STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315506	A. BUILDING _____ B. WING _____	C 02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (WASHINGTON TWP)	378 FRIES MILL ROAD SEWELL, NJ 08080

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F 000	INITIAL COMMENTS Complaint #: NJ160476, NJ160621, NJ160714, NJ160982, and NJ161004 Census: 118 Sample Size: 27 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey. Survey date: 02/17/2023 - 02/24/2023	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		3/24/23

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

Electronically Signed | 03/17/2023

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ160714 and #NJ160621 Based on record review, interviews, facility document review, and facility policy review, it was determined that the facility failed to ensure residents were treated with dignity and respect. Specifically, the facility failed to provide timely call light response times for 5 (Residents #19, #2, #3, #4, and #7) of 7 residents reviewed for call light response. This has the potential to affect all residents. Findings included: The facility's undated policy, titled, "Call Light," indicated, "Answer call lights in a prompt, calm, courteous manner. Staff, regardless of assignment, answer call lights." The policy also stated, "Turn off call light should not be turned off until request is met. Respond to request or, if unable to do so, refer request to appropriate staff	F 550	Residents number 2, 3, 4, and 7 have been EX Order 26 § 4b1. Resident # 19 was interviewed and verbalized a delay in answering call light. Resident # 19 happy to learn staff is being educated on importance of answering call lights timely. Resident # 19 had no negative outcome. All residents have the potential to be affected by delay in call bell response. All departments: Nursing, Dietary, Environmental Services, Therapy and Activity staff will be re-educated by the Administrator or designee on call light procedure so that call lights are answered in a prompt and courteous manner. The administrator or designee will conduct call light audits weekly and will provide report to QA x 3 months.	

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F 550	Continued From page 2 member as soon as possible." 1. A review of an "Order Summary Report" indicated the facility admitted Resident #19 with diagnoses that included EX Order 26 § 4b1 [redacted] The admission Minimum Data Set (MDS), dated 02/10/2023, revealed Resident #19 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident was [redacted]. The resident required EX Order 26 § 4b1 [redacted] Review of Resident #19's care plan, with an initiation date of EX Order 26 § 4b1, revealed the resident was at EX Order 26 § 4b1 [redacted] During an interview on 02/20/2023 at 12:36 PM, Resident #19 stated they had to wait for an hour to two and a half hours for their call light to be answered. The resident stated the staff would come in, ask what the resident wanted, turn off the light, and not come back. Resident #19 stated that after a while they would put the call light back on and go through the entire process again. The resident stated five to fifteen minutes was an acceptable amount of time to wait for assistance after activating the call light. A review of call light response report for Resident #19's room from 02/03/2023 through 02/21/2023 revealed extended wait times of greater than 40 minutes as follows: - 02/04/2023 at 4:35 AM, 47 minutes.	F 550		

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- 02/04/2023 at 4:27 PM, 45 minutes.
- 02/05/2023 at 7:09 AM, 51 minutes.
- 02/05/2023 at 5:04 PM, 40 minutes.
- 02/07/2023 at 2:40 PM, 44 minutes.
- 02/10/2023 at 6:14 PM, 1 hour and 6 minutes.
- 02/11/2023 at 3:53 PM, 53 minutes.
- 02/12/2023 at 6:05 PM, 42 minutes.
- 02/14/2023 at 7:58 PM, 40 minutes.
- 02/15/2023 at 11:13 AM, 1 hour and 23 minutes.
- 02/15/2023 at 2:27 PM, 1 hour and 5 minutes.
- 02/15/2023 at 9:43 PM, 48 minutes.
- 02/19/2023 at 9:39 PM, 1 hour and 57 minutes.
- 02/20/2023 at 9:54 AM, 44 minutes.

2. A review of Resident #2's "Order Summary Report" revealed the facility admitted the resident with diagnoses that included a EX Order 26 § 4b1 [redacted].

A review of the admission Minimum Data Set (MDS), dated 08/09/2022, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating the resident was EX Order 26 § 4b1. According to the MDS, the resident required EX Order 26 § 4b1 EX Order 26 § 4b1 with EX Order 26 § 4b1 including [redacted], EX Order 26 § 4b1 [redacted].

A review of Resident #2's "Care Plan," with an initiation date of 08/03/2022, indicated the resident had a EX Order 26 § 4b1 related to [redacted]. Interventions included to assist with EX Order 26 § 4b1 [redacted] as needed.

A review of a "Concern Form," dated 08/15/2022, indicated Resident #2's family was concerned

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related to call light response times. No resolution or facility follow-up to this concern was documented.

A review of a "Concern Form," dated 08/22/2022, indicated Resident #2 put their call light on and it took over 30 minutes for care to be rendered after a nurse answered the call light and stated he would locate an aide and return to provide assistance. The resolution of concern documented on the form indicated the call light report was consistent with the resident's complaint, and it was re-enforced with the staff that call lights must be answered timely and the staff must "provide the requested need."

A review of a progress note, dated 10/16/2022, indicated Resident #2 required EX Order 26 § 4b1 EX Order 26 § 4b1 with EX Order 26 § 4b1 .

A review of the call light response report for Resident #2's room from 10/01/2022 through 10/17/2022 revealed the resident had to wait over an hour on two different occasions for the call light to be answered. Further review of the response times revealed the following:
- 10/01/2022 at 1:38 PM, 1 hour and 34 minutes.
- 10/03/2022 at 1:18 PM, 29 minutes.
- 10/03/2022 at 2:20 PM, 33 minutes.
- 10/04/2022 at 4:45 PM, 28 minutes.
- 10/05/2022 at 10:20 AM, 30 minutes.
- 10/05/2022 at 3:51 PM, 37 minutes.
- 10/05/2022 at 8:46 PM, 21 minutes.
- 10/05/2022 at 11:13 PM, 27 minutes.
- 10/07/2022 at 6:42 AM, 27 minutes.
- 10/07/2022 at 7:26 AM, 26 minutes.
- 10/07/2022 at 11:48 PM, 23 minutes.
- 10/09/2022 at 1:22 PM, 24 minutes.

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- 10/09/2022 at 8:16 PM, 43 minutes.
- 10/10/2022 at 3:19 PM, 28 minutes.
- 10/11/2022 at 2:58 PM, 29 minutes.
- 10/11/2022 at 9:19 PM, 37 minutes.
- 10/12/2022 at 6:55 PM, 23 minutes.
- 10/13/2022 at 6:08 PM, 26 minutes.
- 10/13/2022 at 11:19 PM, 24 minutes.
- 10/16/2022 at 7:18 AM, 30 minutes.
- 10/16/2022 at 2:00 PM, 1 hour and 4 minutes.
- 10/16/2022 at 6:39 PM, 23 minutes.

3. A review of Resident #3's "Order Summary Report" revealed the facility admitted the resident with diagnoses that included EX Order 26 § 4b1 [redacted]

A review of the admission Minimum Data Set (MDS), dated 12/15/2022, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating the resident was EX Order 26 § 4b1 [redacted]. According to the MDS, the resident had EX Order 26 § 4b1 [redacted] The MDS indicated the resident required EX Order 26 § 4b1 [redacted]

A review of Resident #3's care plan, with an initiation date of 12/09/2022, indicated the resident was at EX Order 26 § 4b1. Interventions included to reinforce the need to call for assistance.

A review of the call light response report for Resident #3's room on 12/24/2022 revealed the resident put their call light on at 9:10 PM with a response time of 1 hour and 9 minutes, and again

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F 550	Continued From page 6 at 11:40 PM with a response time of 24 minutes. 4. A review of Resident #4's "Order Summary" revealed the facility admitted the resident with diagnoses that included EX Order 26 § 4b1 [redacted] A review of the five-day Minimum Data Set (MDS), dated [redacted], revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating the resident was moderately EX Order 26 § 4b1, and the resident had EX Order 26 § 4b1. According to the MDS, the resident required EX Order 26 § 4b1 [redacted]. A review of the call light response report for Resident #4's room, dated 01/05/2023, revealed the following response times: - 01/05/2023 at 6:53 AM, 1 hour and 32 minutes. - 01/05/2023 at 9:29 AM, 57 minutes. - 01/05/2023 at 2:06 PM, 28 minutes. - 01/05/2023 at 3:31 PM, 25 minutes. 5. A review of Resident #7's "Admission Record Report" revealed the facility admitted the resident with diagnoses that included EX Order 26 § 4b1 [redacted] A review of the Admission Minimum Data Set (MDS), dated 01/11/2023, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating the resident was EX Order 26 § 4b1 and the resident had no behavioral symptoms. According to the EX Order 26 § 4b1 [redacted]	F 550		

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A review of the call light response report for Resident #7's room, dated 01/05/2023, revealed the following response times:
- 01/05/2023 at 6:56 AM, 1 hour and 29 minutes.
- 01/05/2023 at 3:36 PM, 20 minutes.
- 01/05/2023 at 6:45 PM, 14 minutes.

6. A review of call light response reports for a randomly selected room on each hallway in the facility on 01/27/2023 revealed the following:

South Unit
- Hall 1, Room 106-1: The average response time was 13 minutes and 47 seconds, and the longest response time was 13 minutes and 47 seconds.

North Unit
- Hall 1, Room 134-1: The average response time was 20 minutes and 37 seconds, and the longest response time was 53 minutes and 13 seconds.
- Hall 1, Room 134-2: The average response time was 25 minutes and 47 seconds; other response times recorded on this date were 52 minutes and 42 seconds and 46 minutes and 29 seconds.
- Hall 3, Room 171-2: The average response time was 16 minutes and 51 seconds with response times as long as 1 hour and 19 minutes and 37 minutes and 36 seconds.

A review of call light response reports for a randomly selected room on each hallway in the facility on 01/30/2023 revealed the following:

South Unit
- Hall 1, Room 106-1: The average response time was 10 minutes and 39 seconds, and the longest response time was 21 minutes and 40 seconds.
- Hall 1, Room 106-2: The average response time was 21 minutes and 21 seconds, and the longest

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response time was 21 minutes and 21 seconds.

North Unit
- Hall 1, Room 134-1: The average response time was 7 minutes and 22 seconds, and the longest response time was 9 minutes and 22 seconds.
- Hall 2, Room 146-2: The average response time was 8 minutes and 10 seconds, and the longest response time was 17 minutes and 25 seconds.
- Hall 3, Room 171-2: The average response time was 10 minutes and 4 seconds, and the longest response time was 30 minutes and 8 seconds.

During an interview on 02/24/2023 at 10:42 AM, Physical Therapist (PT) #24 stated call lights should be answered in less than five minutes. She stated if they were not answered in a timely manner, the resident could be at risk for accidents or incontinence. She stated all staff were required to answer the call lights.

During an interview on 02/24/2023 at 11:01 AM, Certified Occupational Therapy Assistant (COTA) #26 stated call lights should be answered by all staff to make sure resident needs were met. She stated if the staff member responding to the call light could not provide the assistance themselves, then they needed to find the person that could. COTA #26 stated an acceptable call light wait time would be a minute or two. She stated the responding staff needed to at least let the resident know they were aware of the resident's need and reassure them that assistance would be provided. She stated falls could occur or medical needs could go unmet when call lights were not answered in a timely manner.

During an interview on 02/24/2023 at 11:15 AM, Physical Therapy Assistant (PTA) #27 stated call

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lights should be answered within 15 minutes.

During an interview on 02/24/2023 at 11:34 AM, Certified Nurse Aide (CNA) #28 stated a resident should wait no longer that five minutes for their call light to be answered. She stated if the call light was not answered promptly, anything could happen to the resident such as they could be on the floor or having a heart attack.

During an interview on 02/24/2023 at 11:47 AM, CNA #29 stated a resident should wait no more than five minutes for their call light to be answered, and all staff should answer the call lights. She stated if a call light was not answered promptly, a lot of different situations could happen.

During an interview on 02/24/2023 at 12:15 PM, Licensed Practical Nurse (LPN) #30 stated the call light should be answered as soon as possible. He stated he tried not to interrupt medication pass to answer a call light but would not let a call light go unanswered for a period of time if he was able to answer it.

During an interview on 02/24/2023 at 12:32 PM, Registered Nurse (RN) #31 stated call lights should be answered within a minute of the resident's activation of the call light. She stated the resident could have fallen or be incontinent and need assistance.

During an interview on 02/24/2023 at 12:48 PM, CNA #32 stated call lights should be answered as soon as possible but should not be on for longer than five minutes because a fall could occur, or the resident could be incontinent.

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F 550	Continued From page 10 During an interview on 02/24/2023 at 1:29 PM, Activity Assistant (AA) #35 stated call lights should be answered within five minutes. During an interview on 02/24/2023 at 5:32 PM, the Director of Nursing (DON) stated call lights should be answered as soon as possible because the resident could need to use the restroom or need pain medication. The DON said anything could happen when a resident was waiting for their call light to be answered. During an interview on 02/24/2023 at 6:19 PM, the Administrator stated their expectation was that if a staff member saw a call light on, they should answer it, or if they were with another resident, answer the call light after they provided care for the other resident. New Jersey Administrative Code § 8.39 - 4.1(a)(12)	F 550		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Complaint Intake: #NJ160476 Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure residents' call lights were within reach for 5 (Residents #22, #23, #24, #25,	F 558	Resident # 26 has been [NJ Exec. Order 26 4.b.i]. Residents # 22, 23, 24, and 25 have been interviewed and verbalized call bells have been within reach. There have been no negative outcomes for these residents.	3/24/23

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F 558	Continued From page 11 and #26) of 14 residents reviewed for call light accessibility. Findings included: A review of the facility's undated policy titled, "Call Light," indicated in part, "Purpose: To use a call light and/or sound system to alert staff to patient needs." The policy further indicated, "6. Position call light conveniently for use within reach." 1. A review of Resident #22's quarterly Minimum Data Set (MDS), dated 01/27/2023, revealed the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident was [redacted]. Per the MDS, Resident #22 [redacted] On 02/20/2023 at 1:30 PM, Resident #22 was observed in their room and the resident's call light was noted on the nightstand, out of reach of the resident. On 02/20/2023 at 5:38 PM, Resident #22 could be heard calling out for a nurse. The surveyor noted the resident's call light was on the resident's nightstand, out of reach of the resident. At 5:41 PM, a nurse entered the resident's room to answer Resident #22's request; however, the nurse did not place the resident's call light within reach of the resident. 2. A review of Resident #23's "[redacted]" document indicated the resident had diagnoses that included [redacted].	F 558	All residents have the potential to be affected by call lights not being within reach therefore education and audits will be conducted. The Administrator or designee will educate all departments' staff on call light procedure and placement so that call lights are accessible/within reach of the resident. The administrator or designee will conduct 5 call light accessibility audits weekly and will provide report to QA x 3 months.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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A review of Resident #23's quarterly Minimum Data Set (MDS), dated 01/27/2023, revealed the resident had EX Order 26 § 4b1 for EX Order 26 § 4b1. Per the MDS, Resident #23 required EX Order 26 § 4b1

On 02/20/2023 at 5:52 PM and 02/21/2023 at 9:49 AM, Resident #23 was observed in their room and the resident's call light was noted on the nightstand, out of reach of the resident.

3. A review of Resident #24's EX Order 26 § 4b1 document indicated the resident had diagnoses that included EX Order 26 § 4b1

A review of Resident #24's significant change in status Minimum Data Set (MDS), dated 01/22/2023, revealed the resident had EX Order 26 § 4b1 EX Order 26 § 4b1. Per the MDS, the resident required EX Order 26 § 4b1

On 02/20/2023 at 5:53 PM, Resident #24 was observed asleep in bed. The resident's call light was on the nightstand, out of reach of the resident.

On 02/21/2023 at 9:47 AM, Resident #24 was observed dressed and sitting up in their bed. The surveyor noted the resident's call light was on the nightstand, out of reach of the resident.

4. A review of Resident #25's EX Order 26 § 4b1 EX Order 26 § 4b1

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	315506	A. BUILDING _____ B. WING _____	C 02/24/2023

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F 558	Continued From page 13 document indicated Resident #25 had diagnoses that included EX Order 26 § 4b1 [redacted] A review of Resident #25's annual Minimum Data Set (MDS), dated 12/27/2022, revealed the resident had EX Order 26 § 4b1 [redacted]. Per the MDS, Resident #25 required EX Order 26 § 4b1 EX Order 26 § 4b1 with EX Order 26 § 4b1 [redacted] A review of Resident #25's care plan, initiated 01/07/2020, revealed the resident was at EX Order 26 § 4b1 [redacted] care plan intervention, initiated on 11/28/2022, directed staff to EX Order 26 § 4b1 [redacted] During an interview on 02/20/2023 at 12:34 PM, Resident #25's family member stated they occasionally found the resident's call light on the nightstand. On 02/20/2023 at 5:35 PM, Resident #25's call light was observed on the bedside table, out of reach of the resident. On 02/21/2023 at 9:56 AM and 3:04 PM, Resident #25's call light was observed on the nightstand. 5. A review of Resident #26's EX Order 26 § 4b EX Order 26 § 4b1 is" document indicated the resident had diagnoses that included EX Order 26 § 4b1 [redacted]	F 558		

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EX Order 26 § 4b1 .

A review of Resident #26's quarterly Minimum Data Set (MDS), date 12/31/2022, revealed the resident had a Brief Interview for Mental Status (BIMS) score of EX O, which indicated the resident had moderate EX Order 26 § 4b1 . Per the MDS, Resident #26 required EX Order 26 § 4b1

Review of Resident #26's care plan, initiated 06/23/2022, revealed the resident was EX Order 26 § 4b1 A care plan intervention, initiated on 07/28/2022, directed staff to EX Order 26 § 4b1 .

On 02/20/2022 at 5:42 PM, Resident #26 was observed sitting up in a EX Order 26 § 4b1 on the left side of the resident's bed. The resident's call light and television remote were on the right edge of the resident's bed, out of reach of the resident. The resident asked the surveyor to hand them their call light because the resident wanted to go back to bed. The resident stated, "EX Order 26 § 4b1

In an interview on 02/21/2023 at 3:17 PM, Certified Nursing Assistant (CNA) #21 stated the expectation was that a resident's call light should always be within reach or clipped to the resident. CNA #21 stated all the residents on her assignment on the south side unit could use their call light.

During an interview on 02/21/2023 at 3:20 PM, CNA #22 stated residents should always have their call light placed close to them. Per CNA #22,

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all residents on her assignment on the south side unit could use their call light.

In an interview on 02/21/2023 at 3:25 PM, CNA #23 stated a resident's call light should be within the resident's reach. According to CNA #23, sometimes when he came into work, he noticed that some call lights were not within the residents' reach. CNA #23 explained that some residents were not able to use their call light, but the call light was also the television remote and, for that reason, it should be within the resident's reach. During an interview on 02/24/2023 at 10:42 AM, Physical Therapist (PT) #24 stated the call light should be placed where a resident could reach it. PT #24 stated there was a clip on the cord so that it could be placed wherever the resident could reach it.

During an interview on 02/24/2023 at 11:01 AM, Certified Occupational Therapy Assistant #26 stated the call light should be placed next to the resident within reach.

During an interview on 02/24/2023 at 11:15 AM, Physical Therapy Assistant #27 stated the call light should be placed where a resident could reach it.

During an interview on 02/24/2023 at 11:34 AM, CNA #28 stated a resident's call light should be within arm's reach of the resident, either in the resident's hand or clipped to the resident.

During an interview on 02/24/2023 at 11:47 AM, CNA #29 stated the call light should be placed within reach of the resident.

During an interview on 02/24/2023 at 12:32 PM,

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F 558	Continued From page 16 Registered Nurse #31 stated the call light should be placed next to a resident where the resident could reach it. During an interview on 02/24/2023 at 12:48 PM, CNA #32 stated the call light should be placed within reach of a resident. During an interview on 02/24/2023 at 1:29 PM, Activity Assistant #35 stated the call light should be placed right next to a resident, and if the resident was unable to use their call light, the resident should be checked on by staff frequently. During an interview on 02/24/2023 at 5:32 PM, the Director of Nursing stated the call light should be placed within reach of a resident. During an interview on 02/24/2023 at 6:19 PM, the Administrator stated call lights should be placed where a resident wanted it placed and where it could be reached by the resident. Per the Administrator, sometimes where the resident wanted their call light was not where the resident could reach it, so staff had to educate the resident. New Jersey Administrative Code 8:39-31.8(c)(9)	F 558		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and	F 600		3/24/23

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F 600	Continued From page 17 any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ160621 Based on interviews, record review, facility document review, and facility policy review, the facility failed to ensure 1 (Resident #4) of 3 residents reviewed for [EX Order 26] was not [EX Order 26 § 4] by a staff member, Certified Nursing Assistant (CNA) #45. Findings included: A review of the facility's undated policy titled, "Abuse, Neglect and Exploitation," indicated, "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property." According to the policy, "Verbal Abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability." The policy indicated "Mental Abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation."	F 600	Resident # 4 no longer in the facility. CNA # 45 is no longer employed by this facility. All residents have the potential to be affected by forms of [NJ Exec. Order 26] The Administrator or designee will re-educate all departments' staff on [NJ Exec. Order], the types of [NJ Exec. Order], and what to do if [NJ Exec. Order 26] is suspected. The administrator or designee will conduct and conclude staff [NJ Exec. Order] education by March 24, 2023 and review in QA x 3months.	

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A review of Resident #4's "Admission Record Report" revealed the facility admitted the resident with diagnoses that included EX Order 26 § 4b1 [redacted].

A review of the Minimum Data Set (MDS), dated 01/05/2023, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident had EX Order 26 § 4b1 [redacted]. According to the MDS, Resident #4 required EX Order 26 § 4b1 [redacted].

A review of Resident #4's care plan initiated 01/05/2023, indicated the resident had EX Order 26 § 4b1 [redacted]. The care plan interventions included to encourage and assist the resident with EX Order 26 § 4b1 [redacted].

A review of an undated, typed statement by the Administrator revealed a verbal conversation between the Administrator and Licensed Practical Nurse (LPN) #1. According to the statement, LPN #1 stated she witnessed the interaction on 01/05/2023 between CNA #45 and Resident #4. The statement indicated LPN #1 heard the resident say they could not hear everything CNA #45 was saying, and that CNA #45 was not being professional. Per the statement, LPN #1 witnessed CNA #45 pull down his mask so Resident #4 could [redacted] the CNA. LPN #1 also reported, CNA #45 showed the resident his face, stated he was not mad, and smiled. According to the statement, CNA #45 did not do or say anything that was unprofessional.

During an interview on 02/22/2023 at 2:37 PM,

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LPN #1 stated as she stood in the hallway, she asked CNA #45 to assist Resident #4 to eat their meal. LPN #1 stated she started to hear Resident #4, and CNA #45 argue in the resident's room. LPN #1 stated she went into the room and told CNA #45 to leave the resident's room and that she would assist the resident to eat. Per LPN #1, Resident #4 made comments to CNA #45 and the CNA argued with the resident. LPN #1 stated she did not see CNA #45 pull down their mask. LPN #1 further stated she had to tell CNA #45 to leave the resident's room again and reported the incident to LPN #16. LPN #1 stated it was unprofessional for a staff member to argue with a resident.

An attempt to conduct a telephone interview with LPN #16 was made on 02/20/2023 at 2:45 PM. The surveyor left a message, and no response was received by the end of the survey.

During an interview on 02/22/2023 at 2:46 PM, CNA #3 stated she was across the hall when the incident with Resident #4 and CNA #45 occurred. CNA #3 stated she heard the resident and CNA #45 arguing.

A review of CNA #45's handwritten "Witness Statement," dated 01/05/2023, indicated CNA #45 entered Resident #4's room to assist the resident with EX Order 26 §. According to the statement, Resident #4 pushed their EX Order 26 § 4b1 towards CNA #45, NJ Exec. Order 26:4.b.1 at CNA #45. CNA #45 responded and said to the resident not to speak to him like that and if the resident continued "that I wouldn't assist with EX Order 26 § 4b."

A review of an "Employee Warning Notice," dated

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F 600	Continued From page 20 01/11/2023, indicated CNA #45 had poor customer service in their tone, voice, and positioning, and the decision was made to terminate CNA #45's employment with the facility. The notice further indicated the facility accepted CNA #45's voluntary resignation and CNA #45 was not eligible for rehire. During an interview on 02/24/2023 at 5:32 PM, the DON stated she had only been working at the facility for a few weeks. The DON stated she was not at the facility at the time of the incident with Resident #4 and CNA #45 and could not comment. During an interview on 02/24/2023 at 6:19 PM, the Administrator stated LPN #1 told her that CNA #45 pulled down his mask and smiled at Resident #4. According to the Administrator, LPN #1 did not feel CNA #45 had done anything wrong. The Administrator stated CNA #45 was terminated due to in the short time CNA #45 was at the facility, the CNA did not demonstrate the skills to communicate effectively.	F 600		
F 609 SS=D	New Jersey Administrative Code 8:39-4.1(a)(5) Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2	F 609		3/24/23

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F 609	Continued From page 21 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint Intake #: NJ160621 Based on interviews, record review, facility document review, and facility policy review, the facility failed to report an allegation of [NJ Exec. Order 2] to the state agency for 1 (Resident #4) of 3 residents reviewed for [EX Order 26]. Specifically, Resident #4 alleged Certified Nursing Assistant (CNA) #45 EX Order 26 § 4b1 [EX Order 26 § 4b] the resident on 01/05/2023, and the facility failed to report the allegation to the state agency. Findings included: A review of the facility's undated policy, titled, "Abuse, Neglect and Exploitation," indicated, "VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all	F 609	Resident # 4 is no longer in the facility. CNA # 45 no longer is employed by the facility. All residents have the potential to be affected by failure to report an allegation of [NJ Exec. Order 2] to the state agency. The Administrator or designee will reeducate all departments' staff on the requirement to report allegations of [NJ Exec. Order] to the Administrator or designee and the state agency. The administrator or designee will conduct and conclude by March 24, 2023 staff education on the requirements of reporting allegations of [NJ Exec. Order] to the	

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F 609	Continued From page 22 alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes: a. 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 b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury." A review of Resident #4's "Admission Record Report" revealed the facility admitted the resident with diagnoses that included EX Order 26 § 4b1 [redacted] A review of the Minimum Data Set (MDS), dated 01/05/2023, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident had moderate EX Order 26 § 4b1. According to the MDS, Resident #4 required NJ Exec. Order 26:4.b.1 for EX Order 26 § 4b1 [redacted] A review of Resident #4's care plan initiated 01/05/2023, indicated the resident EX Order 26 § 4b1 [redacted]. The care plan interventions included EX Order 26 § 4b1 [redacted]. A review of an undated, typed statement by the Administrator revealed a verbal conversation between the Administrator and Licensed Practical Nurse (LPN) #1. According to the statement, LPN #1 stated she witnessed the interaction on 01/05/2023 between CNA #45 and Resident #4. The statement indicated LPN #1 heard the resident say they could not hear everything CNA	F 609	Administrator or designee and the state agency. In addition this will be reviewed in QA x 3 months. A reportable will be submitted as part of POC for complaint survey dated 2/24/23.	

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F 609	Continued From page 23 #45 was saying, and that CNA #45 was not being professional. Per the statement, LPN #1 witnessed CNA #45 pull down his mask so Resident #4 could hear the CNA. LPN #1 also reported, CNA #45 showed the resident his face, stated he was not mad, and smiled. According to the statement, CNA #45 did not do or say anything that was unprofessional. During an interview on 02/22/2023 at 2:37 PM, LPN #1 stated as she stood in the hallway, she asked CNA #45 to assist Resident #4 to [NJ Exec. Order 26:4] [redacted] LPN #1 stated she started to hear Resident #4, and CNA #45 argue in the resident's room. LPN #1 stated she went into the room and told CNA #45 to leave the resident's room and that she would assist the resident to eat. Per LPN #1, Resident #4 made comments to CNA #45 and the CNA argued with the resident. LPN #1 stated she did not see CNA #45 pull down their mask. LPN #1 further stated she had to tell CNA #45 to leave the resident's room again and reported the incident to LPN #16. LPN #1 stated it was unprofessional for a staff member to argue with a resident. A review of LPN #16's "Witness Statement" indicated on 01/05/2023, LPN #16 was called to Resident #4's room because the resident was [EX Order 26] [redacted]. According to the statement, Resident #4 explained to LPN #16 that they had been [NJ Exec. Order 26:4] [redacted] by CNA #45, but was unable to tell LPN #16 how the resident was [EX Order 26 g 4b] [redacted]. An attempt to conduct a telephone interview with LPN #16 was made on 02/20/2023 at 2:45 PM. The surveyor left a message, and no response was received by the end of the survey.	F 609		

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F 609	Continued From page 24	F 609		

During an interview on 02/22/2023 at 2:46 PM, CNA #3 stated she was across the hall when the incident with Resident #4 and CNA #45 occurred. CNA #3 stated she heard the resident and CNA #45 arguing.

A review of an undated typed statement by the previous Director of Nursing (DON) indicated that on 01/05/2023 at approximately 9:45 AM, she was notified that Resident #4 was [EX Order 26] and did not like CNA #45. According to the statement, Resident #4 stated they pushed their breakfast meal tray towards CNA #45 and CNA #45 pushed the meal tray back towards the resident's bed. CNA #45 then pulled his face mask down and stated he wanted Resident #4 to see who the resident was talking to.

A review of CNA #45's handwritten "Witness Statement," dated 01/05/2023, indicated CNA #45 entered Resident #4's room to assist the resident with [NJ Exec. Order 26] According to the statement, Resident #4 pushed their breakfast meal tray towards CNA #45, [NJ Exec. Order 26:4.b.1] at CNA #45. CNA #45 responded and said to the resident not to speak to him like that and if the resident continued "that I wouldn't assist with feeding." Per the statement, CNA #45 acknowledged being aware that Resident #4 reported being [EX Order 26:§ 4b] by the CNA.

A review of an "Employee Warning Notice," dated 01/11/2023, indicated CNA #45 had poor customer service in their tone, voice, and positioning, and the decision was made to terminate CNA #45's employment with the facility. The notice further indicated the facility accepted CNA #45's voluntary resignation and CNA #45

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315506	A. BUILDING _____ B. WING _____	C 02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (WASHINGTON TWP)	378 FRIES MILL ROAD SEWELL, NJ 08080

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 25 was not eligible for rehire. During an interview on 02/24/2023 at 5:32 PM, the DON stated she had only been working at the facility for a few weeks. Per the DON, the Administrator was the Abuse Coordinator. During an interview on 02/24/2023 at 6:19 PM, the Administrator stated the staff should report any abuse they witnessed or any allegations they received immediately to their supervisor, who should report it to her so she could report it to the state within two hours. According to the Administrator, LPN #1 did not feel CNA #45 had done anything wrong and that was why she did not report it to the state agency as an allegation of abuse.	F 609		
F 610 SS=D	New Jersey Administrative Code 8:39-5.1(a) 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. §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	F 610		3/24/23

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F 610	Continued From page 26 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint Intake # NJ160621 Based on interviews, record review, facility document review, and facility policy review, the facility failed to thoroughly investigate an allegation of [NJ Exec. Order 2] for 1 (Resident #4) of 3 residents reviewed for [EX Order 26 §]. Specifically, the facility failed to investigate an allegation of [EX Order 26 §] [redacted] reported by Resident #4 that involved the resident and Certified Nursing Assistant (CNA) #45. Findings included: A review of the facility's undated policy, titled, "Abuse, Neglect and Exploitation," indicated, "V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur." The policy further indicated, written procedures for investigations include: "4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations;" and "6. Providing complete and thorough documentation of the investigation." A review of Resident #4's "Admission Record Report" revealed the facility admitted the resident with diagnoses that include [EX Order 26 § 4b1] [redacted] A review of the Minimum Data Set (MDS), dated	F 610	Resident # 4 is no longer in the facility. CNA # 45 is no longer employed by this facility. All residents have the potential to be affected by failure to thoroughly investigate allegations of [NJ Exec. Order 2] The Administrator or designee will re educate all departments' staff on the requirement to thoroughly investigate an allegation of [NJ Exec. Order 2] The administrator or designee will conduct and conclude staff education on the requirements of thoroughly investigating allegations of [NJ Exec. Order 2]. And review in QA x 3months.	

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F 610	Continued From page 27 01/05/2023, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident had [redacted]. According to the MDS, Resident #4 required NJ Exec. Order 26:4.b.1 for bed EX Order 26 § 4b1 [redacted]. A review of Resident #4's care plan initiated 01/05/2023, indicated the resident had [redacted] in their NJ Exec. Order 26:4.b.1. The care plan interventions included to encourage and assist the resident with NJ Exec. Order 26:4.b.1. A review of an undated, typed statement by the Administrator revealed a verbal conversation between the Administrator and Licensed Practical Nurse (LPN) #1. According to the statement, LPN #1 stated she witnessed the interaction on 01/05/2023 between CNA #45 and Resident #4. The statement indicated LPN #1 heard the resident say they could not hear everything CNA #45 was saying, and that CNA #45 was not being professional. Per the statement, LPN #1 witnessed CNA #45 pull down his mask so Resident #4 could hear the CNA. LPN #1 also reported, CNA #45 showed the resident his face, stated he was not mad, and smiled. According to the statement, CNA #45 did not do or say anything that was unprofessional. During an interview on 02/22/2023 at 2:37 PM, LPN #1 stated as she stood in the hallway, she asked CNA #45 to assist Resident #4 to eat their meal. LPN #1 stated she started to hear Resident #4, and CNA #45 argue in the resident's room. LPN #1 stated she went into the room and told CNA #45 to leave the resident's room and that she would [redacted] the resident to [redacted]. Per LPN #1,	F 610		

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F 610	Continued From page 28	F 610		

Resident #4 made comments to CNA #45 and the CNA argued with the resident. LPN #1 stated she did not see CNA #45 pull down their mask. LPN #1 further stated she had to tell CNA #45 to leave the resident's room again and reported the incident to LPN #16. LPN #1 stated it was unprofessional for a staff member to argue with a resident.

A review of LPN #16's "Witness Statement" indicated on 01/05/2023, LPN #16 was called to Resident #4's room because the resident was upset. According to the statement, Resident #4 explained to LPN #16 that they had been verbally and physically [redacted] by CNA #45, but was unable to tell LPN #16 how the resident was [redacted]

An attempt to conduct a telephone interview with LPN #16 was made on 02/20/2023 at 2:45 PM. The surveyor left a message, and no response was received by the end of the survey.

During an interview on 02/22/2023 at 2:46 PM, CNA #3 stated she was across the hall when the incident with Resident #4 and CNA #45 occurred. CNA #3 stated she heard the resident and CNA #45 arguing.

A review of an undated typed statement by the previous Director of Nursing (DON) indicated that on 01/05/2023 at approximately 9:45 AM, she was notified that Resident #4 was angry and did not like CNA #45. According to the statement, Resident #4 stated they pushed their breakfast meal tray towards CNA #45 and CNA #45 pushed the meal tray back towards the resident's bed. CNA #45 then pulled his face mask down and stated he wanted Resident #4 to see who the

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F 610	Continued From page 29	F 610		

resident was talking to.

A review of CNA #45's handwritten "Witness Statement," dated 01/05/2023, indicated CNA #45 entered Resident #4's room to [redacted] the resident with [redacted]. According to the statement, Resident #4 pushed their breakfast meal tray towards CNA #45, [redacted] at CNA #45. CNA #45 responded and said to the resident not to speak to him like that and if the resident continued "that I wouldn't [redacted]." Per the statement, CNA #45 acknowledged being aware that Resident #4 reported being [redacted] by the CNA.

A review of an "Employee Warning Notice," dated 01/11/2023, indicated CNA #45 had poor customer service in their tone, voice, and positioning, and the decision was made to terminate CNA #45's employment with the facility. The notice further indicated the facility accepted CNA #45's voluntary resignation and CNA #45 was not eligible for rehire.

During an interview on 02/24/2023 at 5:32 PM, the DON stated she had only been working at the facility for a few weeks. Per the DON, the Administrator was the Abuse Coordinator.

A review of facility documents related to allegation of abuse reported by Resident #4, revealed the facility collected an undated statement from the previous DON, an undated statement from the Administrator and a witness statement from CNA #45 (the alleged perpetrator) and LPN #16. There were no other interviews with others who might have knowledge of the allegation and there was no complete and thorough documentation of the investigation.

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F 610	Continued From page 30 During an interview on 02/24/2023 at 6:19 PM, the Administrator she was the facility's Abuse Coordinator and stated abuse investigation was a collaborative team effort, but she and the DON were ultimately responsible. The Administrator explained that during an investigation, a statement was obtained from the alleged perpetrator before being sent home. A statement would be obtained from the person who made the allegation and statements from anyone who may have participated in or witnessed the allegation. The Administrator stated the social worker would also interview other residents who were cared for by the alleged perpetrator. According to the Administrator, LPN #1 did not feel CNA #45 had done anything wrong and that was why she did not investigate the resident's allegation of [redacted].	F 610		
F 656 SS=D	New Jersey Administrative Code 8:39-5.1(a) Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		3/24/23

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F 656	Continued From page 31 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ161004 and NJ160982 Based on interviews, record review, and facility policy review, the facility failed to develop a comprehensive care plan to address [redacted] 1 (Resident #5) of 8 residents reviewed for [redacted].	F 656	Resident # 5 no longer in the facility. All residents have the potential to be affected by failure to develop a comprehensive care plan to address [redacted] ehaviors. The Administrator or designee will	

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F 656	Continued From page 32 Findings included: Review of the facility policy titled, "Interdisciplinary Care Planning," updated 03/2018, indicated, "Purpose: To provide guidelines on the process of interdisciplinary care planning." The policy further indicated, "Planning the patient's care includes identifying problems and/or risks (potential or actual), strengths, and needs; evaluating whether the problem is acute or chronic; setting measurable goals with time frames; and determining the interventions that will enable the patient to meet their goals." A review of the "Admission Record Report" indicated the facility admitted Resident #5 with diagnoses that included EX Order 26 § 4b1 [redacted] The admission Minimum Data Set (MDS) dated 12/02/2022, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident had EX Order 26 § 4b1 [redacted]. Review of Resident #5's "Progress Notes" dated 11/30/2022 at 1:55 PM, indicated Resident #5 was slightly EX Order 26 § 4b1 about being in the facility and stated, EX Order 26 § 4b1 [redacted] " Per the note, the resident was redirected but became NJ Exec. Order 2 and stated, "EX Order 26 § 4b1 ." Review of Resident #5's "Progress Notes" dated 12/05/2022 at 12:09 PM, indicated the resident was EX Order 26 § 4b1 and EX Order 26 § 4b1 with their family and staff. Per the note, Resident #5 believed they could go home alone and did not	F 656	re-educate all departments' staff on the requirement for the assigned nurse or member of the nursing team to develop a comprehensive care plan addressing NJ Exec. O [redacted] behaviors. The administrator or designee will conduct care plan audits on 4 residents at risk for NJ Exec. Order 26 4.b.1 [redacted] behgaviors weekly and will provide report to QA x 3 months.	

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F 656	Continued From page 33	F 656		

need any help. The note further indicated, the resident's care was discussed with occupational therapy, who felt the resident was EX Order 26 § 4b1 [redacted]. According to the note, Resident #5's had EX Order 2 [redacted].

Review of Resident #5's "Progress Notes" dated 12/09/2022 at 2:24 PM, indicated around 2:35 PM, Resident #5 was caught opening the window in their room. The assigned aide asked Resident #5 what was going on, and the resident replied, "EX [redacted] Per the note, the physician was called, and staff would keep an eye on Resident #5.

Review of Resident #5's "Progress Notes" dated 12/09/2022 at 4:13 PM, indicated the resident insisted on going home.

Review of Resident #5's "Progress Notes" dated 12/09/2022 at 4:45 PM, indicated the resident was EX Order 26 § 4b1 [redacted] Per the note, Resident #5 was unable to be EX Order 26 § 4b1 [redacted]. The resident's family was called and gave permission for the resident to be sent to EX Order 26 § 4b1). The note further indicated, Resident #5's physician was made aware and agreed to a EX Order 26 § 4b1 .

During an interview on 02/24/2023 at 1:11 PM, Registered Nurse (RN) #33, the MDS Coordinator, stated all the resident information would be used to develop the resident's care plan.

During an interview on 02/24/2023 at 6:19 PM, the Administrator stated the care plan would be

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F 656	Continued From page 34 completed based on the MDS assessment. New Jersey Administrative Code § 8:39-11.2(e)(1)	F 656		
F 689 SS=J	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: Complaint Intake #NJ161004 and NJ160982 Based on interviews, record review, facility policy review, and video surveillance review, the facility failed to provide supervision for 1 (Resident #5) of 8 residents reviewed for EX Order 26 § 4b1. The facility failed to identify and implement interventions to prevent EX Order 26 § 4b1 for Resident #5 who had a documented history of EX Order 26 § 4b1 attempts, was EX Order 26 § 4b1, and was NJ Exec. Order 26:4.b.1 safely. On 12/15/2022, Resident #5 left the facility without staff knowledge. A staff member leaving the facility found the resident in the rain by a busy four-lane highway by the facility and assisted the resident back to the facility. Resident #5 was outside unsupervised without staff knowledge for approximately nine minutes. It was determined the facility's noncompliance with one or more requirements of participation caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The	F 689	Resident # 5 no longer in the faciltity. All residents have the potential to be affected by the facility failing to identifying and providing supervision for residents at risk for EX Order 26 § 4b1 EX Removal Plan: "1. Resident #5 no longer resides at the center. All residents who are at risk for EX Order 26 § 4b1 were reviewed by licensed nursing staff on 02/19/2023 using the new EX Order 26 § 4b1 risk assessment. It includes ambulation status, predisposing diseases, mental status, cognitive processes, days of residence, history of EX Order 26 § 4b1 episodes for the last three months, is there a transient medical cause contributing to increasing EX Order 26 § 4b1 and is there a transient cause contributing to	3/17/23

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F 689	Continued From page 35 Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.25 (Quality of Care) at a scope and severity of "J." The IJ began on 11/30/2022 when Resident #5 was expressing the desire to leave the facility by calling a ride-hailing service. The Nursing Home Administrator (NHA) and Regional Director of Operations (RDO) were notified of the IJ on 02/19/2023 at 3:40 PM and provided the IJ template at that time. A Removal Plan was requested. The Removal Plan was accepted by the State Survey Agency (SSA) on 02/24/2023 at 1:03 PM. The IJ was removed on 02/24/2022 at 6:30 PM after the survey team performed onsite verification that the Removal Plan had been implemented. Noncompliance remained at the lower scope and severity that was not immediate jeopardy for F689. Findings included: Review of the facility policy titled, "EX Order 26 § 4b1 and EX Order 26 § 4b1 revised March 2019, indicated, "The facility will identify residents who are at risk of unsafe EX Order 26 § 4b1 and strive to prevent harm while maintaining the least restrictive environment for residents. 1. If identified as at risk for EX Order 26 § 4b1 EX Order 26 § 4b1 or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. 2. If an employee observes a resident leaving the premises, he/she should: a. attempt to prevent the resident from leaving in a courteous manner; b. get help from other staff members in the immediate vicinity, if necessary; and c. instruct another staff member to inform the charge nurse of director of nursing services that a resident is attempting to leave or has left the premises. 4.	F 689	increased EX Order 26 § 4b1 The assessment is currently on paper. The licensed nurses observed the EX Order 26 § 4b EX Order 26 § 4 in place on the six residents that were previously identified as being at risk for EX Order 26 § 4b1 The nursing staff checked the EX Order 26 § 4b guards for functioning. All EX Order 26 § 4b EX Order 26 § 4 functioned appropriately. All six residents had a care plan in place for EX Order 26 § 4b1 risk. All facility residents were reviewed by licensed nurses using the EX Order 26 § 4b1 risk assessment. There is an EX Order 26 § 4b1 risk list at the reception desk. This list has been there since prior ownership. When a resident exhibits a change that indicates they could be at risk for EX Order 26 § 4b1 an EX Order 26 § 4b1 assessment will be completed by a licensed nurse. Changes that may indicate a resident is at risk for EX Order 26 § 4b1 may include exit seeking behaviors, which could include verbalization of wanting to leave the facility. 2. All nursing supervisors, nurses, nurse's aides, and staff in all departments were in-serviced on 02/23/2023 by the NHA/DON/Designee on EX Order 26 § 4b1 assessments, EX Order 26 § 4b1 care planning, and EX Order 26 § 4b1 interventions. Staff who work per diem or who are on time off will be in-serviced at the beginning of their next shift. 3. A new EX Order 26 § 4b1 risk evaluation will be completed by licensed nurses on all residents upon admission, re-admission, quarterly, and with any changes. When a	

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F 689	Continued From page 36 When the resident returns to the facility, the director of nursing services or charge nurse shall: a. examine the resident for injuries; e. complete and file an incident report; and f. document relevant information in the resident's medical record." During an interview on 02/24/2023 at 5:32 PM, the Director of Nursing (DON) stated EX Order 26 § 4b1 and other assessments were done upon admission, quarterly, and with any changes. The DON stated nursing staff completed the admission assessments, and the quarterly assessments were completed by the nurse manager. A review of the "Admission Record Report" indicated the facility admitted Resident #5 on NJ Exec. Order 26 4.b.1 with diagnoses that included EX Order 26 § 4b1 A family member, Family Member #1 was listed as the first emergency contact for Resident #5. Further review of the "Admission Record Report" revealed Resident #5 experienced a EX Order 26 § 4b1, and the resident's "current admission date" was EX Order 26 § 4b1. Review of the pre-admission hospital record revealed a physician history and physical note, dated 11/18/2022, indicating Resident #5 had a history of NJ Exec. Order 26:4.b.1 . The hospital provider indicated the resident NJ Exec. Order 26:4.b.1 on a prior admission several days ago. Review of an "Admission/Re-Admission Evaluation" dated NJ Exec. Order 26 4.b.1, revealed Resident	F 689	resident exhibits signs that they have had a change that indicates they could be at risk for EX Order 26 § 4b1 an EX Order 26 § 4b1 assessment will be completed by licensed nurses. Residents identified as being at risk for EX Order 26 § 4b1 will have a EX Order 26 § 4b EX Order 26 § placed by licensed nurses as well as a care plan for being at risk for EX Order 26 § 4b1 The provider and resident responsible party are also notified. The NHA/DON/Designee will review admissions and if a resident triggers for being at risk for EX Order 26 § 4b1 based on the EX Order 26 § 4b1 risk assessment, the DON/NHA/Designee will confirm placement of the EX Order 26 § 4b EX Order 26 and confirm care planning for risk for EX Order 26 § 4b1 is in place. The NHA/DON/Designee will review residents that have been identified as being at risk for EX Order 26 § 4b1 after admission for placement of the EX Order 26 § 4b EX Order 26 and a care plan for risk for EX Order 26 § 4b1 These audits will be conducted weekly x [for] 4 weeks, then every other week for 4 weeks, and then monthly x [for] three months. All findings will be reviewed at the quarterly quality assurance meetings. The Administrator or designee will re-educate all departments' staff on the removal plan. By March 24, 2023, the Administrator or designee will review admissions and if a resident triggers for being at risk for EX Order 26 § 4b1 based on the EX Order 26 § 4b1 risk assessment, the Administrator or	

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F 689	Continued From page 37 #5 had no history or presence of EX Order 26 § 4b1 history of NJ Exec. Order 26 4.b.1, nor verbalizing a desire to exit. Review of Resident #5's care plan, dated 11/25/2022, revealed resident showed potential for discharge and the patient and relative expressed a wish for EX Order 26 § 4b1 Interventions included discussing the EX Order 26 § 4b1 process, investigating needs for special equipment and referrals, and reviewing progress toward discharge during scheduled meetings. Review of nursing "Progress Notes" dated 12/01/2022 at 11:31 PM, revealed Resident #5 was EX Order 2 but EX Order 26 § 4b1. Review of Resident #5's "Progress Notes," dated 12/01/2022 at 4:08 PM, revealed the resident had EX Order 26 § 4b1 on the Brief Interview for Mental Status (BIMS) assessment, and limited NJ Exec. Order 26:4.b.1. The admission Minimum Data Set (MDS), dated 12/02/2022, revealed Resident #5 had a BIMS score of EX, which indicated the resident had EX Order 26 § 4b1. The MDS indicated the resident had not exhibited EX Order 26 § 4b1 behavior nor behavioral symptoms during the previous seven days. The MDS indicated Resident #5 required EX Order 26 § 4b1 The MDS indicated the resident did not walk in the resident's room or in the corridor. According to the MDS, Resident #5 was NJ Exec. Order 26:4.b. and utilized a EX Order 26 § 4b1 for mobility. Further review of Resident #5's care plan, dated 12/05/2022, revealed the resident was at risk for	F 689	designee will confirm placement of the EX Order 26 § 4b1 and confirm care planning for risk for EX Order 26 § 4b1 is in place. The Administrator or designee will review residents that have been identified as being at risk for EX Order 26 § 4b1 after admission for placement of the EX Order 26 § 4b guard and a care plan for risk for EX Order 26 § 4b1 These audits will be conducted weekly for 4 weeks, then every other week for 4 weeks, and then monthly for three months. All findings will be reviewed at the quarterly quality assurance meetings.	

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complications related to EX Order 26 § 4b1 due to the resident's desire to participate in outdoor hot/cold weather activities. The facility developed interventions that included avoiding extended amounts of time outdoors, observing for signs and symptoms of over exposure, and offering and assisting with "protective garb" such as gloves, hat, and coat. There was no documented evidence the facility addressed the resident's supervision needs while outdoors.

Review of "Progress Notes" revealed on 11/30/2022 at 1:55 PM, the Infection Preventionist (IP Nurse) documented Resident #5 was EX Order 26 § 4b1 " and stated the resident would 'EX Order 26 § 4b1 ." The note indicated the IP Nurse attempted to redirect Resident #5, but the resident became EX Order 26 and said, 'EX Order 26 § 4b1 ." The note revealed the IP nurse called the family who stated the resident had been EX Order 26 § 4b1 since being in the hospital and indicated the resident, 'EX Order 26 § 4b1 ." The IP Nurse notified the nurse practitioner of the incident. The Progress Notes further indicated the nurse practitioner saw the resident on 11/30/2022 at 3:24 PM and indicated the resident wanted to leave the facility.

Review of "Progress Notes," dated 12/05/2022 at 12:09 PM, revealed Resident #5 was 'EX Order 26 § 4b1 The note further indicated the resident believed the resident could go EX Order 26 § 4b1 . However, the provider had discussed this with EX Order 26 § 4b1 stated the resident was EX Order 26 § 4b1 The note further indicated the resident had NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26 . According to the Progress Notes,

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Resident #5 had a diagnosis of EX Order 26 § 4b1 [redacted].

Review of "Progress Notes," dated 12/09/2022 at 11:43 AM, revealed Registered Nurse (RN) #9 documented Resident #5 was EX Order 26 § 4b1 himself/herself in and out of other residents' rooms and the resident was unable to be redirected. The resident would become EX Order 26 § 4b1 and EX Order 26 § 4b1 " in the hallway. The Progress Notes further indicated at EX Order 26 § 4b1 on EX Order 26 § 4b1, Resident #5 was 'EX Order 26 § 4b1 [redacted]" in the resident's room. The note indicated the resident stated, 'EX Order 26 § 4b1 [redacted] and the physician was notified immediately.

The "Progress Notes" indicated at 4:13 PM on 12/09/2022, the physician saw the resident and was 'EX Order 26 § 4b1 " and 'EX Order 26 § 4b1 [redacted]"

There was no documented evidence the facility reassessed the resident for EX Order 26 § 4b1 or identified Resident #5 as a EX Order 26 § 4b1 EX Order 26 § 4b1 [redacted].

A review of "Progress Notes," dated 12/09/2022 at 4:45 PM, revealed Resident #2 was very NJ Exec. Order 26:4 [redacted]. The resident was "Demanding to go home. EX Order 26 § 4b1 [redacted]. Unable to be NJ Exec. Order 26:4.b.1 [redacted]." The note indicated the resident's family was notified and gave permission to transfer the resident. EX Order 26 § 4b1 [redacted] was notified, and the resident willingly left with EX Order 2 [redacted].

A review of an EX Order 26 § 4b1 " form dated 12/09/2022, revealed Resident #5 had "At

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Risk Alerts" that included being a "EX Order 26 § 4b1" and being at risk for EX Order.

A review of the hospital history and physical, dated 12/09/2022 at 8:45 PM, revealed Resident #5 presented to the NJ Exec. Order 26:4.b.1 with altered EX Order 26 § 4b1. The resident was EX Order 26 § 4b1 and not offering any subjective history. The resident became EX Order 26 § 4b1 toward other residents and became EX Order 26 § 4b1 which prompted the facility to send the resident to the NJ Exec. The resident was found to have a EX Order 26 § 4b1 for which the resident was being admitted.

A review of a hospital physician "Progress Note," dated 12/13/2022, revealed while at the NJ Exec. Order 26:4.b.1 Resident #5 tried to leave, and the NJ Exec. Order 26 I had a one-to-one sitter with the resident. The note revealed the resident had EX Order 26 § 4b1 that had been EX Order 26 § 4b1.

A review of a hospital physician's progress note, dated 12/14/2022 at 10:36 AM, revealed Resident #5 had no EX Order 26 § 4b1 EX Order 26 § 4b1 The physician indicated the resident was EX Order 26 § 4b1.

Review of the resident's NJ Exec. Order 26:4.b.1 stay record, which was part of Resident #5's facility readmission packet on NJ Exec. Order 26 4.b.1, revealed a progress note from a NJ Exec. Order 26:4.b.1 nurse dated 12/13/2022 at 4:45 AM, that indicated "Patient got NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 after using the restroom at 4:45 AM." The note indicated Resident #5 "EX Order 26 § 4b1 " The resident was immediately placed on NJ Exec. Order 26:4.b.1 with

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nursing staff helping. However, the resident "got out of [his/her] room and begun to walk out of the building AMA." Security was called; however, before security could reach Resident #5, the resident unexpectantly NJ Exec. Order 26:4.b.1 [redacted] Upon arrival, security escorted the resident to the resident's room and one on one supervision continued.

A review of a "Fast Track" form, dated 12/15/2022, revealed Resident #2 was readmitted to the facility on NJ Exec. Order 26 4.b.1 at 11:30 AM.

Review of Resident #5's MDS assessments revealed the facility completed an entry MDS on 12/15/2022, following the NJ Exec. Order 26:4.b.1 stay and submitted the MDS on 12/19/2022.

A review of an "Admission/Re-Admission Evaluation-V7," with an admission date of 12/15/2022 but signed by the nurse on 11/25/2022, submitted by the facility following the survey exit date, indicated the resident had no EX Order 26 § 4b1 [redacted] symptoms. There was no documented evidence that the facility identified the resident was at risk of EX Order 26 § 4b1 nor developed interventions to address the resident's risk.

A review of a "Witness Statement" revealed Certified Nurse Aide (CNA) #3 provided a statement to the facility regarding an incident with Resident #5 on 12/15/2022 at 3:42 PM. According to the statement, CNA #3 was in her car going home when she saw Resident #5 walking in the rain. The CNA parked her car and walked with the resident back inside the facility. The statement indicated CNA #3 told the nurse who was responsible for Resident #5's care about the incident and the nurse told the CNA to be

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quiet.

A review of Resident #5's electronic medical record revealed the surveyor was unable to determine what transpired with Resident #5 from readmission to the facility on [NJ Exec. Order 26 4.b.1] at 11:30 AM until a staff member found the resident outside unsupervised by a four-lane highway near the facility at approximately 3:05 PM.

A review of the weather history for the area on [NJ Exec. Order 26 4.b.1] at 2:54 PM and 3:19 PM, obtained from www.wunderdground.com, revealed the temperature was 43 degrees Fahrenheit and it was raining.

On 02/17/2023 at 1:32 PM, CNA #3 was interviewed. CNA #3 stated she primarily worked on the 7:00 AM to 3:00 PM shift at the facility. CNA #3 stated when she was leaving work on [NJ Exec. Order 26 4.b.1], she was driving out of the facility parking lot when she observed Resident #5 standing outside in the rain. It was approximately 3:05 PM. Resident #5 was close to the busy, four-lane highway, by the facility's monument sign. The CNA indicated she parked her car and walked up to Resident #5 to see if the resident was okay. The resident told CNA #3 that the resident was waiting for the bus. CNA #3 stated she was able to coax the wet resident back into the facility. CNA #3 stated Resident #5 had just returned to the facility from a [NJ Exec. Order 26.4] stay at approximately 1:00 PM. CNA #3 stated when she assisted Resident #5 back to the North Unit, CNA #3 reported the resident's [EX Order 26 § 4b1] to the Charge Nurse, Registered Nurse (RN) #15. RN #15 responded to CNA #3 by making a "Shhh" sign, by using her index finger over her mouth. CNA #3 stated she was always taught to report

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things such as an EX Order 26 § 4b1 and she did not appreciate being told to "shhh" when this was important, and the resident's safety was at risk. CNA #3 stated, "They like to sweep things under the rug around here." CNA #3 further stated the facility had video surveillance and the Director or Maintenance (DOM) had access to the footage. Further interview with CNA #3 revealed the CNA wrote a statement about Resident #5's EX Order 26 § 4b1 and gave it to Licensed Practical Nurse (LPN) #16.

On 02/17/2023 at 2:50 PM, the DOM was interviewed in the maintenance office that housed the video surveillance equipment. While the DOM was retrieving the video, he stated that Resident #5 could be seen walking right out the front door. He continued by stating the camera on the front of the building was not very clear, but Resident #5 could be seen standing at the edge of the property by the monument sign. The DOM revealed that the Nursing Home Administrator (NHA) reviewed the video the day the resident EX Order 26 § 4b The DOM stated that while he did not have a lot of information about the EX Order 26 § 4b1 he knew no one in the facility was aware that Resident #5 had walked out the front of the facility and the police were never called. The DOM revealed the facility would routinely follow up with in-service training after an event such as an EX Order 26 § 4b1 but nothing was done following the EX Order 26 § 4b1 with Resident #5.

Observation of the facility's video surveillance footage with the DOM revealed on 12/15/2022 at 3:06 PM there were approximately five people standing around the front lobby reception desk. Per the video, Resident #5 walked around the people at the desk and proceeded to walk out the

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front door. The front entry to the facility had two sets of doors. Resident #5 first walked out the door into a vestibule area and then out the second door to the outside. An observation of the video footage revealed that no one acknowledged Resident #5 leaving the facility. The camera located on the front of the building showed Resident #5 walking towards the four-lane highway. At EX Order 26 § 4b1, Resident #5 was seen walking back toward the facility, escorted by CNA #3. Resident #5 returned to the front lobby at EX Order 26 § 4b1.

On 02/20/2023 at 10:03 AM, Receptionist #20 was interviewed. Receptionist #20 stated that unless the resident had a EX Order 26 § 4b1 EX Order 26 § 4b1 EX Order 26 § 4b1 EX Order 26 § 4b1 EX Order 26 § 4b1 EX Order 26 § 4b1, she would not necessarily realize if a resident went out the front door. She stated she never saw Resident #5 walk out. Receptionist #20 stated the day Resident #5 walked out there were about four or five people standing around the reception desk, "and it wasn't until I saw CNA #3 bring Resident #5 back in that I found out the resident had walked out." She revealed the facility had a notebook at the front desk with a list of residents who EX Order 26 § 4b1, but the same residents also had a EX Order 26 § 4b1 EX Order 26 § 4b1. If one of those residents came near the front door, the door would lock, and an alarm would sound. Resident #5 did not have EX Order 26 § 4b1 EX Order 26 § 4b1.

On 02/18/2023 at 10:18 AM, RN #15 was interviewed regarding EX Order 26 § 4b1. RN #15 stated that when a resident EX Order 26 § 4b1 out of the facility they called a code, they notified the DON and/or the nursing supervisor, and if the resident could not be found, the police were also notified. RN

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#15 stated her definition of [EX Order 26 § 4b1] was anyone who left the facility without staff letting them out. RN #15 stated she did not recall any recent [EX Order 26 § 4b1]. When asked specifically about the day Resident #5 [EX Order 26 § 4] on [NJ Exec. Order 26 4.b.1] RN #15's response was, "Now you did it." RN #15 followed up and stated she did not remember a resident with Resident #5's name. RN #15 stated if any resident left the building, it should be considered an [EX Order 26 § 4b1] and should always be reported.

A follow-up interview with RN #15 on 02/18/2023 at 11:25 AM, revealed RN #15 had no recollection of CNA #3 reporting that a resident had [EX Order 26 § 4]. RN #15 stated if she was giving report, then she had no memory of CNA #3 reporting an [EX Order 26 § 4b1]

On 02/18/2023 at 11:41 AM, LPN #16 was interviewed. LPN #16 defined [EX Order 26 § 4b1] as a time when a resident walked out the door unsupervised. LPN #16 stated the procedure following an [EX Order 26 § 4b1] was to report the incident and place a [EX Order 26 § 4b1] on the resident. LPN #16 indicated Resident #5 walked out the front door because the resident did not want to be at the facility. During the previous admission, LPN #16 stated Resident #5 was always looking for his/her purse so the resident could go home. According to LPN #16, Resident #5 had not previously [EX Order 26 § 4b1] off the unit, but would [EX Order 26 § 4b] into other resident rooms. LPN #16 stated one of the CNAs (CNA #3) found Resident #5 outside when she was leaving for the day. LPN #16 indicated CNA #3 wrote out a statement about the [EX Order 26 § 4b1] and LPN #16 gave the statement to the NHA to use for reporting the incident.

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On 02/18/2023 at 4:35 PM, LPN #18 was interviewed via the telephone. LPN #18 defined EX Order 26 § 4b1 as "when a resident steps outside that front door." He stated if a resident was trying to leave, a EX Order 26 § 4b1 would be placed on the resident, and the DON, physician, and family would be notified. LPN #18 did not recall ever working with Resident #5 and did not recall being notified of an EX Order 26 § 4b1

On 02/20/2023 at 10:33 AM, LPN #2 was interviewed. LPN #2 stated a resident needed to be supervised if they were going out the front door. LPN #2 recalled Resident #5 and remembered the resident was transferred to the NJ Exec. Order 26. LPN #2 stated she received a report from the hospital about 30 minutes prior to Resident #5 returning to the facility on NJ Exec. Order 26 4.b.1. However, LPN #2 stated she never saw Resident #5 when the resident returned and was never told that the resident was EX Order 26 § 4b1 . LPN #2 stated when a resident was EX Order 26 § 4b1 , the nurse was expected to take NJ Exec. Order 26:4.b.1 right away. She stated it would be unusual for a resident to EX Order 26 § 4b1 . LPN #2 also stated that as a nurse, "You don't forget when you hear about an EX Order 26 § 4b1 LPN #2 stated it was a huge concern if an EX Order 26 § 4b1 happened during a shift change, and both nurses did not remember the incident. LPN #2 followed up by stating, "I have been told by leadership to not discuss some situations."

On 02/18/2023 at 1:05 PM, the NHA was interviewed. The NHA defined EX Order 26 § 4b1 as someone who left a secured area without people knowing they were gone and without having eyes on the resident. She stated a EX Order 26 § 4b1

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bracelet would be placed on a resident who had EX Order 26 § 4b The NHA stated she did not view the instance when Resident #5 left the facility as an EX Order 26 § 4b1 The NHA stated when Resident #5 returned from the EX Order 26 § 4b1, the resident indicated a desire to go home and was not going to stay at the facility. According to the NHA, if assessments were not completed when the resident came back from the NJ Exec. Order 26:4.b on NJ Exec. Order 26 4.b.1, she did not consider the resident as having been readmitted to the facility. After learning that an entry MDS had been completed and submitted for Resident #5, the NHA then stated that she would have to agree "that Resident #5 was re-admitted, if there was an MDS done." The NHA stated she had reviewed the incident with Regional Director of Operation (RDO) #17, who agreed that it was not a reportable occurrence.

On 02/19/2023 at 1:11 PM, RDO #17 was interviewed via the telephone. Initially during the interview, RDO #17 stated he understood the facts to be that Resident #5 was a EX Order 26 § 4b1 and did not want to stay. He stated it was his understanding that there was no consent to treat, no assessments had been completed, and the family picked up the resident. The RDO acknowledged he told the staff Resident #5 did not EX Order 26 if the resident was never EX Order 26 § 4b1. He stated, "EX Order 26 § 4b1 " RDO #17 revealed he did not know Resident #5 was a EX Order 26 § 4b1 to the facility. He stated the NHA had not made him aware of this information. RDO #17 stated the staff should have kept Resident #5 safe.

On 02/18/2023 at 1:57 PM, the Regional Director of Clinical Services (RDCS) was interviewed.

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The RDCS stated her definition of an EX Order 26 § 4b1 was when a resident exited the building without the staff being aware. Regarding Resident #5, the RDCS stated if none of the staff knew the resident had gone outside, then it was an EX Order 26 § 4b1 The RDCS stated if the resident had not allowed the staff to complete the admission assessment because the resident wanted to go home, then the facility would have to call the NJ Exec. Order 26 to get the resident somewhere safe. The RDCS stated if those assessments did not occur, then the resident would not be considered admitted. The RDCS continued by stating the facility was responsible for Resident #5 as long as the resident was in the facility. However, the RDCSF stated she would need more information about what happened from the time Resident #5 returned to the facility to when Resident #5 left to determine if there was an EX Order 26 § 4b1

Removal Plan:

"1. Resident #5 no longer resides at the center. All residents who are at risk for EX Order 26 § 4b1 were reviewed by licensed nursing staff on 02/19/2023 using the new EX Order 26 § 4b1 risk assessment. It includes EX Order 26 § 4b1 , days of residence, history of EX Order 26 § 4b1 for the last three months, is there a transient medical cause contributing to increasing EX Order 26 § 4b1, and is there a transient cause contributing to increased EX Order 26 § 4b1 The assessment is currently on paper. The licensed nurses observed the EX Order 26 § 4b EX Order 26 § 4 in place on the six residents that were previously identified as being at risk for EX Order 26 § 4b1 The nursing staff checked the EX Order 26 § 4b EX Order 26 § 4 for functioning. All EX Order 26 § 4b1 functioned appropriately. All six

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residents had a care plan in place for EX Order 26 § 4b1 risk. All facility residents were reviewed by licensed nurses using the EX Order 26 § 4b1 risk assessment. There is an EX Order 26 § 4b1 risk list at the reception desk. This list has been there since prior ownership.

When a resident exhibits a change that indicates they could be at risk for EX Order 26 § 4b1, an EX Order 26 § 4b1 assessment will be completed by a licensed nurse. Changes that may indicate a resident is at risk for EX Order 26 § 4b1 may include NJ Exec. Order 26 4.b.1 behaviors, which could include verbalization of wanting to leave the facility.

2. All nursing supervisors, nurses, nurse's aides, and staff in all departments were in-serviced on 02/23/2023 by the NHA/DON/Designee on EX Order 26 § 4b1 assessments, EX Order 26 § 4b1 care planning, and EX Order 26 § 4b1 interventions. Staff who work per diem or who are on time off will be in-serviced at the beginning of their next shift.

3. A new EX Order 26 § 4b1 risk evaluation will be completed by licensed nurses on all residents upon admission, re-admission, quarterly, and with any changes. When a resident exhibits signs that they have had a change that indicates they could be at risk for EX Order 26 § 4b1 an EX Order 26 § 4b1 assessment will be completed by licensed nurses. Residents identified as being at risk for EX Order 26 § 4b1 will have a EX Order 26 § 4EX Order 26 § placed by licensed nurses as well as a care plan for being at risk for EX Order 26 § 4b1. The provider and resident responsible party are also notified.

4. The NHA/DON/Designee will review admissions and if a resident triggers for being at risk for EX Order 26 § 4b1 based on the EX Order 26 § 4b1

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assessment, the DON/NHA/Designee will confirm placement of the EX Order 26 § 4b1 and confirm care planning for risk for EX Order 26 § 4b1 is in place. The NHA/DON/Designee will review residents that have been identified as being at risk for EX Order 26 § 4b1 after admission for placement of the EX Order 26 § 4b1 EX Order 26 § and a care plan for risk for EX Order 26 § 4b1 These audits will be conducted weekly x [for] 4 weeks, then every other week for 4 weeks, and then monthly x [for] three months. All findings will be reviewed at the quarterly quality assurance meetings.

5. All corrections were completed on 02/23/2023.

6. The immediacy of the IJ was removed on 02/23/2023."

Onsite Verification of Removal Plan:

The survey team conducted an onsite verification that the Removal Plan had been implemented on 02/24/2023. The IJ was removed on 02/24/2023 at 6:30 PM. The survey team verified the use of a new NJ Exec. Order 26:4.b.1 assessment and verified that the facility completed NJ Exec. Order 26:4.b.1 assessments on all residents in the facility. The survey team verified that the residents identified at risk for NJ Exec. Order 26 4.b.1 had a care plan in place and were identified on a list kept at the reception desk. The survey team verified educational sign-in sheets for staff education regarding NJ Exec. Order 26 4.b.1 were completed. All staff members were identified by the facility as having received the education and signed the in-service sheets. This was verified by interviews on 02/24/2023 with two staff from housekeeping, three staff from therapy, two dietary staff, an activity assistant, four CNAs, one LPN, one RN, the MDS

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F 689	Continued From page 51 coordinator, the DON, and the Administrator. Interviews with these staff revealed education had been provided regarding when NJ Exec. Order 26:4.b.1 assessments would be completed, what to do if a resident exhibited NJ Exec. Order 26:4.b.1, interventions to prevent an NJ Exec. Order 26:4.b.1, and notifying responsible parties and providers of NJ Exec. Order 26:4.b.1 attempts. The survey team verified new residents admitted to the facility had an NJ Exec. Order 26 4.b.1 assessment completed upon admission. The survey team verified the facility had completed an initial audit to identify residents at risk for NJ Exec. Order 26:4.b.1 t and interviews with the DON and Administrator verified that these audits would be completed weekly on Mondays.	F 689		
F 842 SS=D	New Jersey Administrative Code § 8:39-27.1(a) Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 842		3/24/23

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F 842	Continued From page 52 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F 842		

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F 842	Continued From page 53 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ160982 and #NJ161004 Based on interviews, record review, and facility policy review, the facility failed to maintain complete and accurate records for 1 (Resident #5) of 1 resident EX Order 26 § 4b1 [redacted]. Findings included: Review of a facility policy titled, "Medical Records," dated 03/2022, specified, "One of the most important responsibilities in Medical Records is the accuracy and completeness of each patient's clinical record. Responsibilities of the Medical Records department staff include, but are not limited to: Protect and collect records." The policy further specified, "Track incomplete records; Produce records on request." Review of a facility policy titled, "Against Medical Advice," revised 2022, specified, "Policy. A resident/resident representative may leave the Facility against the advice of his/her physician. Procedure. I. Mitigating circumstances influencing the resident's decision to leave should be evaluated and addressed in an effort to prevent the resident from leaving against medical advice	F 842	Resident # 5 is no longer in the facility All residents have the potential to be affected by the facility failing to maintain complete and accurate records. The Administrator or designee will re-educate all departments' staff on the facility's responsibility to maintain complete and accurate resident records. The administrator or designee will conduct medical record audits on all AMA weekly for 1 month then monthly for 3 months then bring to QAPI review for 3 months.	

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(AMA). II. A licensed nurse will notify the attending physician, on call physician, or medical director of the resident's desire to leave the facility AMA. III. The Facility and/or physician will discuss with the resident and/or the resident's personal representative, if applicable, the reason for the AMA decision and will advise them of the potential consequences of the AMA decision. IV. A licensed nurse will have the resident or the resident's personal representative sign Against Medical Advice. A. If the resident or personal representative refuses to sign, the licensed nurse will read the form to the resident, make a specific notation in the progress notes of the refusal to sign, and have a witness sign the form as acknowledgment of the resident's or resident's personal representative's refusal to sign." The policy further specified, "VI. If the resident demonstrates the following risks, the charge nurse will notify the Administrator/designee, Director of Nursing Services, Attending Physician, Responsible Party, and law enforcement: A. Resident displays impaired cognition. B. Resident is at risk of harming self or others. VII. Nursing staff will document in the progress notes all pertinent information concerning the resident's actions, including the resident's stated reasons for his/her desire to leave the Facility."

Review of the "Admission Record Report" revealed Resident #5 was admitted to the facility with diagnoses that included EX Order 26 § 4b1 [redacted] The Admission Record Report identified a family member as the first emergency contact for Resident #5.

The admission Minimum Data Set (MDS), dated 12/02/2022, revealed Resident #5 had a Brief

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Interview for Mental Status (BIMS) score of [redacted], which indicated the resident had [redacted].

Review of the "Care Plan," initiated 11/25/2022, revealed Resident #5 showed a potential for [redacted] and the resident and a relative had expressed a need for [redacted].

Review of the "Admission Record Report" indicated Resident #5 was re-admitted to the facility on [redacted], following a [redacted].

Review of the "Progress Notes" revealed a discharge planning/discharge entry, dated [redacted] at 4:26 PM. The entry indicated that at 3:50 PM, the resident's emergency contact gave the facility permission to have another family member sign Resident #5 out against medical advice (AMA) and take the resident home. The Progress Notes further indicated the family member signed the AMA form and took Resident #5 from the facility.

During a telephone interview on 02/17/2023 at 3:48 PM, Resident #5's emergency contact did not recall who they spoke with from the facility, but the other family member was supposed to sign paperwork to allow Resident #5 to go home. The emergency contact stated the facility was supposed to have Resident #5 and the family member sign discharge paperwork. The emergency contact stated the facility had called to inform him/her that Resident #5 was at the front desk and wanted to be discharged.

During an interview on 02/18/2023 at 11:41 AM, Licensed Practical Nurse (LPN) #16 stated that on [redacted], after Resident #5 had [redacted] from

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the facility, a family member arrived to take Resident #5 home AMA. The Administrator was still fairly new and did not know where to locate the AMA paperwork. LPN #16 stated she gave the AMA paperwork to the Administrator to have the resident fill out and sign. LPN #16 stated to the best of her knowledge, the AMA paperwork was signed by Resident #5 and the family member who picked up the resident, but she was not aware of what happened with the AMA paperwork.

During an interview on 02/18/2023 at 1:05 PM, the Administrator stated since Resident #5 had just returned to the facility and expressed not wanting to stay, the Administrator did not feel as though Resident #5 had actually been admitted back into the facility. The Administrator stated she thought it was "worthwhile noting" to have the AMA paperwork filled out. The Administrator viewed the AMA paperwork as Resident #5 was refusing the admission and that was against medical advice.

On 02/18/2023 at 4:20 PM, the Administrator stated she did not have Resident #5 sign AMA paperwork. The Administrator stated maybe LPN #16 had the family member sign it. At this time, the facility was unable to locate the AMA paperwork. The Administrator stated Resident #5's emergency contact gave verbal permission for Resident #5 to leave the facility AMA.

On 02/19/2023 at 10:43 AM, the Administrator stated LPN #16 had the family sign the AMA paperwork. The facility was still unable to produce Resident #5's AMA paperwork.

During an interview on 02/24/2023 at 5:32 PM,

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F 842	Continued From page 57 the Director of Nursing (DON) stated that when a resident requested to leave and the resident was not medically stable per the physician, the resident was asked to fill out AMA paperwork. The DON stated the AMA paperwork should remain in the resident's medical record, whether it was uploaded into the electronic record or the paper chart. During an interview on 02/24/2023 at 6:19 PM, the Administrator stated if a resident wanted to leave without a discharge plan, the facility staff would call the physician and let the physician know. The Administrator stated the physician might say it was okay, but if the physician said it was not safe, then the facility staff had the resident sign AMA paperwork. Per the Administrator, sometimes residents refused to sign the AMA paperwork. The Administrator stated that once the AMA paperwork was signed, it should be put in the resident's chart. According to the Administrator, Resident #5's AMA paperwork should have gone to medical records to be put into the resident's record. New Jersey Administrative Code § 8:39-35.2(d)12	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		3/24/23

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F 880	Continued From page 58	F 880		

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
(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

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F 880	Continued From page 59 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, and facility policy review, the facility failed to ensure 3 (Certified Nursing Aide [CNA] #12, CNA #13, and Registered Nurse [RN] #14) of 3 staff observed working on the COVID-19 (coronavirus disease 2019) Hallway removed their N95 mask and face shield before exiting the room of a resident who tested positive for COVID-19. This had the potential to affect 16 of 16 residents residing on the COVID-19 Hallway. Findings included: The facility policy titled, "Donning and Doffing PPE (Personal Protective Equipment)," revised 03/2022, indicated the purpose of the policy was, "To guide the proper procedure to don and doff PPE." The policy specified, "How to take off (doff) PPE gear. 1. Remove Gloves. Ensure glove removal does not cause additional contamination of hands. Gloves can be removed using more	F 880	C.N.A. #12, C.N.A. #13, and R.N. #14 were immediately re-educated and in addition staff have been re-educated on the importance of when to wear PPE and how to properly wear and donn/doff PPE. There was no negative outcome related to the three staff members improperly donning/doffing. All residents have the potential to be affected by the facility failing to ensure staff wear, donn, and doff PPE appropriately. The Administrator or designee will re-educate all departments' staff will be re-educated with inservices as directed: Module 1: Infection Prevention and Control Program; CDC Covid-19 Prevention Messages for Front Line Long-Term Care Staff: Keep Covid 19	

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F 880	Continued From page 60 than one technique (e.g., glove-in-glove or bird beak). 2. Remove gown. Untie all ties (or unsnap all buttons). Some gown ties can be broken rather than untied. Do so in gentle manner, avoiding a forceful movement. Reach up to the shoulders and carefully pull down and way from the body. Rolling the gown down is an acceptable approach. Dispose in trash receptacle with a covering/lid. 3. Healthcare personnel may now exit patient room. 4. Perform hand hygiene. 5. Remove face shield or goggles. Carefully remove face shield or goggle by grabbing the strap and pulling upwards and away from the head. Do not touch the front of face shield or goggles. Face shields or goggles should be cleaned with an EPA (Environmental Protection Agency) approved product according to the manufacture's guidelines. 6. Remove and discard respirator (or facemask if used instead of respirator). Respirator: Remove the bottom strap by touching only the strap and bringing it carefully over the head. Grasp the top strap and bring it carefully over the head, and then pull the respirator away from the face without touching the front of the respirator. Facemask: Carefully untie (or unhook from the ears) and pull away from the face without touching the front. 7. Perform hand hygiene after removing the respirator/face mask and before putting it on again if your workplace is practicing reuse." During interview on 02/17/2023 at 11:30 AM, the Infection Preventionist Nurse (IP Nurse) stated staff provided by a staffing agency received a packet of documents to review and check off along with an orientation to the unit. The IP Nurse stated it was her expectation that before staff entered a room where a resident who tested positive for COVID-19 resided, staff would don an	F 880	Out!; CDC Covid-19 Prevention Messages for Front Line Long-Term Care Staff: Use PPE Correctly for Covid-19; Module 5: Outbreaks; Module 6A-Principles of Standard Precaution; Module 6B-Principles of Transmission Based Precautions Completed RCA The administrator or designee will conduct and conclude education on Module 1: Infection Prevention and Control Program; CDC Covid-19 Prevention Messages for Front Line Long-Term Care Staff: Keep Covid 19 Out!; CDC Covid-19 Prevention Messages for Front Line Long-Term Care Staff: Use PPE Correctly for Covid-19; Module 5: Outbreaks; Module 6A-Principles of Standard Precaution; Module 6B-Principles of Transmission Based Precautions. The administrator or designee will conduct PPE, donning, and doffing audits weekly and will provide report to QA x 3 months. Staff will be reducated by April 21, 2023, any staff not present will be re-educated prior to next shift worked.	

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N95 mask, gown, face shield, and gloves. She added that before the staff person exited the COVID-19 positive room, the staff person should doff all PPE including, their face shield and N95 mask. The IP Nurse stated she had not been doing return demonstrations with staff to ensure they were donning and doffing PPE properly.

On 02/17/2023 at 12:32 PM, CNA #12 who was wearing an N95 mask and face shield, was observed donning a gown and gloves prior to entering a COVID-19 positive room, Room 157. Prior to leaving the COVID-19 positive room, CNA #12 was observed doffing the gown and gloves inside the room but exited the room wearing the N95 mask and face shield. At 12:35 PM, CNA #12 was interviewed. CNA #12 revealed she had not been changing her N95 mask and face shield when leaving a COVID-19 positive room and wore the same N95 mask and face shield throughout the day while caring for residents who tested positive for COVID-19 and residents who were not positive for COVID-19. When asked about doffing the N95 mask and face shield, CNA #12 asked, "Am I supposed to?" CNA #12 stated she had not received any training from the facility..

During an interview on 02/17/2023 at 12:40 PM, CNA #13 indicated it was her second day working at the facility through a staffing agency. CNA #13 said she was given an orientation packet to read through and sign but had not been asked to demonstrate how to don/doff the PPE. CNA #13 stated she wore the same face shield and N95 mask when providing care for various residents in COVID-19 positive and COVID-19 negative rooms and was never told the N95 mask and face shield had to be changed.

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F 880	Continued From page 62 On 02/17/2023 at 3:43 PM, the Administrator was interviewed. The Administrator stated the facility was addressing education for agency CNAs about how to properly don and doff PPE, including doffing the N95 mask and face shield when exiting a COVID-19 positive room. On 02/18/2023 at 9:50 AM, Registered Nurse (RN) #14 was observed exiting a NJ Exec. Order 26:4.b.1 [redacted] RN #14 did not remove her N95 mask or face shield. RN #14 was interviewed, and stated she was trained to doff PPE, including N95 masks and face shields, inside the NJ Exec. Order 26:4.b.1 prior to exiting. RN #14 stated she had been working at the facility for a few months and her training did not consist of any return demonstration. During an interview on 02/24/2023 at 5:32 PM, the Director of Nursing (DON) stated that when staff went into an isolation room, they should wear a gown, N95 mask, eye protection, and gloves, and when exiting the room, they should doff all the PPE and clean the goggles. She stated the staff could wear a surgical mask over their N95 mask and then discard the surgical mask when they came out of the room or just change the N95 mask. She stated training was being done with agency staff regarding PPE use, and it was part of their training checklist that was completed by all agency staff. The checklist was requested at that time and was not provided by the end of the survey. During an interview on 02/24/2023 at 6:16 PM, the Administrator stated that staff should be wearing an N95 mask, face shield, gown, and gloves when going into an isolation room. She	F 880		

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F 880	Continued From page 63 stated the staff could also put a surgical mask over the N95 and then remove the surgical mask when they came out of the room. Otherwise, they would remove their N95 mask and clean the face shield. The Administrator stated they had a checklist for agency CNAs that covered PPE use. New Jersey Administrative Code §8:39-19.4(a)1-6	F 880		

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S 000	Initial Comments Census: 118 Sample Size: 27 TYPE OF SURVEY: Complaint The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:39, Standards for Licensure of Long-Term Care Facilities. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of 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: Complaint Intake #NJ160714, #NJ160982, and #NJ161004 Based on interviews, facility document review, and New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, it was determined that the facility failed to ensure staffing ratios were met. The facility was deficient in certified nursing assistant (CNA) staffing for residents on 35 of 42 day shifts and deficient in CNAs to total staff on 1 of 42 overnight shifts from 01/01/2023 through	S 560	Staffing ratios not met. There were no negative outcomes to residents related to staffing. All residents have the potential to be affected by the facility failing to ensure staffing ratios are met. The facility will continue to recruit new staff through word of mouth and posting on corporate recruitment site. The staffing	3/24/23

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

Electronically Signed | 03/17/23

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S 560	Continued From page 1 02/11/2023. This deficient practice had the potential to affect all residents. Findings included: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One certified nurse aide to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each direct staff member shall be signed in to work as a certified nurse aide 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 certified nurse aide and perform certified nurse aide duties. A review of the "Nurse Staffing Report," completed by the facility from 01/01/2023 through 02/11/2023, revealed staff-to-resident ratios that did not meet the minimum requirements. The facility was deficient in CNA staffing for residents on 35 of 42 day shifts and deficient in CNAs to total staff on 1 of 42 evening shifts as follows:	S 560	coordinator/designee will support staffing with the use of agency staffing. The Administrator or designee will re-educate staff on the importance of not calling out. The administrator or designee will conduct 1 audit of daily staffing weekly and will provide report to QA x 3 months. Staff will be re-educated on the importance of not calling out for scheduled shifts.	

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S 560	Continued From page 2 - 01/04/2023 CNA day shift staff was 12.4 for 106 residents. Staffing should have been 13. - 01/05/2023 CNA day shift staff was 11.9 for 106 residents. Staffing should have been 13. - 01/06/2023 CNA day shift staff was 9 for 109 residents. Staffing should have been 14. - 01/07/2023 CNA day shift staff was 11 for 109 residents. Staffing should have been 14. - 01/08/2023 CNA day shift staff was 9.8 for 111 residents. Staffing should have been 14. - 01/09/2023 CNA day shift staff was 11.9 for 111 residents. Staffing should have been 14. - 01/11/2023 CNA day shift staff was 9.7 for 111 residents. Staffing should have been 14. - 01/12/2023 CNA day shift staff was 9.8 for 111 residents. Staffing should have been 14. - 01/13/2023 CNA day shift staff was 9 for 113 residents. Staffing should have been 14. - 01/14/2023 CNA day shift staff was 9.9 for 112 residents. Staffing should have been 14. - 01/15/2023 CNA day shift staff was 11.9 for 111 residents. Staffing should have been 14. - 01/16/2023 CNA day shift staff was 7 for 111 residents. Staffing should have been 14. - 01/17/2023 CNA day shift staff was 11 for 111 residents. Staffing should have been 14. - 01/18/2023 CNA day shift staff was 12 for 111 residents. Staffing should have been 14. - 01/19/2023 CNA day shift staff was 13 for 111 residents. Staffing should have been 14. - 01/20/2023 CNA day shift staff was 8.8 for 112 residents. Staffing should have been 14. - 01/21/2023 CNA day shift staff was 9.8 for 106 residents. Staffing should have been 13. - 01/22/2023 CNA day shift staff was 9 for 103 residents. Staffing should have been 13. - 01/23/2023 CNA day shift staff was 7.9 for 103 residents. Staffing should have been 13. - 01/25/2023 CNA day shift staff was 6.1 for 103 residents. Staffing should have been 13.	S 560		

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- 01/26/2023 CNA day shift staff was 8.9 for 103 residents. Staffing should have been 13.
- 01/27/2023 CNA day shift staff was 4.3 for 108 residents. Staffing should have been 13.
- 01/28/2023 CNA day shift staff was 9.8 for 108 residents. Staffing should have been 13.
- 01/29/2023 CNA day shift staff was 8.5 for 108 residents. Staffing should have been 13.
- 01/30/2023 CNA day shift staff was 4.1 for 108 residents. Staffing should have been 13.
- 01/31/2023 CNA day shift staff was 10 for 108 residents. Staffing should have been 13.
- 02/01/2023 CNA day shift staff was 4.8 for 108 residents. Staffing should have been 13.
- 02/02/2023 CNA day shift staff was 7.5 for 108 residents. Staffing should have been 13.
- 02/03/2023 CNA day shift staff was 9.8 for 110 residents. Staffing should have been 14.
- 02/04/2023 CNA day shift staff was 11.5 for 114 residents. Staffing should have been 14.
- 02/05/2023 CNA day shift staff was 12 for 116 residents. Staffing should have been 14.
- 02/06/2023 CNA day shift staff was 7.6 for 113 residents. Staffing should have been 14.
- 02/08/2023 CNA day shift staff was 13.2 for 113 residents. Staffing should have been 14.
- 02/10/2023 CNA day shift staff was 12.9 for 113 residents. Staffing should have been 14.
- 02/11/2023 CNA day shift staff was 13 for 113 residents. Staffing should have been 14.

- 01/08/2023 Night shift staff was 7 for 111 residents. Staffing should have been 8.

During an interview on 02/24/2023 at 11:15 AM, Physical Therapist Assistant (PTA) #27 stated she felt that on most days they had enough staff to provide the care the residents needed. She stated she thought they were short staffed every two to three weeks. PTA #27 stated the facility

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had hired agency staff to fill in the gaps.

During an interview on 02/24/2023 at 11:34 AM, CNA #28 stated she felt like staffing had gotten better recently. She stated she had 12 people to care for that day and always stayed late to make sure all her tasks were done.

During an interview on 02/24/2023 at 11:47 AM, CNA #29 stated she felt staffing was adequate and that she could do a good job on a consistent basis.

During an interview on 02/24/2023 at 12:15 PM, Licensed Practical Nurse (LPN) #30 stated sometimes they did not have enough staff to meet the residents' needs. He stated it was far better with the new company though. He stated they were used to working shorthanded and just did the best they could even though some tasks, such as showers, did not get done. He stated they tried to give a bed bath if the shower could not be done.

During an interview on 02/24/2023 at 12:32 PM, Registered Nurse (RN) #31 stated staffing for the nurses was better but they were still short CNA staff. She stated tasks such as showers and fresh water being passed did not get done when they were short staffed.

During an interview on 02/24/2023 at 12:48 PM, CNA #32 stated they worked short staffed all the time, and some things did not get done when they were short staffed, such as showers. She stated they tried to do bed baths instead to save time.

During an interview on 02/24/2023 at 5:32 PM, the Director of Nursing (DON) stated they had a couple of occasions when staff called out (were

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 5 absent from work) and they were not able to cover it. She stated she had been meeting with the staff and talking to them about their commitment and the need for them to be at the facility. She stated she had been doing some education with staff members who were calling out. She stated most of the issues were with the CNAs. The DON said they were using agency staff more and had seen an improvement. She stated she met with the staffing coordinator and worked to get shifts covered. She stated she thought she had approximately four to five day-shift CNA positions available at that time (on 02/24/2023). She stated most of the call outs she had were the day shift and agency staff use was highest on the day shift. She stated they were working on getting consistent CNAs even if they were agency staff. During an interview on 02/24/2023 at 6:19 PM, the Administrator stated the facility struggled with staffing just like other facilities, but they did their best. She stated they were supplementing the facility staff with agency staff for support but would only allow those staff from the agency who were high quality to remain. She stated if the agency staff did not meet the needs of the residents, then they did not come back. She stated some days facility staff did work short because of call offs. She stated she did not cut the budget on staffing and wanted to provide the best care and advocate for staffing.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08004	A. BUILDING: _____ B. WING _____	R-C 05/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (WASHINC	378 FRIES MILL ROAD SEWELL, NJ 08080

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S 000}	Initial Comments Census: 118 Sample Size: 27 TYPE OF SURVEY: Revisit Based on the revisit survey, the facility remains out of substantial compliance with the standards in the New Jersey Administrative Code 8:39, Standards for Licensure of Long-Term Care Facilities. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of 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 interview, facility document review, and New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, it was determined that the facility failed to ensure staffing ratios were met. The facility was deficient in certified nursing assistant (CNA) staffing for residents on 14 of 14 day shifts reviewed for the weeks of 04/16/2023 - 04/29/2023. This deficient practice had the potential to affect all residents.	{S 560}	1. All residents who were in the facility for the weeks of 4/16/2023-4/29/2023 and 6/5/2022-6/18/2022 were reviewed by their attending physician and none were determined to have had a negative outcome due to facility staffing below the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey on the listed dates and shifts. Nursing management,	5/25/23

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

Electronically Signed | 05/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08004	A. BUILDING: _____ B. WING _____	R-C 05/01/2023

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PROMEDICA SKILLED NURSING & REHAB (WASHINC	378 FRIES MILL ROAD SEWELL, NJ 08080

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S 560}	Continued From page 1 Findings included: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One certified nurse aid 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 certified nurse aides, and each direct staff member shall be signed in to work as a certified nurse aide 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 certified nurse aide and perform certified nurse aide duties. 1. A review of the "Nurse Staffing Report," completed by the facility for the weeks of 04/16/2023 - 04/29/2023, revealed staff-to-resident ratios that did not meet the minimum requirements. The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: - 04/16/2023 had 6 CNAs for 106 residents on the day shift, required 13 CNAs.	{S 560}	administrative staff and contracted agency were also in the facility to ensure resident needs were being met. The staffing coordinator was immediately reeducated by the Licensed Nursing Home Administrator (LHNA) on the State of New Jersey required minimum direct care staff-to-resident ratios. 2. Any residents have the potential to be affected by the deficient practice. 3. The facility has placed the following measures in place to ensure the deficient practice will not occur: The facility has implemented significant above market rate for nurses and certified nursing assistants. Including sign-on bonus where appropriate. The facility continues to conduct ongoing job fairs with immediate interviews and contingency offers. The facility implemented expedited but robust onboarding process to new hires. The facility will use agency staff as needed to meet staffing needs. The facility will utilize or use licensed nurses in the leadership team to compliment call outs or no shows as needed. Non-licensed staff and the facility will assist in rounding's and assisting residents where they can. The facility will use call agency staff to cover for call-outs and no show. 4. The DON/Designee meets with the staffing coordinator daily to review census vs staffing needs. The DON/Designee reviews any call-outs on daily basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{S 560}	Continued From page 2 - 04/17/2023 had 5 CNAs for 105 residents on the day shift, required 13 CNAs. - 04/18/2023 had 8 CNAs for 105 residents on the day shift, required 13 CNAs. - 04/19/2023 had 5 CNAs for 104 residents on the day shift, required 13 CNAs. - 04/20/2023 had 8 CNAs for 104 residents on the day shift, required 13 CNAs. - 04/21/2023 had 12 CNAs for 104 residents on the day shift, required 13 CNAs. - 04/22/2023 had 10 CNAs for 104 residents on the day shift, required 13 CNAs. - 04/23/2023 had 10 CNAs for 104 residents on the day shift, required 13 CNAs. - 04/24/2023 had 8 CNAs for 104 residents on the day shift, required 13 CNAs. - 04/25/2023 had 6 CNAs for 107 residents on the day shift, required 13 CNAs. - 04/26/2023 had 8 CNAs for 107 residents on the day shift, required 13 CNAs. - 04/27/2023 had 7 CNAs for 107 residents on the day shift, required 13 CNAs. - 04/28/2023 had 12 CNAs for 105 residents on the day shift, required 13 CNAs. - 04/29/2023 had 11 CNAs for 105 residents on the day shift, required 13 CNAs. During an interview on 05/01/2023 at 4:00 PM, the Administrator was made aware the staffing deficiency could not be cleared as part of the revisit and had to be re-cited. The Administrator stated they were doing all they could do to ensure staffing met the state standards.	{S 560}	The DON/Designee will monitor call outs and submit findings tot he administrator and QAPI committee for further review and recommendation. The DON/Designee audits staffing needs weekly x 3 months and the results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.	

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
315506 Y1	A. Building B. Wing Y2	5/1/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (WASHINGTON TWP)	378 FRIES MILL ROAD SEWELL, NJ 08080

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0558	Correction	ID Prefix F0600	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(e)(3)	Completed	Reg. # 483.12(a)(1)	Completed
LSC	03/24/2023	LSC	03/24/2023	LSC	03/24/2023
ID Prefix F0609	Correction	ID Prefix F0610	Correction	ID Prefix F0656	Correction
Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	03/24/2023	LSC	03/24/2023	LSC	03/24/2023
ID Prefix F0689	Correction	ID Prefix F0842	Correction	ID Prefix F0880	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	03/17/2023	LSC	03/24/2023	LSC	03/24/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
2/24/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
08004 Y1	A. Building B. Wing Y2	6/16/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (WASHINGTON TWP)	378 FRIES MILL ROAD SEWELL, NJ 08080

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/25/2023	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	
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	
2/24/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO