 2. All Investigation reports will be reviewed five days a week for six months by the Director of Nursing and/or Administrator to determine if a reportable must be submitted. Element Four 1. The Director of Nursing and/or Administrator will be notified upon discovery of an injury of unknown origin. The nurse will initiate an investigation and collect statements. 2. The Director of Nursing and/or the Administrator will review all incidents to confirm that a reportable does not need to be submitted. The results will be reported to the Quality Assurance Committee quarterly for two quarters.	

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F 609	Continued From page 3	F 609		

that measured 12 x 7 x 0 cm. "Immediate Actions Taken" included Ex.Order 26.4(b)(1) . The "Nurse's Note of what happened" portion of the form detailed that the CNA who provided morning care to the resident called the nurse to inspect the resident's Ex.Order 26.4(b)(1) which had Ex.Order 26.4(b)(1) described as Ex.Order 26.4(b)(1) to the outer perimeter with Ex.Order 26.4(b)(1) noted under the Ex.Order 26.4(b)(1) Further review of the document revealed that there were no witnesses to the event and the resident was unable to explain what happened. The nurse documented that the resident demonstrated Ex.Order 26.4(b)(1) at that time and both the resident's family member and physician were notified. Review of the "Conclusion" portion of the form revealed that Resident #14 was alert and able to make his/her needs known and denied any trauma when interviewed. Through investigation, it was identified that some staff used the Sit to Stand in which the straps fit underneath bilateral armpit and hoyerlift device in which resident was positioned on a sling device and mechanically lifted and applied no contact to the armpit. The resident was assessed by PT (Physical Therapy) and identified to be a Hoyerlift only for safety on an unspecified date. All staff were in-serviced on the preferred technique for transfer. The resident was noted to have been on Ex.Order 26.4(b)(1).

The surveyor reviewed a second incident investigation dated Ex.Order 26.4(b) at 6:00 PM, which detailed that it was related to an "Injury of Unknown Origin", that was described as Ex.Order 26.4(b)(on Resident #14's Ex.Order 26.4(b)(1) which further detailed a Ex.Order 26.4(b)(1) . "Immediate Actions Taken" included the following: Ex.Order 2 when Ex.Order 26

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F 609	Continued From page 4	F 609		

(Ex.Order 26.4(b)(1)) performed, Ex.Order 26.4(b)(1) assessment, physician notified and Ex.Order 26.4(b)(was ordered to rule out Ex.Order 26.4(b) of the Ex.Order 26.4(b) and Ex.Order 26.4(b)(1), and the Administrator was notified. The "Nurse's Note of what happened" portion of the form detailed that the CNA reported Ex.Order 26.4(b)(on the resident's Ex.Order 26.4(b)(1). On assessment, the nurse noted Ex.Order 26.4(b)(1). Resident complained Ex.Order 26.4(b)(1) Physician was notified, a new order for Ex.Order 26.4(b)(1) was obtained and the resident's family was notified. Further review of the form revealed that the resident was unable to verbalize what happened and that there were no witnesses to the event. Review of the "Conclusion" portion of the form revealed that the resident looked like he/she was, "going through Ex.Order 26.4(b)(1)."

The surveyor reviewed a third incident investigation dated Ex.Order 26.4(b) at 6:20 PM, which detailed that it was related to a "Ex.Order 26.4(b)(1)" that was described as Ex.Order 26.4(b)(on Resident #14's Ex.Order . The "Nurse's Note of what happened" portion of the form detailed that the assigned aide requested that the nurse assess the resident's Ex.Orde The nurse documented that that the resident had Ex.Order 26.4(b)(1) when the nurse assessed the area. Further review of the entry, revealed that the resident was disoriented and not able to explain how Ex.Order 26.4(b)(1) occurred. The nurse documented that the physician was called and ordered to transfer the resident to the hospital for further evaluation. She documented that the DON (Director of Nursing) was notified. Further review of the document

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F 609	Continued From page 5	F 609		

revealed that there were no witnesses to the event.

During an interview with the surveyor on 9/07/21 at 10:54 AM, the surveyor asked the DON if the facility reported the injuries that were detailed in the incident investigations that pertained to Resident #14 which were dated Ex.Order 26.4(b)(1) and [redacted] to the NJDOH or Office of the Ombudsman for the Institutionalized Elderly. The DON then asked the LNHA in the presence of the surveyor if the aforementioned incidents were reported and he stated that he had not reported any reportable events to the NJDOH since November 2020. The DON further stated that when Resident #14 was sent to the hospital for Ex.Order 26.4(b)(1), "initially, we thought that it was a fall, then we thought someone fought her." She stated that the facility did not immediately know that it was not abuse until after the hospital was called and reported that the resident was being observed [redacted], then the facility decided to view the cameras. She stated that she "might" have reported the incident. She further stated that the Administrator was responsible for reporting, but stated, "I can too."

During an interview with the surveyor on 9/07/21 at 11:50 AM, the Administrator stated that on 6/25/21 he was informed by the Registered Nurse (RN) when he phoned the facility to check on staffing, that Resident #14 had [redacted] and the physician wanted to send the resident out to the hospital to evaluate [redacted]. He stated that he needed to do an investigation. He stated that he was able to see the hospital documentation in real time and saw that that the resident had [redacted]. He stated that he did not suspect abuse, so he did not call the DOH to report suspected

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F 609	Continued From page 6 abuse. He stated that he based his decision according to the information that was provided to him. The surveyor asked the Administrator why he reviewed the camera footage if abuse was not suspected? He stated that he viewed the camera to determine the cause of Ex.Order 26.4(b)(1). The surveyor reviewed the facility policy, "Abuse (Elder Abuse)" (Revised 10/12/2020) which revealed the following: Guidelines for recognizing an Abused Elder: Unexplained bruises. A written report will be submitted to: New Jersey-the Office of the Ombudsman and the State Department of Health within 72 hours. The surveyor reviewed the facility policy, "Incident Reporting" (Revised 02/01/21) which revealed the following: A completed Reportable Event Form, Incident Investigation Form and any collaborating statements shall be sent to the NJHHSS and the Office of the Ombudsman for the Institutionalized Elderly within 72 hours. NJAC 8:39-9.4(f)	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610		10/16/21

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F 610	Continued From page 7 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to complete a thorough investigation related to an injury of unknown origin for 1 of 3 residents reviewed for accidents and incidents, (Resident #14). This deficient practice was identified by the following: On 9/01/21 at 10:11 AM, the surveyor observed Resident #14 seated in a wheelchair at the bedside. The resident had a fabric transfer sling (a device that is used in conjunction with a mechanical lift to transfer a patient between various surfaces such as a bed to chair) placed beneath his/her back and lower body in the wheelchair. The resident was Ex.Order 26.4(b)(1) and was unable to be interviewed. According to Resident #14's Face Sheet (an admission summary) the resident was initially admitted to the facility in Ex.Order 26.4(b)(1) and had diagnoses which included but were not limited to: Ex.Order 26.4(b)(1) According to the Significant Change in Status Minimum Data Set (MDS), an assessment tool dated Ex.Order 26.4(b), Resident #14 was readmitted to the facility on Ex.Order 26.4(b) from an acute hospital.	F 610	Element One All residents have the potential to be affected by this practice. 1. A review of the documentation for the Ex.Order 26.4(b)(1) for Resident #14 was completed. Element Two 1. All residents have the potential to be affected by this practice. Element Three 1. In-service for all nursing staff on the importance of completing an incident report and initiating an investigation. a. Completion and timely collection of statements. 2. Incident reports and the 24 hour reports will be reviewed five days a week by the Director of Nursing, or Designee, to ensure an investigation was initiated and follow up to ensure completion. a. This will continue for two quarters.	

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F 610	Continued From page 8 Further review of the MDS revealed that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated that the resident was Ex.Order 26.4(b)(1) [redacted]. Review of the Functional Status portion of the MDS indicated that the resident was totally dependent for transfers and required two-person assistance to transfer from the bed to wheelchair. A review of the Care Plan Report effective [redacted] to present, revealed that Resident #14 required help with activities of daily living (ADLs) due to Ex.Order 26.4(b)(1) [redacted] diagnosis. An intervention was added to the entry on [redacted] for two-person assistance with transfers via Hoyer Lift. Further review of the Care Plan Report included another entry which specified that the resident was [redacted] secondary to needing assistance with ADLs, Ex.Order 26.4(b)(1) [redacted] and was on medications which may [redacted]. The entry included: Ex.Order 26.4(b)(1) [redacted] area. Goals included: Ex.Order 26.4(b)(1) [redacted] will resolve without any complications and resident will not have [redacted] 90 days through [redacted]. Interventions included: During the shower times the resident's CNA would use 2 assist to move the resident with the Hoyer lift "to carry me from one place to another." The surveyor reviewed three incident investigations that pertained to Resident #14. One of which was dated [redacted] at 6:00 PM, which pertained to an Injury of Unknown Origin. The Registered Nurse (RN) documented that the	F 610	Element Four 1. The Director of Nursing, or designee, will report the findings audits to the Quality Assurance Committee on a quarterly basis for two quarters.	

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F 610	Continued From page 9	F 610		

CNA (Certified Nursing Assistant) reported a Ex.Order 26.4(b)(1) the resident's Ex.Order 26.4(b)(1). On assessment, the nurse documented that she noted Ex.Order 26.4(b)(1) with resident Ex.Order 26.4(b)(1) The RN documented that the resident was unable to verbalize what happened and that there were no witnesses to explain the Ex.Order 26.4(b)(1) The RN documented that she notified the physician who ordered an Ex.Order 26.4 of the resident's Ex.Order 26.4(b)(1) to rule out Ex.Order 26.4(b)(. Further review of the investigation revealed that the resident's last Ex.Order 26.4(b)(1) was conducted on Ex.Order 26.4(b) at 8:00 AM and illustrated that the resident's Ex.Order 26.4(b)(1). A review of the "Conclusion" portion of the investigation contained in the attached "Follow up Report", revealed that on Ex.Order 26.4(b)(at 2:02 PM, the Director of Nursing (DON) documented that resident looked like he/she was going through an Ex.Order 26.4(b)(. The Root Cause was documented as "no fault." In the area provided if abuse was suspected, the DON documented "no." There were no staff interviews available according to the documentation reviewed.

During a later interview with the surveyor on 9/07/21 at 3:19 PM, the Administrator stated on Ex.Order 26.4(b) the staff should have provided statements with in the past 24 hours according to facility policy to determine if there were any changes or if something occurred that caused the injury.

The DON, who was present during the interview, stated that Ex.Order 26.4(b)(was done of Resident #14's Ex.Order 26.4(b) which was negative. She stated that she concluded that Ex.Order 26.4(b)(1) that was reported on the resident's Ex.Order 26.4(b)(was related to

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F 610	Continued From page 10	F 610		

a history of Ex.Order 26.4(b)(1) [redacted]. She stated that she thought that maybe it was Ex.Order 26.4(b)(1). She further stated that the staff should have been interviewed and thought that maybe the resident kicked somebody or something because the resident kicked a lot. She concluded by stating that if she had viewed the proper description of the affected area then she would have interviewed the staff as required. The DON could not provide documented evidence of infection when requested.

The surveyor reviewed the facility policy, "Abuse (Elder Abuse)" (Revised 10/12/2020) which revealed the following:

Guidelines for recognizing an Abused Elder: Unexplained bruises.
A written report will be submitted to: New Jersey-the Office of the Ombudsman and the State Department of Health within 72 hours. The Administrator and/or a nursing supervisor will conduct a thorough investigation. The investigation will include but not be limited to,...interviewing all staff, elders and visitors who are believed to have knowledge of the event...Also, a review of any past allegations, patterns of unexplained injuries, or unusual events will be conducted if appropriate. All bruising or injuries of unknown etiology will be investigated in a manner similar to patient/elder abuse or neglect.

The surveyor reviewed the facility policy, "Incident Reporting" (Revised 02/01/21) which revealed the following: Policy: It is the policy of the community that all incidents are properly reported, recorded

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F 610	Continued From page 11 and analyzed for causative factors and trends. Corrective and/or preventative measures shall be implemented as indicated. Assure incidents are recorded and reported to the proper agencies and internal departments. Procedure: Incident Documentation: All sections of the form must be completed. State Notification: Unexplained injury. Significant Event/Injury: A resident transported to a local medical facility for treatment related to the injury event. NJAC 8:39-4.1(a)5	F 610		
F 689 SS=G	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 observation, interview, record review, as well as a review of pertinent facility documents, it was determined that the facility failed to ensure that a resident was transferred using the correct mechanical lift device and utilized the sufficient required staff assistance to prevent accidents and injury for 1 of 3 residents reviewed; (Resident #14). On 6/23/21, Resident #14 was improperly transferred by 1 staff instead of 2, which resulted i Ex.Order 26.4(b)(1) [redacted]	F 689	Element One All residents have the potential to be affected by this practice: 1. At the time of discovery, the Director of Nursing immediately provided one-on-one education on adhering to the care plan, proper modes of transfer, the mechanical lift policy, and the abuse policy. Staff member received disciplinary action.	10/23/21

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F 689	Continued From page 12 by an Ex.Order 26.4(b)(1)) and Ex.Order 26.4(b)(1) that resulted in emergency room services and hospitalization. This deficient practice was evidenced by the following: On 9/01/21 at 10:11 AM, the surveyor observed Resident #14 seated in a wheelchair at the bedside. The resident had a fabric transfer sling (a device used in conjunction with a mechanical lift to transfer a patient between various surfaces such as a bed to chair) placed beneath their back and lower body in the wheelchair. The resident was Ex.Order 26.4(b)(1) and was unable to be interviewed. According to Resident #14's Face Sheet (an admission summary), the resident was initially admitted to the facility on Ex.Order 26.4(b)(1), and had diagnoses which included but were not limited to: Ex.Order 26.4(b)(1) According to the Significant Change in Status Minimum Data Set (MDS), an assessment tool dated Ex.Order 26.4(b)(1), Resident #14 was readmitted to the facility on Ex.Order 26.4(b)(1), from an acute hospital. Further review of the MDS revealed that the resident had a Brief Interview for Mental Status (BIMS) score of Ex.Ord which indicated that the resident was Ex.Order 26.4(b)(1) . A review of the Functional Status portion of the MDS noted that the resident was totally dependent for transfers and required two-person assistance to transfer from the bed to wheelchair.	F 689	2. In-service for all Certified Nursing Assistants on a Resident-centered education for Resident #14 was completed at the time of discovery. All nursing staff attended education for proper mode of transfer and the use of mechanical lifts. 3. A Quality Assurance and Performance Improvement (QAPI) project was initiated at the time of discovery. Element Two 1. All residents admitted to the skilled unit have the potential to be affected by this practice. Element Three 1. Care plans will be reviewed on a quarterly, or as needed, basis to ensure that mod of transfer reflects the Rehabilitation team□s recommendation by the Interdisciplinary Team. In-service nursing staff on following the designated mode of transportation and transfer competencies. Element Four 1. A random audit will be conducted by the Director of Nursing, or designee, twice a month to monitor that staff are using the proper modes of transfer. a. Two observations will be conducted each month b. This will be monitored by the Director	

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F 689	Continued From page 13 A review of the Care Plan report effective Ex.Order 26.4(b) to present, revealed that Resident #14 required help with activities of daily living (ADLs) due to Ex.Order 26.4(b)(1) related to Ex.Order 26.4(b)(1) diagnosis. An intervention was added to the entry on Ex.Order 26.4(b), for two-person assistance with transfers via Hoyer Lift. Further review of the Care Plan Report included another entry that specified that the resident was at Ex.Order 26.4(b)(1) secondary to needing assistance with ADLs, Ex.Order 26.4(b)(1), and was on medications that may cause Ex.Order 26.4(b)(1). The entry included: On Ex.Order 26.4(b)(1) and Ex.Order 26.4(b)(1) area. Goals included; Ex.Order 26.4(b) to the resident's Ex.Order 26.4(b)(1) area will resolve without any complications, and the resident will not have Ex.Order 26.4(b)(1) x 90 days through 10/31/21. Interventions included that during shower times, the resident's CNA would use 2 assist to move the resident with the Hoyer lift "to carry [Resident #14] from one place to another." A review of the Facility's Accident/Incident Report, dated Ex.Order 26.4(b) and timed 8:00 AM, indicated that Resident #14 had injuries that included a Ex.Order 26.4(b)(1) and Ex.Order 26.4(b)(1)). The Nurse's Note from the "what happened" portion of the form detailed that the CNA called the nurse to inspect the resident's Ex.Order 26 when the resident received morning care. Nursing documented that Ex.Order 26.4(b)(was observed on the Ex.Order 26.4(b)(1). There was Ex.Order 26.4(b)(1) presented under Ex.Order 26.4(b)(1) upon palpation.	F 689	of Nursing, or designee. c. The findings will be presented to the Quality Assurance Committee on a quarterly basis for two quarters, with the committee to determine when said audits can be concluded.	

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The resident demonstrated no signs of discomfort. The "Ex.Order 26.4(b)(1)e Type" was described as a Ex.Order 26.4(b)(1) that measured 12 x 7 x 0 cm. The Ex.Order 26.4(b) was further described as a Ex.Order 26.4(b)(1) to the Ex.Orde. The "Conclusion" was dated Ex.Order 26.4(b)(at 3:42 PM, and detailed that through investigation it was identified that some staff used the Sit to Stand (a device used to transfer patients from one seated surface to another) in which the straps fit underneath the arms, using a stand and pivot technique in which two people interlock their arm underneath the bilateral armpit or the Hoyer Lift device in which resident is positioned on a sling device and mechanically lifted applying no contact to the armpit. Resident #14 was assessed [No date specified] by PT (Physical Therapy) and identified to be a Hoyer Lift [sic.] only for safety. It included that the resident was on Ex.Order 26.4(b)(1), denied Ex.Order at the site, and the Root Cause was "no-fault."

A review of an additional Accident/Incident Report, dated Ex.Order 26.4(b) and timed 6:20 PM, indicated that Resident #14 had an injury that included Ex.Order 26.4(b)(1). The Nurse's Note portion of "what happened" on the form detailed that the resident's assigned aide notified the nurse to assess the resident's Ex.Order 26.4(b)(Upon entering the resident's room, the resident had Ex.Order 26.4(b)(to the Ex.Order 26.4(b)(1), and the Ex.Order 26.4(b)(1); and noted Ex.Order 26.4(b)(1) The resident Ex.Order 26.4(b)(1) nursing assessed the Ex.Order 26.4(b)(1). There was Ex.Order 26.4(b) with movement to the Ex.Order 26.4(b)(1). The resident was Ex.Order 26.4(b)(1) to

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explain how the Ex.Order 26.4 occurred. The physician was called and informed and ordered to transfer the resident to the hospital for further evaluation. The "Conclusion" was dated Ex.Order 26.4 1 at 3:59 PM and detailed that Resident #14 sustained Ex.Order 26.4(b)(1 on the Ex.Order 26.4(b)(1) area from the skin pad area when the aide transferred [sic.] without another assistant [sic.] using the sit to stand [sic] lift. The aide was educated on the proper use of devices. The root cause was "Human Error."

During an interview with the surveyor on 9/03/21 at 11:55 AM, Resident #14's Certified Nursing Assistant (CNA) stated that Resident #14 was dependent for activities of daily living which included bathing, oral care, and feeding assistance. She noted that the prior year, the resident was able to be transferred with the aid of two staff members without the use of a transfer assistive device. The CNA explained that not too long ago, she utilized a Sit to Stand Transfer Assistance Device alone without a second caregiver to transfer the resident to a shower chair, and the resident Ex.Order 26.4(b)(1) the transfer. The CNA stated that she did not know that the resident was injured at the time of the transfer. She noted that the resident only said, "Put me down." She stated that she lowered the resident down as directed and transferred the resident into the shower chair. She noted that the resident did not like the "machine." She further stated the resident later complained of Ex.Order 26.4(b)(1) and was sent to the hospital. She said that she was unsure which Ex.Order 26.4(b)(1) was affected, and when the resident returned from the hospital, she noted that the resident had Ex.Order 26.4(b)(1 which resolved in one week. She stated that the facility provided her with in-service training and informed her that she was required to use a Hoyer lift to

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transfer the resident. She stated that the resident did not like the Hoyer lift and did not want it every time, but once the resident was up in the chair, the resident was okay.

During a subsequent interview, that day, with the surveyor at 1:18 PM, the CNA explained that she knew that she was required to have a second staff member present to assist when she transferred Resident #14 with the use of the Sit to Stand or Hoyer Lift because she had used both devices for this resident. She further stated that before the resident was hospitalized, she transferred the resident alone with the Sit to Stand without the aid of another staff member because she could not find anyone available to help at that time. So, she transferred the resident alone instead.

During an interview with the surveyor on 9/03/21 at 1:23 PM, the Licensed Practical Nurse (LPN) stated that she had begun working at the facility in Ex.Order 26.4(b)(1), and Resident #14 was dependent for ADLs and required two CNAs to transfer with the Hoyer Lift. She stated that one CNA was needed to spot the resident, and one was responsible for handling the machine itself and guiding it to avoid bumps and falls. She stated that the Sit to Stand was not permitted to be utilized for Resident #14. She further stated that she was unsure how the CNA's knew what care to provide for the residents as they had worked at the facility longer than her. She further stated that nursing was required to inform them if there were any changes in the resident's care plan.

During an interview with the surveyor on 9/03/21 at 1:33 PM, the Registered Nurse Unit Manager

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(RNUM) stated that Resident #14 required total care and two-person assistance for transfers using a Hoyer Lift. She noted that the nurses gave the CNAs report in the morning and advised them of any change in the resident's condition. She stated that the resident's care plan illustrated that the resident required two-person assistance to be transferred with the Hoyer Lift. She further noted that a Sit to Stand could not be used for this resident as the Hoyer Lift was ordered with two-person assistance. She explained that the resident was required to be hospitalized after their Ex.Order 26.4(b)(1).

The Director of Rehabilitation (DOR) stated during an interview with the surveyor on 9/03/21 at 3:22 PM, that Resident #14 was seen by Therapy after Ex.Order 26.4(b)(1) status was noted in the resident post-hospitalization from Ex.Order 26.4(b) through Ex.Order 26.4(b). She said that the resident could not sit on the edge of the bed independently and required two-person assistance. She stated that the resident had a variable Ex.Order 26.4(b)(1) and the staff often went by the resident's wishes. She maintained the resident was assessed in Ex.Order 26.4(b)(1) and required a Hoyer lift for all transfers. She said the resident was unsafe to use a Sit to Stand transfer device as of Ex.Order 26.4(b)(1) after the resident demonstrated non-compliance for therapy sessions. She further stated that a "Nursing and CNA Communication" was completed at that time, though she was unsure if she had a copy.

A review of an Occupational Therapy (OT) Daily Treatment Note dated Ex.Order 26.4(b)(1), revealed that the DOR, an Occupational Therapist, documented that Resident #14 demonstrated noncompliance for therapy sessions, Sit to Stand Lift and difficulty

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for transfers. The Hoyer Lift was recommended as a safe and optimal mode of transfer.

During an interview with the surveyor on 9/07/21 at 10:38 AM, the DOR stated that the Administrator confirmed a "Nursing to Therapy Referral" was done in Ex.Order 26.4(b)(1), and staff received training specific to Resident #14 and the use of the Hoyer Lift for transfer. When the surveyor inquired why Resident #14 was determined not to be safe to use the Sit to Stand Transfer Device, the DOR stated that a person must be able to stand up and hold onto the bars while standing for the device to be deemed appropriate for resident transfers. She explained that the resident must have some ability to bear weight and have shoulder range of motion. The machine helped them to bear weight. She explained that if a resident was not compliant or not cognitively intact, they may give up, and it was a safety risk if the resident fell, or staff may have to lift them. She stated that the resident might not fall on the ground because they were harnessed, but they may try to let go or try to sit down. She stated that the resident must have the ability to follow directions and that two people were needed during transfers if something went wrong.

The DOR further explained that a Hoyer Lift was used for a resident with total dependence, with no partial control. She stated that therapy would not even consider a Sit to Stand if a resident was dependent. She said two people were needed to guide the Hoyer Lift and the sling if "they acted up" or something went wrong for safety. She stated that if the resident was prone to behaviors and was noncompliant with a Sit to Stand Device, it could cause pressure on the skin and cause bruising. She further stated that the aides must

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F 689	Continued From page 19 follow the instructions that they have been given. During an interview with the surveyor on 9/07/21 at 10:54 AM, the Director of Nursing (DON) stated the probable cause of the injury was related to the resident transfer. She stated that the staff received a follow-up staff in-service in August 2021 after the CNA used the Sit to Stand alone instead of with two persons as required for both resident and staff safety so that no one got hurt. She stated that the CNA transferred Resident #14 alone, which resulted in Ex.Order 26.4(b)(1) She stated that the nurse saw the Ex.Order 26.4(b)(1) and sent the resident to the hospital as the resident Ex.Order 26.4(b)(1). She noted that the resident held their Ex.Order 26.4(b)(1) and that the nurse reported Ex.Order 26.4(b)(1) but the cause was unknown. She stated, "initially, we thought that it was a fall, then we thought someone fought her." Then the Administrator reviewed the cameras that were present in the hallway and saw "two persons" go into the resident's room. Further review of the video revealed that the CNA took the resident to the shower room via wheelchair. She stated that when she got to the shower room, she took the Sit to Stand into the shower room alone. When interviewed, the CNA admitted that she transferred the resident alone with the Sit to Stand because she could not find anyone to assist her. The DON stated that the CNA did not want to wait for another aide to be free and transferred the resident by herself. The DON said that the resident had a Ex.Order 26.4(b)(1) when they called the hospital the next day. She further stated that was why they reviewed the camera. The DON said that the nurse documented the incident in the 24-Hour Report and called her to inform her of the resident's condition.	F 689		

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A review of the 24-Hour Report dated Ex.Order 26.4(b)(1) documented on the 3-11 PM shift under Safety Precautions, revealed the following: Patient (Resident #14) had Ex.Order 26.4(b)(1) area. Ex.Order 26.4(b)(1) for [sic.] Ex.Order 26.4(b)(1) when Ex.Order 26.4(b)(1). Doctor informed, ordered to transfer the patient to the hospital. POA (Power of Attorney) and DON informed.

During an interview with the surveyor on 9/07/21 at 11:50 AM, the Administrator stated that he was informed by the assigned Registered Nurse (RN) that Resident #14 had Ex.Order 26.4(b)(1) and that the doctor wanted to send the resident out to evaluate the Ex.Order 26.4(b)(1) noted on the Ex.Order 26.4(b)(1). He stated that he initiated an investigation and did not suspect abuse based on the information presented to him.

During an interview with the surveyor on 9/07/21 at 12:51 PM, the MDS RN stated that Resident #14 was recently sent out to the hospital and experienced an Ex.Order 26.4(b)(1) after readmission to the facility. She stated that the resident had required the total assistance of two persons to transfer with a Hoyer Lift. She said that meant that the resident was totally dependent and was unable to participate in transfers. She stated that the resident was determined to have required extensive assistive of two persons according to the quarterly MDS dated Ex.Order 26.4(b)(1), as the resident may not have needed staff assistance and was lifted instead. She stated that she obtained the information from observation and interview with nurses and staff and documentation review. She further stated that in Ex.Order 26.4(b)(1), the resident

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either did not require a Hoyer Lift Transfer or if, the resident got scared and refused, two aides may have assisted the resident in transferring instead of using a Hoyer Lift. She further stated that she reviewed a seven-day look-back period which indicated that she would have coded the observation accordingly as a "3/3", extensive assistance of two persons rather than a "4/3", total dependence of two-person physical assistance as the resident has been coded since that time period.

During a later interview with the surveyor on 9/07/21 at 3:19 PM, the Administrator stated that he obtained statements from the CNAs. He said through investigation, he learned of an error that occurred when Resident #14 was transferred improperly. He stated that this led to 1:1 education, abuse education, and disciplinary action for the involved CNA. He said that the CNA had an in-service in Ex.Order 26.4 about transfers, abuse, and following the Care Plan. He further stated that the CNA noted that she did not see anyone outside of the shower room and thought she could transfer the resident with the Sit to Stand by herself and made a poor decision not to transfer the resident the right way. The Administrator could not provide the surveyor with documented evidence of the CNA's in-service in Ex.Order 26.4(b)(1).

During a phone interview with the surveyor on 9/08/21 at 9:04 AM, the Registered Nurse (RN) stated that she recalled that she sent Resident #14 out to the hospital during the 3 to 11 PM shift when the CNA informed her that the resident had Ex.Order 26.4(b)(1). She stated that when she touched the affected area, the resident Ex.Order 26.4(b)(1). She said that Ex.Order 26.4(b)(1) was "huge"

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from the Ex.Order 26.4(b)(1). She stated that it looked like the resident fell or someone grabbed him/her. The RN further noted that the resident Ex.Order 26.4(b)(1), which was out of character for them. She stated that she observed a Ex.Order 26.4(b)(1) that was hard to touch. She said that she reported it to the DON and called the physician.

During a phone interview with the surveyor on 9/08/21 at 9:25 AM, Resident #14's physician described the resident as elderly, with Ex.Order 26.4(b)(1) He stated that the resident had Ex.Order 26.4(b)(1) which was Ex.Order 26.4(b)(1). He noted that the resident was sent to the ER, where the hospital indicated that there had been Ex.Order 26.4(b). He stated that the resident was unable to communicate what happened due Ex.Order 26.4(b)(1). He noted that the resident had an Ex.Order 26.4(b)(1)) that was treated with Ex.Order 26.4(b)(1).

A review of Resident #14's Hospital Records for admission date Ex.Order 26.4(b)(through discharge date of Ex.Order 26.4(b) revealed that the principle discharge diagnoses was Ex.Order 26.4(b)(1). Details of Hospital Stay/Hospital Course included:..."According to transfer papers, the staff at the skilled nursing facility noticed Ex.Order 26.4(b)(1) and the patient was transferred to the hospital for evaluation. There were no signs of Ex.Order 26.4(b)(. They were, however, noted to have Ex.Order 26.4(b)(1) and it was unclear if they fell at the nursing home. An Ex.Order 26.4(b)(1) showed a large Ex.Order 26.4(b)(1)). An Ex.Order 26 of the Ex.Order 26.4(b)(r showed suspected Ex.Order 26.4(b)(1)

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F 689	Continued From page 23	F 689		

Ex.Order with Ex.Order 26.4(b)(1) . Ex.Order 26.4(b)(1) showed a large Ex.Order 26.4(b)(1) . Patient was evaluated by surgery, and Ex.Order 26.4(b)(1) was recommended ...Patient is Ex.Order 26.4 for transfer back to the skilled nursing facility."

A review of a Physician's Progress Note dated Ex.Order 26.4 revealed that Resident #14's attending physician saw the resident after readmission to the facility and documented that the resident's Ex.Orde was evaluated by surgery and was felt to be a Ex.Order 26.4(b)(1)

On 9/08/21 at 9:52 AM during an interview with the surveyor , in the presence of the survey team, the CNA stated that nursing did rounds with her in the morning before she began her day to inform her of resident care needs. However, she stated that did not happen every day. She said that she used a Hoyer Lift to get Resident #14 out of bed since last year. She stated that prior to that, the resident was able to participate in transfers "a little" and was able to bear some weight with two-person assistance. When the resident became difficult to transfer, she reported it to the nurse. Therapy evaluated the resident and told her that the resident required a Hoyer lift to get out of bed and into bed. She stated that when she took the resident into the shower room, she had to use the Sit to Stand because she could not use the Hoyer Lift in the shower room; She used a shower chair because the facility did not have a shower bed. She stated that Therapy did not instruct her to use the Sit to Stand in the shower, but she knew how to use it, and that nursing delegated approval to use the Sit to Stand in the shower. She stated that she had access to the resident's Care Plan on the computer but had not

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F 689	Continued From page 24 reviewed it. She said that she received a [redacted] due to improper resident transfer of Resident #14. She stated that she had not utilized the Sit to Stand since that time and had instead washed the resident in the bed. The surveyor reviewed the facility policy, "Mechanical Lift For Transfers" (revised November 2017), which revealed the following: Policy: To safely transfer elders who are unable to stand and pivot and/or require lifting to move from bed to chair. Procedure: At least two people are required to transfer an elder using a mechanical lift. NJAC 8:39-27.1(a)	F 689		
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		10/23/21

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F 812	Continued From page 25 standards for food service safety. 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: a) properly handle and store potentially hazardous foods in a manner that is intended to prevent the spread of food borne illnesses; and, b) maintain equipment and kitchen areas in a manner to prevent microbial growth and cross contamination. This deficient practice was observed and evidenced by the following: On 8/31/21 from 9:42 AM until 10:46 AM, the surveyor toured the kitchen in the presence of the Food Service Director (FSD) and observed the following: 1. In the freezer there was one 18.75 pound unsealed, opened box of cinnamon roll dough with the inner clear plastic bag opened with the rolls visible and exposed to air and no opened date. There was one 20 pound unsealed, opened box of oatmeal raisin cookies that were dated opened 8/16 with the inner clear plastic bag opened and the rolls visible and exposed to air. There was one 18 pound unsealed, opened box of Italian loaf rolls with the inner clear plastic bag opened with the rolls visible and exposed to air and no opened date. There was one opened, unsealed brown bag that the FSD identified as French fries that were not labeled or dated. There was one clear plastic bag of French fries wrapped in clear plastic wrap that had no open date. During an interview at that time, the FSD acknowledged the boxes should have opened	F 812	Element One All residents have the potential to be affected by this practice: 1. In-service dietary staff on the policy and procedure of proper labeling and storage of frozen foods. The orientation checklist developed for all dining employees will be updated to include proper labeling and storage of frozen foods. All undated items were discarded including all spices identified, dented cans removed and discarded, cutting boards were replaced. Can opener , oven and slicer were cleaned and sanitized. Oatmeal raisin cookies were discarded. Wet nested pot was removed from the rack, rewashed and dried according to New Jersey Department of Health state regulations. 2. In-service all dietary staff on the proper labeling and storage of dry goods including removing dented cans from use and how to properly store away from usable cans. The orientation checklist for all dining employees will be updated to include proper labeling and storage of dry goods. 3. In-service all dietary staff on labeling spices of date when opened. Spices and dry goods will be discarded after 1 year.	

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F 812	Continued From page 26 dates so they know the food items are not old. 2. In the dry storage area on a metal rack, there were two 6 pound 10 ounce cans of mandarin oranges that were dented. The FSD acknowledged they were dented and moved them to the dented can section. On another metal rack, there were six tied clear plastic bags the FSD identified as cranberries with no label or dates. There was one untied clear plastic bag with contents that fell to the floor, with no label or date which the FSD identified as cranberries. On a metal rack was one opened bag of linguine wrapped in clear plastic wrap with no opened date. During an interview at that time the FSD stated the cranberries should have been sealed to keep them safe from bacteria. The FSD further stated that the cranberries and the linguini should have had an open and use by date. 3. On the spice rack there was: one opened 12 ounce jar of gumbo file spice with no open date, one opened 18 ounce jar of mild chili powder with no open date, one opened 17 ounce jar of smoked paprika with no open date, one 14 ounce jar of ground cumin with no open date, one 14 ounce jar of whole fennel seeds with no open date, and one 16 ounce jar of whole caraway seeds with no open date. The FSD acknowledged the spices did not have open dates and stated they should have been dated when opened. 4. In the free-standing ice cream freezer there was one opened 3 gallon covered container of chocolate ice cream with no open date. There was one opened 3 gallon covered container of vanilla ice cream with no open date. There was	F 812	4. In-service all dietary staff on labeling ice cream containers of date when opened. Ice cream will be discarded after 60 days. 5. Ovens will be checked on a nightly basis for cleanliness and added to nightly checklist. Ovens will be cleaned weekly on Mondays and as needed if noted to be dirty prior. All utility staff will be in serviced on proper cleaning. 6. In-service utility staff on wet nesting and proper storage of food pans and any equipment that can pool water droplets. Staff will be instructed to allow sufficient time to air dry tools, equipment and pans before stacking / at their storage locations. 7. Discard all worn cutting boards and purchased new. In-service all dining staff on proper cleaning and sanitizing of cutting boards and when to discard if not in good repair. 8. In-service staff on properly cleaning the can opener and nightly checks by closing dining manager to ensure can opener is clean. 9. In-service all staff trained to use slicer on proper cleaning techniques and how to properly store the clean slicer. Competency testing to be completed on all staff trained to use slicer on the proper cleaning and storage procedures. 10. In-service dietary staff on the policy	

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F 812	Continued From page 27 one opened 3 gallon covered container of moose tracks ice cream with no open date. The FSD stated he was unsure when they were opened and they would be discarded. 5. On the top convection oven there was a brown sticky substance on the outer panel of the right door, a brown substance on both inner glass doors and a brown substance on the surrounding trim. On the lower convection oven there was a brown substance on both inner glass doors and a brown substance on the surrounding trim. The FSD acknowledged they were dirty and stated they were cleaned weekly. 6. On the top rack of the drying rack was one "third pan" that was nestled on top of another pan. The FSD separated the two nesting pans where the surveyor observed moisture between the pans. The FSD acknowledged they were wet with water, stated it should be dry and removed the pan to the dishwashing area. 7. There was one large white cutting board with several thin brown lines and one large yellow cutting board with a few thin brown lines and two black smudges. The FSD acknowledged they were dirty, stated they would be cleaned, and removed them to the sanitizing sink. 8. At the cook's station was: one 6 ounce jar of rubbed sage with no opened date, one 18 ounce jar of ground cinnamon with no opened date, one 12 ounce jar of crushed red pepper with no opened date, one 18 ounce jar of mild chili powder with no opened date, and one 18 ounce jar of cajun seasoning with no opened date. 9. There was black debris on the can opener and	F 812	and procedure of proper labeling and storage of frozen foods. The orientation checklist for all dining employees will be updated to include proper labeling and storage of frozen foods. 11. In-service dietary staff on the policy and procedure of proper labeling and storage of refrigerated foods. Weekly kitchen audits include checking for proper labeling and dating of items. Element Two 1. All residents admitted to the skilled unit have the potential to be affected by these practices. Implement a quality improvement checklist that monitors all areas of the kitchen sanitation and dining services to help maintain standards of practice. Audits will be done daily, weekly and monthly and will be reported to the dining Services Director, or designee, and reported at the quarterly Quality Assurance Committee meetings for two quarters. Element Three 1. The Health care training manual will be updated and monthly in-service agendas will review proper procedures. Competency tests will also be given monthly to demonstrate the employees knowledge of the proper procedure, at random.	

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F 812	Continued From page 28 black debris on the base connected to the counter. The FSD stated it was not clean and it should be cleaned after every use so you don't cross contaminate. 10. There was a clear plastic bag covering the meat slicer. The FSD removed the bag and the surveyor observed red and brown debris on the blade and on the food tray. During an interview at that time, the FSD acknowledged the slicer had debris and it was not clean. He stated it was important to clean and bag the slicer after use so no one gets sick. On 9/01/21 from 12:02 PM until 12:24 PM, the surveyor toured the kitchen in the presence of the Executive Chef (EC) and observed the following: 1. In the freezer was one metal dessert rack with two metal trays each containing 15 individual clear plastic containers that the EC identified as containing one sticky bun and one muffin, all with no label or date. There was one metal tray containing 10 individual clear plastic containers that the EC identified as containing assorted desserts, all with no label or date. There was one metal tray containing 5 individual clear plastic containers that the EC identified as containing assorted desserts, all with no label or date. The EC stated that the containers would be disposed of. There was one 4 inch half pan containing 15 meat patties individually wrapped in clear plastic that the EC identified as Canadian bacon, with no label and no dates. The EC threw the patties in the garbage. During an interview at that time the EC acknowledged there were "no tags" and stated it	F 812	2. Daily, weekly and monthly audits will be conducted by the Dining Director and /or Designee as part of our quality improvement program. This will be implemented to monitor each of the deficient practices in addition to ensure all standards of practice will be maintained. 3. Quality improvement audits conducted by Dining Services Managers and by the Registered Dietitian as designated by the Dining Services Director. 4. Scores are reported to the Dining Services Director for review upon completion and to devise a corrective plan if necessary. Element Four 1. Quality improvement audit results will be reported to the Dining Service Director, or designee, upon completion for review to ensure the scores meet the acceptable threshold. 2. If quality improvement Plan of Correction is needed for an audit it will be initiated immediately by the Food Service Director, or designee, and include other Interdisciplinary team members. The Plan of Correction will be reviewed by the Administrator and reported at the quarterly Quality Assurance Committee meetings with Interdisciplinary team for two quarters. Dining Service	

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F 812	Continued From page 29 was important to label items correctly so everyone would know if it was good or bad, to prevent freezer burn, and so it would have an expiration date. 2. In the walk-in refrigerator there was one 4 inch six pan containing a thick red gelatinous material that the EC identified as pureed tomato with no label and no date. The EC stated it should be labeled and dated and threw it away. A review of the facility's policy "General Food Preparation and Handling", with a revision date of 5/23/2018, revealed Procedure: 1.a. The kitchen surfaces and equipment will be cleaned and sanitized as appropriate. 3. Food preparation: e. cutting boards will be cleaned and sanitized after each use, following the dish machine or 3 compartment sink method, and will be air dried before storing. k. The can opener will be cleaned and sanitized daily and/or as needed. 5. Equipment: a. All food service equipment should be cleaned, sanitized, air-dried, and reassembled after each use. A review of the facility's policy "Food Safety and Sanitation", with a revision date of 5/30/2018, revealed 3. Bulging or leaking cans, cans with severe dents on the seams, or broken containers of food will not be used. They will be returned to the vendor or discarded. 4. Food storage: when a food package is opened, the food item should be marked to indicate the open date. This date is used to determine when to discard the food. A review of the facility's policy "Cleaning Dishes/Dish Machine", with a revision date of 5/30/2018, revealed Procedure: 11. Dishes should not be nested unless they are completely	F 812	Director/Designee will ensure acceptable threshold is met for entire quality improvement process.	

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F 812	Continued From page 30 dry. A review of the facility's policy "Cleaning Instructions: Slicers", with a revision date of 5/24/2019, revealed Policy: the slicer will be cleaned and sanitized after each use. Review of the facility's policy "Accepting Food Deliveries", with a revision date of 5/23/2018, revealed Procedure: 4. Perishable foods will be properly covered, labeled and dated and promptly stored in the refrigerator or freezer as appropriate. A review of the facility's policy "Food Storage", with a revision date of 5/24/2019, revealed Procedure: 3. Plastic containers with tight-fitting covers must be used for storing cereals, cereal products, flour, sugar, dried vegetable, and various bulk foods. All containers must be legible and accurately labeled and dated. 6.b. Food should be dated as it is placed on the shelves. 6.c. Food should be dated when the original container or packaging is opened. 6.d. Date marking to indicate the date or day by which a ready-to-eat, time/temperature control for safety food should be used will be visible on all high-risk food. 10.d. Refrigerated foods will be dated and stored upon delivery. 10.g. All foods should be covered, labeled, and dated. 11.c. Frozen foods will be dated upon delivery. 11.d. All foods should be covered, labeled and dated. NJAC 8:39-17.2(g)	F 812		
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	F 880		10/28/21

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F 880	Continued From page 31	F 880		

infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

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F 880	Continued From page 32 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to maintain infection control standards and procedures to address the risk of infection transmission by failing to perform a Ex.Order 26.4(b)(1) in a safe and sanitary manner for 1 of 1 nurse observed providing a Ex.Order 26.4(b)(1) treatment to 1 of 1 resident, (Resident #2). This deficient practice was evidenced by the following: On 8/31/21 at 11:39 AM, the surveyor observed	F 880	Element One All residents have the potential to be affected by this practice: 1. In-service education was immediately provided to the nursing staff that provided treatment for Resident #2. Staff was given education on providing Ex.Order 26.4(b)(1) and infection control standards. Ex.Order 26.4(b) [redacted] competencies were conducted as well. Resident #2 was monitored for signs and symptoms for Ex.Order 26.4(b)(1). Physician/Nurse Practitioner is made	

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F 880	Continued From page 33 Resident #2, nonverbal, seated in a recliner chair in his/her room, with a Ex.Order 26.4(b)(1) [redacted] According to the Face Sheet, Resident #2 was admitted to the facility in Ex.Order 26.4(b)(1) [redacted] with diagnoses that included but were not limited to Ex.Order 26.4(b)(1) [redacted] A review of Resident #2 Quarterly Minimum Data Set (MDS), an assessment tool, dated Ex.Order 26.4(b) [redacted], revealed that the resident's Brief Interview for Mental Status (BIMS) score Ex.Order [redacted] indicated that the resident had Ex.Order 26.4(b)(1) [redacted]. A review of the Ex.Order [redacted] portion of the MDS indicated that the resident had Ex.Order 26.4(b)(1) [redacted]. Further review revealed the resident required extensive to total dependency for bed mobility, dressing, toilet use and personal hygiene. On 9/07/21 at 09:46 AM, the surveyor observed the Registered Nurse (RN) perform Ex.Order 26.4(b [redacted] treatments on Resident #2 and observed the following: The surveyor observed the RN remove a pair of metal scissors from her pocket. She then applied alcohol-based hand rub (ABHR) on a piece of gauze, cleaned the scissors and placed them on the over bed table. She then donned gloves and used the scissors to remove Ex.Order 26.4(b)(1) [redacted] from Resident #2's Ex.Order 26.4(b)(1) [redacted]. The RN removed her gloves, without performing hand hygiene, walked to the treatment cart, reached into her pockets for the keys to open the cart, and removed a roll of one inch tape. She placed the tape on the	F 880	aware of break in technique. 2. In-service training will be provided for all nurses regarding: a. Performing wound care b. Cleaning and disinfecting of equipment c. Hand hygiene d. Infection control Clean dressings Education will be completed in accordance with Directed Plan of Correction(DPOC) a. Module 1: Nursing home infection preventionist- topline staff and infection prevention b. CDC COVID-19: Keep COVID-19 out- Frontline staff c. CDC COVID-19: Sparkling Surfaces- Frontline staff d. CDC COVID-19: Clean hands- Frontline staff e. Module 5- outbreaks- Topline staff and infection preventionist f. Module 11B- Environmental and disinfection- All staff including frontline staff, topline staff and infection preventionist g. Module 7- Hand hygiene- All staff including frontline, topline staff and infection preventionist h. Module 6A- Principles of Standard precautions- All staff including frontline staff,topline staff and infection preventionist Element Two	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315486	A. BUILDING _____ B. WING _____	09/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	100 HOLLINSHEAD SPRING ROAD SKILLMAN, NJ 08558

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 34 overbed table with the other Ex.Order 26.4(b)(1) supplies. She then performed hand hygiene and donned gloves. The RN, with gloved hands, used the bed controller to elevate the resident's head. She picked up the plastic garbage bag, that had fallen on the floor. The RN, without changing gloves or performing hand hygiene, removed a piece of 4 x 4 gauze from a cup that contained normal saline solution and several other 4 x 4 gauze in it. Wearing the same gloves, the RN removed the gauze from the cup and separated one piece of gauze. She then returned the remaining gauze to the cup and Ex.Order 26.4(b)(1) She removed the gloves and performed hand hygiene. She donned gloves, then removed a piece of gauze from the same cup and Ex.Order 26.4(b)(1) She removed the gloves and performed hand hygiene. She opened a Ex.Order 26.4(b)(1) and squeezed the Ex.Order 26.4(b)(1) on a piece of folded gauze. The RN did not apply gloves before applying the Ex.Order 26.4 to Resident #2's Ex.Order 26.4(b)(1) and covering the Ex.Order 26.4(b)(1) with a Ex.Order 26.4(b)(1). When interviewed that day, the RN stated she usually used disinfectant wipes to clean the scissors and did not know why she used the ABHR. When asked about not wearing gloves and cross contamination during the Ex.Order 26.4(b)(1), she stated she did not remember doing those things and she was nervous. She stated she would normally wear gloves and should have worn gloves during the Ex.Order 26.4(b)(1). During an interview with the surveyor on 9/07/21 at 1:55 PM, the Director of Nursing (DON) stated	F 880	1. All residents admitted to the skilled unit have the potential to be affected by this practice. 2. All residents admitted to the skilled unit who require wound care have the potential to be affected. Element Three 1. Competencies will be conducted on all nurses annually by Director of Nursing, and/or designee, through observations a. Findings will be presented to the Administrator and to the Quality Assurance Committee on a quarterly basis for two quarters. 2. Audits of wound care will be conducted at random on a monthly basis by the Director of Nursing and/or Designee. a. Findings will be presented to the Administrator and to the Quality Assurance Committee on a quarterly basis for two quarters, with the committee to determine when said audits can be concluded. 3. Infection preventionist will provide education to the nursing staff for infection control and hand hygiene. 4. A Root Cause Analysis was conducted. The staff member was confident in the process but the error was made due to feeling nervous and under pressure with the surveyors observing the entire treatment.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315486	A. BUILDING _____ B. WING _____	09/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	100 HOLLINSHEAD SPRING ROAD SKILLMAN, NJ 08558

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F 880	Continued From page 35 the RN should not have used ABHR to clean the scissors and she should never perform treatments with bare hands. On 09/07/21 at 03:30 PM, the surveyor informed the Administrator of the findings. The surveyor reviewed the facilities policy titled, "General Guidelines Wound and Skin Care" dated 07/22/21, which revealed the facility would use clean technique when performing dressing change. The surveyor reviewed a "Clean Dressing Competency" used by the facility which revealed a clean pair of gloves should be used when cleaning wound, performing treatment, and redress wounds. Further review revealed the overbed table should be cleaned with germicidal wipes. NJAC 8:39-19.4(a)	F 880	Element Four 1. Director of Nursing, or designee, will present findings of audits to the Quality assurance Committee on a quarterly basis for two quarters. a. This will be monitored by the Director of Nursing, or designee 2. Director of Nursing, or designee, will prevent findings of competencies to the Quality assurance Committee on a quarterly basis for two quarters. a. This will be monitored by the Director of Nursing, or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	806112	A. BUILDING: _____ B. WING _____	09/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CE	100 HOLLINSHEAD SPRING ROAD SKILLMAN, NJ 08558

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments The facility 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 observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	Element One All residents who live in our healthcare center have the potential to be affected by this practice. 1. Staffing ratios are reviewed daily by our scheduler and Director of Nursing. Staffing levels are compared to the census each day and replacement efforts are taken accordingly. A log is kept for efforts made to replace an open shift or a call out. This log serves as a record for who was contacted to fill an open shift. Element Two	10/16/21

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

Electronically Signed | 10/01/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	806112	A. BUILDING: _____ B. WING _____	09/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CE	100 HOLLINSHEAD SPRING ROAD SKILLMAN, NJ 08558

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 nursing homes. The following ratio(s) were effective on 2/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. On 9/07/21 at 10:24 AM, the surveyor reviewed the 7-3 shift unit assignment sheet which had 3 CNA's assigned for 29 residents. During an interview with the surveyor on at 9/07/21 11:20 AM, a CNA on the unit stated that she was assigned to ten residents that day and that there were usually four CNA's assigned, but an aide was scheduled off. The surveyor requested staffing reports for the weeks of 8/15/21 and 8/22/21. A review of the "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" revealed the following dates and shifts that the facility did not meet the minimum staffing requirements: 7-3 shift: 8/15/21,8/16/21,8/17/21,8/19/21,8/20/21,8/21/21, 8/22/21,8/23/21, 8/28/21.	S 560	1. All residents have the potential to be affected by this practice. Element Three 1. Stonebridge continues to increase our recruiting efforts for Certified Nursing Assistants. Incentive programs such as sign-on bonuses, referral bonuses, and increased rates have been implemented in an effort to attract and retain staff. We have contracted with staffing agencies and contacted them when a shift is needed to be filled. 2. Clinical staff- Therapists, LPNs, RNs and MDS, have assisted with activities of daily living when support is needed. 3. Certified nursing assistants are asked to stay an extra shift when there is a gap in our schedule. Element Four 1. The facility will continue to monitor staffing levels and ratios for each shift, each day. The staffing compliance will be presented on a quarterly basis to the Quality Assurance Committee meeting for two quarters. 2. Recruitment efforts will continue and results will be tracked.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	806112	A. BUILDING: _____ B. WING _____	09/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 2 3-11 shift: 8/18/21 staffing reflected that fewer than half of the evening staff were CNA's. During an interview with the surveyor on 9/07/21 at 1:29 PM the staffing coordinator stated that she utilized a spreadsheet to determine staffing. During an interview with the surveyor on 9/07/21 at 3:16 PM, the Administrator stated that staffing was a struggle and the facility was scheduled to be full staff most days.	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
315486 Y1	A. Building B. Wing Y2	11/16/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	100 HOLLINSHEAD SPRING ROAD SKILLMAN, NJ 08558

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 F0609	Correction	ID Prefix F0610	Correction	ID Prefix F0689	Correction
Reg. # 483.12(c)(1)(4)	Completed	Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	10/16/2021	LSC	10/16/2021	LSC	10/23/2021
ID Prefix F0812	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	10/23/2021	LSC	10/28/2021	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	
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?
9/9/2021	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
806112	A. Building B. Wing	11/16/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	100 HOLLINSHEAD SPRING ROAD SKILLMAN, NJ 08558

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 10/16/2021	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
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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	
9/9/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315486	A. BUILDING **01** B. WING _____	**09/09/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	**100 HOLLINSHEAD SPRING ROAD** **SKILLMAN, NJ 08558**

(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 This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/09/2021 Stonebridge Montgomery was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Stonebridge Montgomery is a two story Type II Un-Protected building that was built in November 2004. The facility is divided into 10 smoke zones.	K 000		
K 291 SS=D	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: Based on observation, and interview, it was determined that the facility failed provide a battery backup emergency light above the emergency generator's transfer switch, independent of the building's electrical system and emergency generator in accordance with NFPA 101:2012 - 7.9, 19.2.9.1.	K 291	Element One Emergency Lighting: Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. Element Two	10/16/21

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

Electronically Signed | 10/01/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315486	A. BUILDING **01** B. WING _____	**09/09/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	**100 HOLLINSHEAD SPRING ROAD** **SKILLMAN, NJ 08558**

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K 291	Continued From page 1 This deficient practice was evidenced by the following: During the building tour with the facility Director of Facilities Services (DFS) on 9/09/2021 at 12:32 PM, an inspection inside the Main Electrical room where the generators three (3) transfer switches were located was performed. The surveyor observed the Main Electrical room was not equipped with emergency lighting independent of the building's electrical system and emergency generator. This finding was verified by the facility's DFS at the time of inspection. The Administrator was notified of the above findings during the Life Safety Code exit conference on 9/09/2021 at 2:10 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	All residents have the potential to be affected by this practice. Element Three Emergency lighting has been installed with at least a 1 ¿ hour rated duration above the emergency generator□s transfer switch that is independent of the building□s electrical system and emergency generator. This has been added to the monthly fire exit sign checklist to ensure proper functioning. Director of Facilities, or Designee, will monitor monthly checklists. Element Four The results of the monthly audits will be presented at the Quality Assurance Committee quarterly, for two quarters.	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and review of facility documentation on 9/09/2021, in the presence of facility management, it was determined the facility failed to perform and document on the tag attached to the fire extinguisher a monthly visual	K 355	Element One Portable Fire Extinguishers are selected, install, inspected, and maintained in accordance with NFPA 10, Standard for	10/16/21

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 355	Continued From page 2 examination for 2 of 25 fire extinguishers, as required by code and National Fire Protection Association (NFPA) 10 and N.J.A.C. 5:70. requirements. This deficient practice was evidenced by the following: Reference: NFPA 10 Edition 2010 Standard for portable fire extinguishers reads: 7.3 Maintenance; 7.3.1.1 All Fire Extinguishers; 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. According to NFPA 10- 4-3.4, at least monthly the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguisher. During the building tour starting at 10:40 AM in the presence of the facility's Director of Facilities Services (DFS), the surveyor observed 25 fire extinguishers in various locations throughout the basement, first and second floors. The surveyor observed that the fire extinguishers were last annually inspected December 2020 which was documented on the tags attached to the fire extinguishers. The surveyor observed two fire extinguishers that had no evidence of a monthly visual examinations being performed and documented on the tags attached to two fire extinguishers in the following locations:	K 355	Portable Fire Extinguishers. Documentation on the tag attached to the fire extinguisher was incorrect for 2 of 25 fire extinguishers. Element Two All residents have the potential to be affected by this practice. Element Three Checklist completion is to be performed by the Maintenance Department along with other monthly checklist/Life Safety items. This will be monitored as part of the monthly Life Safety Program. Element Four Audits will be conducted at random by Director of Facilities, or designee. Will be completed monthly to ensure all extinguishers are charged and operational. Audit findings will be presented at the Quality Assurance Committee meeting quarter, for two quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315486	A. BUILDING **01** B. WING _____	**09/09/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	**100 HOLLINSHEAD SPRING ROAD** **SKILLMAN, NJ 08558**

(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
K 355	Continued From page 3 1) At 11:35 AM on the second floor, one ABC type fire extinguisher next to stairwell #3 (and across from Resident room #238) had no evidence of a monthly examination documented on the tag attached to the extinguisher for June and July 2020. 2) At 12:20 PM on the first floor, one ABC type fire extinguisher inside elevator #5 mechanical room had no evidence of a monthly examination documented on the tag attached to the extinguisher for June and July 2020. Later at 2:02 PM, a review of the facility provided monthly fire extinguisher check list was performed. Although the June 28, 2021 and July 28, 2021 list was checked as being inspected, there was no evidence documented on the tags attached to the two extinguishers. The Administrator was notified of the above findings during the the Life Safety Code exit conference on 9/09/2021 at 2:10 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 10.	K 355		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315486	A. Building 01 - STONEBRIDGE AT MONTGOMERY B. Wing	11/16/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	100 HOLLINSHEAD SPRING ROAD SKILLMAN, NJ 08558

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 Reg. # NFPA 101 LSC K0291	Correction Completed 10/16/2021	ID Prefix Reg. # NFPA 101 LSC K0355	Correction Completed 10/16/2021	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	
9/9/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO