STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315506	A. BUILDING _____ B. WING _____	07/01/2022

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 SURVEY DATE: 07/01/22 CENSUS: 107 SAMPLE SIZE: 26 An Onsite Revisit Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documents, it was determined that the facility failed to complete [redacted] evaluations [redacted]) after an unwitnessed fall for 1 of 2 residents (Resident #39) reviewed for accidents. This deficient practice was evidenced by the following: On 06/24/2022 at 10:22 AM, the surveyor observed Resident #39 sitting up in a wheelchair. The resident stated he/she had a history of [redacted]	F 684	1. Resident #39 has not had any further falls requiring neurological evaluations. 2. All falls for July were audited to confirm completion of neurological evaluations. 3. Education provided to all licensed nurses regarding policy and completion of Neurological Evaluations 4. Unit Managers/Designee to complete weekly audit of all falls to confirm that Neurological Evaluations are completed timely and appropriately. 5. Unit Managers/Designee will provide	8/24/22

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

Electronically Signed | 07/22/2022

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F 684	Continued From page 1 at the facility. According to the Admission Record, Resident #39 was admitted with diagnoses which included, but were not limited to, unspecified fracture, [redacted] Review of Resident #39's Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], included the resident had a Brief Interview for Mental Status of [redacted] which indicated that the resident's cognition was [redacted]. Further review of the MDS revealed that the resident had [redacted] since the prior MDS. Review of Resident #39's Care Plan included a focus, dated [redacted], that the resident was "at [redacted] due to [redacted]." Review of Resident #39's Progress Note (PN), dated 04/01/2022 at 12:01 AM, included, [redacted] No injuries were noted at this time," and, "Patient was [redacted] and then [redacted]. Vital signs and [redacted] evaluation were all within normal limits." Further review of Resident #39's PNs did not include documentation of [redacted] checks for the dates of [redacted].	F 684	weekly documentation to DON/Designee weekly for review. DON/Designee will review documentation and will report findings monthly to QAPI for three months. After three months, QAPI team will review the need to continue monthly reporting/auditing and/or change to existing plan.	

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F 684	Continued From page 2 Review of Resident #39's [redacted] Evaluation Flow Sheet included plotted dates and times from [redacted] however, the [redacted] checks were only completed from [redacted]. The [redacted] checks for [redacted] were blank. Further review of the flow sheet included directions to, "Complete [redacted] evaluation with vital signs initially, then every 30 minutes x 4, then every hour x 4, then every 8 hours x 9 (72 hours)," and, "Complete [redacted] charting for at least 72 hours including any pertinent evaluation finding related to the [redacted] evaluation." During an interview with the surveyor on 06/28/2022 at 1:32 PM, the Certified Nursing Assistant #1 stated Resident #39 had a [redacted] During an interview with the surveyor on 06/28/2022 at 1:36 PM, the Licensed Practical Nurse #2 (LPN) stated that if a residen[redacted], the nurse would assess the resident, notify the physician, and initiate[redacted] checks if the fall was unwitnessed. LPN #2 further stated that [redacted] checks should be completed in their entirety so that the nurse can identify any [redacted] changes after the [redacted] During an interview with the surveyor on 06/28/2022 at 1:46 PM, the Registered Nurse/Unit Manager #2 (RN/UM) stated that if a resident [redacted] the nurse would assess the resident, notify the physician and family, complete an incident report, and initiate [redacted] checks if the [redacted] was unwitnessed. RN/UM #2 further stated that [redacted] checks are "started right away and go for 72 hours," and should be completed in their	F 684		

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F 684	Continued From page 3 entirety to monitor any changes in mental status. During an interview with the surveyor on 06/28/2022 at 1:52 PM, the Director of Nursing (DON) stated that if a resident falls, the nurse would assess the resident, complete an incident report, and initiate [redacted] checks. The DON further stated that [redacted] checks "start as soon as the resident is assessed and goes for 72 hours," and should be completed in their entirety "to be sure there isn't any [redacted] changes." Review of the facility's Neurological Evaluation policy, dated 03/2010, included, "A neurological evaluation is used to establish a baseline neurological status upon which subsequent evaluations may be compared and changes in neurological status may be determined," and, "After completion of initial neurological evaluation with vital signs, continue evaluations every 30-minutes x4, then every 1-hour x4, then every 8-hours x9 (for the next 72 hours)." Review of the facility's Post-Fall Evaluation policy, dated 11/2021, included, "Neurological evaluation (neuro check) is completed whenever there is a witnessed fall when a patient has hit their head; following an unwitnessed fall when a head injury may be suspected and following non-fall patient events which result in a known or suspected head injury," and, "The licensed nurse is responsible for completing this evaluation and reporting changes in condition to the attending physician."	F 684		
F 695	NJAC 8:39-29.2(d) Respiratory/Tracheostomy Care and Suctioning	F 695		8/24/22

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F 695 SS=D	Continued From page 4 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow the oxygen administration policy for 2 of 2 residents (Residents #1 and #503) reviewed for respiratory care. This deficient practice was evidenced by the following: 1. On 06/23/22 at 10:37 AM, 06/24/22 at 10:19 AM, and 06/27/22 at 10:14 AM, the surveyor observed Resident #1 wearing [redacted] at [redacted]. The surveyor observed the [redacted] was undated and the [redacted] was lying directly on the nebulizer machine, not stored in a plastic bag. According to the Admission Record, Resident #1 was admitted to the facility with diagnoses that included, but were not limited to, acute [redacted]	F 695	1. Resident #1 and Resident #503 were discharged from the facility. 2. An audit of all residents utilizing O2 and nebulizers was conducted to confirm that all residents have orders for O2, tubing change orders and mask change orders. An additional audit was conducted on these same individuals to confirm tubing was appropriately labeled and dated and that all O2 had appropriate storage that was labeled, dated and initialed for when not in use. 3. Education provided to all licensed nurses regarding Oxygen Administration policy regarding obtain physician orders for the administration of oxygen as well as weekly tubing and mask changes. Education was also provided regarding the appropriate labeling and dating of tubing and appropriate storage in a plastic bag that was labeled, dated and initialed for when not in use. 4. Unit Managers/Designee to complete weekly audit of all individuals who receive O2. Audit to include confirmation that	

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F 695	Continued From page 5 [redacted] with late onset. Review of the Admission Minimum Data Set (MDS), dated [redacted], revealed a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated Resident #1 had [redacted]. Further review of the MDS revealed the resident received [redacted]. Review of the Order Summary Report revealed a physician's order (PO), dated [redacted], to wean [redacted] Further review of the Order Summary Report for Resident #1 revealed a PO, dated [redacted], for [redacted] Review of the [redacted] Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not reveal a PO to change and date the oxygen tubing weekly. Further review of the [redacted] MAR revealed a PO for [redacted] Solution [redacted] one application inhaled via [redacted] every [redacted] for [redacted] with a start date of [redacted]. The MAR also revealed that the resident was administered a [redacted] treatment every six hours and was last administered a [redacted]	F 695	orders are active to receive O2 as well as weekly changing of tubing and masks. Additional audit to be completed weekly by Unit Managers/Designee to observe all individuals receiving O2/Nebulizer treatment have appropriate plastic bag that is labeled, dated and initialed for storage when not in use and to confirm those not in use are stored appropriately. 5. Unit Managers/Designee will provide weekly audit documentation to DON/Designee weekly for review. DON/Designee will review documentation and will report findings monthly to QAPI for three months. After three months, QAPI team will review the need to continue monthly reporting/auditing and/or change to existing plan.	

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F 695	Continued From page 6 treatment on 06/27/22 at 6:00 PM. During an interview with the surveyor on 06/27/22 at 10:19 AM, the Registered Nurse #1 (RN) stated the [redacted] should be dated and changed weekly. RN #1 also stated the [redacted] and [redacted] should be changed once a week and should be stored in a plastic bag when not in use. RN #1 further stated that it was important to store the [redacted] and [redacted] in a plastic bag for infection control reasons and, "We don't want the residents to get an infection." On 06/27/22 at 10:23 AM, the surveyor, accompanied by RN #1, entered Resident #1's room and observed the [redacted] not dated and the [redacted] on the [redacted] machine. RN #1 stated the [redacted] should have been dated and the [redacted] mask should have been stored in a plastic bag. 2. On 06/23/22 at 10:27 AM, 06/24/22 at 10:22 AM, and 06/27/22 at 10:16 AM, the surveyor observed Resident #503 awake and alert, lying in bed wearing [redacted] at [redacted] via [redacted] and the [redacted] was undated. During an interview with the surveyor on 06/27/22 at 10:15 AM, Resident #503 stated that the staff had not changed his [redacted]. According to the Admission Record, Resident #503 was admitted to the facility with diagnoses that included, but were not limited to, [redacted]	F 695		

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F 695	Continued From page 7 [redacted]	F 695		

Review of the Admission MDS, dated [redacted] revealed a BIMS score of "[redacted]" which indicated Resident #503 was [redacted]. Further review of the MDS indicated the resident received [redacted].

Review of the Order Summary Report did not include a PO for [redacted] or to change and date the [redacted]

Review of the [redacted] MAR and TAR did not include an PO for [redacted] and to change and date the [redacted] weekly.

During an interview with the surveyor on 06/27/22 at 11:04 AM, RN #1 confirmed Resident #503's [redacted] was not labeled or dated.

During an interview with the surveyor on 06/27/22 at 11:21 AM, the Registered Nurse/Unit Manager #1 (RN/UM) stated that al[redacted] treatments should have a physician's order which included [redacted] in [redacted]. RN/UM #1 further stated, "I would expect the [redacted]r mask be cleaned after each use and stored in a plastic bag when not in use," and, "I would expect the[redacted] to be changed weekly and dated." RN/UM #1 also stated it was important to keep the [redacted] mask clean, stored in a plastic bag and the [redacted] tubing should be dated and changed weekly to reduce and prevent infection.

During an interview with the surveyor on 06/27/22 at 1:13 PM, the interim Infection Preventionist (IP) stated al[redacted] and

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F 695	Continued From page 8 [redacted] masks were to be changed and dated every Thursday on the 11:00 PM-7:00 AM shift to promote hygiene and prevent infections. The IP further stated the [redacted] masks should be stored in a plastic bag when not in use. The IP also stated that there should be a PO for [redacted] and if there was not an order, the nurse should call the doctor to obtain an order. During an interview with the surveyor about Resident #503 on 06/28/22 at 1:30 PM, the Director of Nursing (DON) stated, "The resident doesn't have a physician's order for [redacted] It is important for the resident to have a physician's order because [redacted] requires a physician's order. Without a physician's order there is no way to know what the setting for the [redacted] should be." The DON further stated, "The nurses should be checking to make sure there is a physician's order for [redacted] " The DON then observed, after record review, Resident #503 had a physician's progress note on 06/12/22 that "mentioned" [redacted], but there was no mention of [redacted] on the original admission note by the nurses. After further investigation by the DON, the DON observed a note from 06/11/22 that "mentioned" [redacted] the nurses. The DON stated, "They forgot to write an order for the [redacted]. The nurses would be the ones to set up the [redacted] for the resident. At this point, there was no verified physician's order for [redacted] in the chart." A review of the facility's policy titled " Oxygen Administration," updated 03/2001, revealed under "Procedure" to verify the physician's order. Under "Completion of Procedure," the policy reflected that when oxygen was not in use, store	F 695		

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F 695	Continued From page 9 oxygen tubing and nasal cannula or mask in a separate, labeled plastic bag and to change tubing and masks and label with date and initials. NJAC 8:39-27.1(a)	F 695		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756		8/24/22

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F 756	Continued From page 10 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documents, it was determined that the facility failed to ensure recommendations made by the Consultant Pharmacist were acted upon in a timely manner for 1 of 5 residents (Resident #33) reviewed for unnecessary medications. This deficient practice was evidenced by the following: According to the Admission Record, Resident #33 was admitted with diagnoses that included, but were not limited to, [redacted] Review of Resident #33's Order Recap Report included a Physician's Order (PO) for [redacted] Give 1 tablet by mouth every [redacted] hours [redacted] for [redacted] at [redacted]," with an order date of [redacted] and a discontinuation date of [redacted]. The PRN [redacted] order did not include a duration and was in effect for approximately [redacted] months. Review of Resident #33's [redacted] Medication Administration Record (MAR) revealed [redacted] was not administered	F 756	1. Resident #33 order for [redacted] was discontinued on [redacted] 2. An audit of all pharmacy recommendations received in July from the pharmacist were reviewed by providers. Physician recommendations to change or discontinue medications have been documented in patients' medical records and have been updated accordingly. 3. Education provided to all licensed nurses regarding facility policy of Medication Regimen Review policy specific to Consultant Pharmacist Review (MRR). 4. Consultant Pharmacist will provide recommendations to DON for review. Copies of recommendations will be provided to providers for review and notation. Unit Manager/Designee will receive a copy of recommendations and will audit each recommendation to ensure that any orders to change or discontinue are updated as ordered. Unit Manager/Designee will provide monthly audit to DON with findings. 6. DON/Designee will review documentation and will report findings	

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F 756	Continued From page 11 after being ordered on 1/19/2022. Review of Resident #33's Medication Regimen Review (MRR) in the Electronic Health Record (EHR), dated [redacted], included a recommendation from the Consultant Pharmacist (CP) of, "suggest [redacted] order for [redacted]." The facility was unable to provide the hard copy of the recommendation which would have included the physician's response. Review of the [redacted] MAR revealed the PRN [redacted] order remained unchanged without a duration and had not been administered. Review of the MRR in the EHR, dated [redacted] included a recommendation from the CP of, "is [redacted] still needed? If so, suggest order includes a length of therapy up to 'x 90 days.'" The hard copy of the recommendation revealed the physician's response of, "okay," dated [redacted]. Review of the [redacted] MAR revealed the [redacted] order remained unchanged without a duration and had been administered once. Review of the MRR in the EHR, dated 04/17/2022, included a recommendation from the CP of, "is [redacted] for [redacted] still needed? If so, suggest order includes a length of therapy up to 'x [redacted] days.'" The hard copy of the recommendation revealed the physician circled [redacted]" and responded, "add." The physician also checked off the box that included, "Accept	F 756	monthly to QAPI for three months. After three months, QAPI team will review the need to continue monthly reporting/auditing and/or change to existing plan.	

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F 756	Continued From page 12 the recommendation(s) above, please implement as written," dated 04/21/2022. Review of the [redacted] MAR revealed the [redacted] order remained unchanged without a duration and had not been administered. Review of the MRR in the EHR, dated 06/15/2022, included a recommendation from the CP of, "is [redacted] for [redacted] still needed? If so, suggest order includes a length of therapy up to 'x [redacted] days.'" The hard copy of the recommendation revealed the physician checked off the box that included, "Accept the recommendation(s) above with the following modifications: if taking - keep, if not - D/C [discontinue]," dated [redacted] Review of the [redacted] MAR revealed the PRN [redacted] order remained unchanged without a duration and had not been administered prior to being discontinued on 06/17/2022. Review of Resident #33's Progress Notes, dated [redacted] did not include documentation from the nurse or physician in response to the CP's recommendations until [redacted] which included, "Pharmacy consult - review need for [redacted] - was d/c'd [discontinued] already." During an interview with the surveyor on 06/28/2022 at 1:36 PM, the Licensed Practical Nurse #2 (LPN) stated that when the CP makes recommendations, it is entered into the EHR and the nurse will then notify the physician of the recommendation. LPN #2 further stated that if	F 756		

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F 756	Continued From page 13	F 756		

the physician agrees with the recommendation, the nurse should log into the EHR to discontinue the old PO and initiate the new PO. LPN #2 also stated that after changing the PO, the nurse should write a progress note and that the entire process should be completed on the same shift that the CP's recommendation was received.

During an interview with the surveyor on 06/28/2022 at 1:46 PM, the Registered Nurse/Unit Manager #2 (RN/UM) stated that when the CP makes recommendations, the nurse will notify the physician who will agree or disagree with the recommendation. RN/UM #2 further stated that if the physician agrees with the recommendation, the nurse will write a new PO.

During an interview with the surveyor on 06/28/2022 at 1:52 PM, the Director of Nursing (DON) stated that when the CP makes recommendations, the recommendation is given to the physician who will then write their response on the hard copy. The DON further stated that if the physician agrees with the CP's recommendation, the nurse will write a new PO and that the entire process should be completed within a few days.

Review of the facility's Medication Regimen Review policy, revised 08/2018, included, "Consultant Pharmacists perform Medication Regimen Review (MRR) for patients and will generate recommendations with the overall goal of promoting positive outcomes and minimizing adverse consequences." Further review of the policy also included, "The Nursing Center's Consultant Pharmacist will present MRR recommendations on individual patient specific

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F 756	Continued From page 14 reports on the day of their review. The process to ensure MRR recommendations are addressed timely:... The pharmacist generates 3 copies of the MRR recommendations on the day of their review with one copy provided to the DON... one copy provided to the medical director, and one copy provided to the attending physician or prescriber," and, "The DON, or designee reviews the MRR and contacts the attending physician to review and obtain orders as warranted. The DON, or designee documents on the MRR and in the patient's clinical record, the physician order(s) and forwards the completed MRR to the DON within 30 days of the Consultant Pharmacist's review." NJAC 8:39-29.3	F 756		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow professional standards of nursing practice by administering expired insulin medication. This deficient practice was identified for Resident #66 on 1 of 3 medication carts inspected during the medication storage task and was evidenced by the following: On 06/28/22 at 1:14 PM, in the presence of Registered Nurse Supervisor (RNS), the surveyor inspected Medication Cart #1 located	F 760	1. Resident #66 [redacted] was discarded. A new [redacted] was received and was appropriately labeled. Individual nurse who administered medication received individual re-education. 2. An audit was conducted for all other individuals receiving administration of [redacted] through [redacted] administration to confirm that all [redacted] in use were appropriately labeled and were not expired. 3. Education provided to all licensed	8/24/22

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F 760	Continued From page 15 on the [redacted] Unit. During the inspection, the surveyor observed a [redacted] pen [redacted], which was stored on the top shelf of the medication cart. The surveyor observed that the [redacted] label had a handwritten opened date of [redacted]. Just below the [redacted] opened date, there was a printed cautionary label to discard unused medication after 56 days of the date the insulin pen was opened, which indicated the medication should have been discarded by [redacted] During an interview with the surveyor on 06/28/22 at 1:35 PM, the RNS stated that Resident #66 receives [redacted] units of [redacted] every [redacted] The RNS inspected Resident #66's [redacted], in the presence of the surveyor, and confirmed the [redacted] open date. At that time, the RNS confirmed that was the only [redacted] on the medication cart and stated that she administered the [redacted] dated [redacted] to Resident #66 that morning. According to the Admission Record, Resident #66 was admitted to the facility with diagnoses which included, but were not limited to, [redacted] Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], revealed that Resident #66 was [redacted] and had received [redacted] out of [redacted] days during	F 760	nurses regarding facility policy for Storage and Expiration Dating of Drugs, Biologicals, syringes and needles" policy as related to insulin pens. 4. Unit Manager/Designee will conduct weekly audit of all orders for insulin pens and will confirm that all insulin pens in use are appropriately labeled and are not expired. Weekly audits will be provided to DON/Designee. 5. DON/Designee will review documentation and will report findings monthly to QAPI for three months. After three months, QAPI team will review the need to continue monthly reporting/auditing and/or change to existing plan.	

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F 760	Continued From page 16 the assessment period. Review of Resident #66's physician order detail reflected a physician order, dated [redacted] to [redacted]. Review of Resident #66's [redacted] Medication Administration Record (MAR) reflected the corresponding [redacted] physician order for [redacted] with a scheduled with an administration time of [redacted] AM. Further review of the [redacted] MAR reflected that nurses administered the expired [redacted] pen on the following dates [redacted]. During an interview with the surveyor on 06/28/22 at 1:52 PM, the Registered Nurse/Unit Manager #2 (RN/UM) stated that insulin pens should be dated when opened in order to prevent administration of expired medications. At that time, RN/UM #2 inspected Resident #66 insulin pen and confirmed the surveyor's findings. During a follow up interview with the surveyor on 06/30/22 at 1:06 PM, the RNS stated that insulin pens have a certain number of days the medication is good after opening. The RNS further stated she wasn't aware that Resident #66's [redacted] was good for only 56 days after opening and that she should not have administered the medication on [redacted] because it was expired.	F 760		

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F 760	Continued From page 17 During an interview with the surveyor on 07/01/22 at 12:15 PM, the Director of Nursing (DON) stated Resident #66's [redacted] should have been discarded. The DON further stated the nurse should not have administered the medication because it was expired. Review of the facility's "Storage and Expiration Dating of Drugs, Biologicals, syringes, and needles" policy, revised on 08/2018, revealed that once any drug was opened, the Nursing Center should follow manufacturer guidelines with respect to expiration dates for opened medications. NJAC 8:39-29.2(b)	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs	F 761		8/24/22

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F 761	Continued From page 18 listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documents, it was determined that the facility failed to properly label and store medications in accordance with acceptable standards. This was observed for 1 of 2 medication rooms ([redacted] Unit) and for 1 of 3 medication carts (Cart 1) reviewed during the medication storage and labeling task. This deficient practice was evidenced by the following: On 06/28/22 at 1:00 PM, the surveyor, in the presence of the Registered Nurse/Unit Manager (RN/UM #2), observed the following within the medication room on the [redacted] Unit: -one open box of [redacted], containing [redacted] of medication in the refrigerator [redacted] is a medication that may be used to [redacted] in the [redacted]). The box was labeled with a date of [redacted] and was for Resident #352. During an interview with the surveyor at that time, RN/UM #2 stated the resident for whom the medication was prescribed was deceased and the medication should not have been left in the refrigerator. RN/UM #2 further stated that since	F 761	1. Resident #352 was discharged from facility. Medication was discharged. Bottle of [redacted] 0 was discarded. Bottle of [redacted] dated [redacted] was discarded. Bottle of [redacted] was discarded. [redacted] for resident #74 was discarded and replaced. Open [redacted] for resident #37 was discarded and replaced. Open and undated [redacted] was discarded for resident #37. One unopened [redacted] resident #37 was discarded. [redacted] r and unopened [redacted] for resident #30 were discarded and replaced. Opened and undated [redacted] and one opened and unlabeled inhaler of [redacted] were discarded and replaced. One opened and undated [redacted], one opened and undated [redacted] and one unopened [redacted] for resident #87 were discarded and replaced. One [redacted] was discarded and replaced for #87. 2. All medication storage areas and medication carts were audited for unlabeled/undated medications to identify	

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F 761	Continued From page 19 the resident expired, the referenced medication should have been removed and returned to the pharmacy. The surveyor, in the presence of RN/UM #2, then proceeded to check the storage cabinet in the medication room and observed the following items: -one open and undated bottle of [redacted] milligram (mg) tablets (a dietary supplement that [redacted]) -one open bottle of [redacted] (a [redacted]) dated [redacted]. The bottle was visibly soiled, sticky to the touch, and surrounded by a dried, pink substance on the shelf. -one open and undated bottle of [redacted] (a [redacted]). The bottle was soiled, sticky to the touch, and surrounded by a dried, pink substance on the shelf. During an interview with the surveyor at that time, RN/UM #2 stated the bottle of [redacted] should have been labeled with a date, once opened. RN/UM #2 further stated the bottles of cough syrup should have been stored in the medication cart once opened, not in the cabinet of the medication room. RN/UM #2 also stated that the unlabeled, open bottle should have been labeled accordingly. On 06/28/22 at 1:14 PM, the surveyor, in the presence of the Registered Nurse Supervisor (RNS), observed the following items in the [redacted]	F 761	any others affected. 3. All Licensed nurses received education on facility policy Storage and Expiration of Drugs, Biologicals, Syringes and Needles specific to the expiration dates on labels, recording date opened on items without dates, following manufacturer guidelines with respect to expiration and destroying and reordering drugs or biologicals with soiled, worn, makeshift, incomplete, damaged or missing labels. 4. Unit Manager/Designee to complete weekly audit of all medication storage areas and medication carts to confirm compliance with labeling, dating, expired medications and destroying and reordering drugs or biologicals not in compliance. Weekly audits will be provided to DON/Designee for review. 5. Director of Nursing/Designee will review documentation and will report findings monthly to QAPI for three months. After three months, QAPI team will review the need to continue monthly reporting/auditing and/or change to existing plan.	

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F 761	Continued From page 20 Unit medication cart (Cart 1): -one open and undated [redacted] for Resident #74 -one opened and undated [redacted] for Resident #37 -one opened and undated [redacted] for Resident #37 -one unopened [redacted] Resident #37 During an interview with the surveyor at that time, the RNS stated that the unopened [redacted] should have been kept in the refrigerator until opened, rather than on the medication cart. Additional items observed in Cart 1 included: -one opened and undated [redacted] for Resident #30 -one opened and undated [redacted] /ml [redacted] for Resident #30 -one opened and undated [redacted] ([redacted]) for Resident #26 -one opened and unlabeled inhaler of [redacted], with a	F 761		

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F 761	Continued From page 21 handwritten date of [redacted] and the name of Resident #26 -one unopened Insulin [redacted] to [redacted]) for Resident #87 -one opened and undated [redacted] for Resident #87 -one opened and undated [redacted] for Resident #87 During an interview with the surveyor at that time, the RNS acknowledged, that an unopened insulin pen should have been stored in the refrigerator, rather than within the medication cart. Additional items observed in Cart 1 included: -one [redacted] labeled with an opened date of [redacted] and directions to discard the item after 56 days, for Resident #66 During an interview with the surveyor on 06/28/22 01:29 PM, the RNS described the process of opening and labeling medication for storage on the medication cart. According to the RNS, the nurse should label medications with the open date because some medications have an expiration date once opened, which precedes the expiration date of the manufacturer. The RNS inspected the medications in the presence of the surveyor and confirmed that the medications were not labeled, as they should have been, at the time they were opened. During the same interview with the surveyor at 1:35 PM, the RNS further confirmed that the	F 761		

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F 761	Continued From page 22 referenced [redacted] pen was opened on [redacted] and should have been discarded 56 days from the day the item was opened. During an additional interview with the surveyor on 06/28/22 at 1:52 PM, RN/UM #2 reiterated that medication should be dated once a nurse opens it. When asked about the opened but unlabeled [redacted], RN/UM #2 stated the inhaler must have been removed from the automated pharmacy dispensing machine (APDM) and that the APDM was capable of printing a label. RN/UM #2 further stated that it was best for nursing staff not to use the medication, because it was potentially unclear as to whom the medication belonged. RN/UM #2 also stated the nurse should have gotten a new physician order and obtained a correctly labeled inhaler to avoid any possible confusion. In addition, RN/UM #2 inspected the insulin pens and confirmed the surveyor's findings. RN/UM #2 stated the [redacted] should be dated when opened, to prevent administration of expired medications. During a follow-up interview with the surveyor on 06/30/22 at 1:06 PM, the RNS stated that the [redacted] have a limit to the number of days in which they may be used after opening them. She stated she was not aware that the [redacted] had a limit of use for 56 days once opened and acknowledged that it was expired on the date the surveyor found it. During an interview with surveyor, in the presence of the survey team, on 07/01/22 at 12:15 PM, the Director of Nursing (DON)	F 761		

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acknowledged that the medications found should not have been left opened and undated in the respective areas, as observed by the surveyor in the presence of various staff members. The DON clarified that the unlabeled Albuterol Inhaler should have come labeled appropriately from the pharmacy when the resident was using it in January of 2022, and upon discontinuation of the order, the inhaler should have been removed from the cart. In addition, the DON stated that unopened and unused insulin pens should have been stored in the refrigerator, rather than in the medication cart. Finally, the DON confirmed the nurse should not have administered the Tresiba FlexTouch pen because it was expired per manufacturer guidelines.

Review of the facility's policy titled, "STORAGE AND EXPIRATION DATING OF DRUGS, BIOLOGICALS, SYRINGES AND NEEDLES," revised 08/18, revealed it is necessary for the nursing center to ensure that drug and biologicals have an expiration date on the label or medication container, have not been retained longer than recommended by manufacturer or supplier guidelines, and have not been contaminated or deteriorated and are stored separately from other medications until destroyed or returned to the supplier. In addition, the policy included that once any drug or biological is opened, the nursing center should follow manufacturer guidelines with respect to expiration dates for opened medications. The nursing center staff should record the date opened on the medication container in cases where the medication has a shortened expiration date once opened. Finally, the policy indicated it was necessary for the nursing center to destroy

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F 761	Continued From page 24 and reorder drugs or biologicals with soiled, illegible, worn, makeshift, incomplete, damaged, or missing labels. NJAC 8:39-29.4(h)	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §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	F 880		8/24/22

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 25 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 880	1. Resident #602 and #657 was	

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	315506	A. BUILDING _____ B. WING _____	07/01/2022

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 880	Continued From page 26 and review of other facility documents, it was determined that the facility failed to perform hand hygiene and don (put on) proper Personal Protective Equipment (PPE) to minimize the potential spread of infection when caring for 2 of 6 residents (Residents #602 and #654) reviewed for Transmission Based Precautions and for one resident (Resident #657) during observation of medication pass for 1 of 3 nurses observed on 1 of 2 units ([redacted] Unit). This deficient practice was evidenced by the following: 1.) On 06/24/22 at 10:33 AM, the surveyor observed Certified Nursing Assistant #2 (CNA) enter Resident #654's room wearing only a face shield and N95 face mask. Outside Resident #654's room were isolation precaution signs for Airborne, Droplet, and Contact Precautions reflecting directions for everyone entering the room to wear an N95 mask, isolation gown, gloves, and eye protection, as well as performing hand hygiene before entering and after exiting the room. At that time, the surveyor interviewed CNA #2 regarding the required PPE to enter the isolation room. CNA #2 stated, "I know I'm supposed to put a gown on, but I saw the call light and I just went in and forgot." CNA #2 confirmed that the precaution signs on the resident's door reflected a staff member would wear full PPE which included a N95 mask, isolation gown, gloves, and eye protection. Review of Resident #654's Electronic Health Record (EHR) revealed under "Orders" a	F 880	discharged from the facility. CNA and Unit Manager received individualized education. Resident #657 - LPN who did not wear gloves/wash hands received individualized education. 2. All residents have the potential to be affected by this practice. 3. All staff to receive education regarding PPE donning/doffing and handwashing. In addition, staff received the following education as per DPOC. CDC COVID-19 Prevention Messages for Front Line LongTerm Care staff (You Tube Videos watched): Keep COVID-19 Out! (frontline staff) Closely Monitor Residents (frontline staff) Clean Hands (frontline staff) Use PPE Correctly for COVID-19 (frontline Staff) Nursing Home Infection Preventionist Training Course: Module 1 - Infection Prevention & Control Program - (topline staff and Infection Preventionist) Module 5 - Outbreaks (topline staff and Infection Preventionist (IP) Module 4 - Infection Surveillence (topline staff and IP) Module 7 - Hand Hygiene (all staff including topline staff and IP) Module 6A - Principles of Standard Precautions (all staff including topline staff and IP) Module 6B - Principles of Transmission Based Precautions (all staff, including topline staff and IP)	

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	315506	A. BUILDING _____ B. WING _____	07/01/2022

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F 880	Continued From page 27 physician's order for Contact/Airborne/Droplet precautions until 06/29/22. During an interview with the surveyor on 06/24/22 at 11:16 AM, the Infection Preventionist (IP) stated that isolation rooms required a face shield, gown, gloves, and a mask to enter, and droplet and airborne precaution rooms needed an N95 mask. The IP further stated that the purpose of the entire process was to prevent the spread of infectious diseases. The IP further confirmed that full PPE was required when entering isolation rooms even when staff are not performing care. 2.) On 06/27/22 at 8:54 AM, the surveyor observed Resident #602 exit his/her room via a wheelchair and entered the hallway. At that time, the Registered Nurse Unit Manager #1 (RN/UM) assisted Resident #602 by pushing his/her wheelchair back into the room. Outside of Resident #602's room were signs for Contact, Droplet, and Airborne Precautions. The Contact Precaution sign revealed, "EVERYONE MUST: Clean their hands, including before entering and leaving the room." The sign also revealed, "PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry. Discard gloves before room exit; put on gown before room entry, discard gown before room exit." During the surveyor's above observation, RN/UM #1 did not wear a gown or gloves when entering Resident #602's room. After she exited the room and returned to the nurse's station, she did not	F 880	Root Cause Analysis was completed. It was identified that although staff had previously received education, there was not a consistent process in place for monitoring/evaluation to ensure that the appropriate donning/doffing of PPE and handwashing was being performed. 4. Infection Preventionist/Designee will conduct Infection Control audits daily on each shift for one month to identify potential infection control breaches. After one month, audits will occur daily on random shifts. Results of audits will be provided to DON/Designee. 5. DON/Designee will review documentation and will report findings monthly to QAPI for three months. After three months, QAPI team will review the need to continue monthly reporting/auditing and/or change to existing plan.	

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F 880	Continued From page 28	F 880		

perform hand hygiene. There were approximately four alcohol-based hand rub dispensers mounted to the wall from Resident #602's room to the nurse's station.

Review of Resident #602's EHR revealed under "Orders" a physician's order for Contact/Droplet/Airborne precautions until 06/29/22.

3.) On 06/27/22 at 9:32 AM, during medication pass, the surveyor observed the Licensed Practical Nurse #1 (LPN) administer medications to Resident #657. Outside of the resident's room were Contact, Droplet, and Airborne Precaution signs. The Contact Precaution sign revealed, "Put on gloves before room entry." While in Resident #657's room, the surveyor observed LPN #1 did not wear gloves and moved the bed side table located in the room with her bare hand prior to administering the medications.

On the same date and time, during an interview with the surveyor, LPN #1 stated, "I didn't wear gloves in the room because I wasn't really touching anything."

Review of Resident #657's EHR revealed under "Orders" a physician's order for Contact/Airborne/Droplet precautions until 06/30/22.

During an interview with the surveyor on 06/27/22 at 9:38 AM, RN/UM #1 confirmed the precaution signs were located outside of Resident #602's room and they reflected the required PPE to be worn.

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	315506	A. BUILDING _____ B. WING _____	07/01/2022

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F 880	Continued From page 29 During an interview with the surveyor on 06/29/22 at 12:40 PM, the Director of Nursing (DON) stated "Yes" when asked if a staff member should wear a gown when entering a room on isolation precautions. The DON further stated, "Yes" when asked if a nurse should wear gloves when administering medications within a room on isolation precautions. Lastly, the DON confirmed that staff should perform hand hygiene after exiting a resident's room and in between resident contact. Review of the facility's policy, "Hand Hygiene," updated on 03/2020, revealed under subsection, "When to wash hands or use alcohol-based hand rub," that washing hands or using alcohol-based hand rub is done, "After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient." Review of the facility's Practice Guideline, dated 07/2021, indicated "Standard precautions include: Hand hygiene (hand washing with soap and water or use of an alcohol-based hand sanitizer) before and after patient contact and after contact with the immediate patient care environment ...." The Practice Guideline further reflected "In addition to standard precautions, the following measures are necessary for contact precautions: Wear gloves for any interactions with patient or their environment ... Wear gown when clothing anticipated to come in contact with the patient, environmental surfaces or items in room contaminated with organism" and "PPE that is required based on exposure risk is donned prior to providing direct care for the patient." NJAC 8:39-19.4(a)(n)	F 880		

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	315506	A. BUILDING _____ B. WING _____	07/01/2022

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	08004	A. BUILDING: _____ B. WING _____	07/01/2022

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

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the day shift as mandated by the State of New Jersey for 10 of 14 days shifts. The deficient practice was evidenced by the following: 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,	S 560	1. No residents were affected by this practice. 2. All residents have the potential to be affected by this practice. 3. Daily meetings will occur Monday through Friday and will include Director of Nursing, Administrator, Staffing manager and HR Director to review open shifts, positions and recruitment. 4. Staffing Manager/Designee will audit weekly staffing for 7am-3pm shift for CNAs to identify trends related to staffing/scheduling. Staffing Manager/Designee will provide weekly audits to HR Manager. 5. HR Manager will review	8/24/22

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

Electronically Signed | 07/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08004	A. BUILDING: _____ B. WING _____	07/01/2022

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S 560	Continued From page 1 codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. "Direct care staff member" means any registered professional nurse, licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021: One CNA to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 06/05/22-06/11/22 and 06/12/22-06/18/22, the staffing-to-resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift are documented below: -06/07/22 had 12 CNAs for 110 residents on the day shift, required 14 CNAs. -06/09/22 had 11 CNAs for 110 residents on the day shift, required 14 CNAs. -06/11/22 had 10 CNAs for 110 residents on the	S 560	documentation and will report findings monthly to QAPI for three months. After three months, QAPI team will review the need to continue monthly reporting/auditing and/or change to existing plan.	

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S 560	Continued From page 2 day shift, required 14 CNAs. -06/12/22 had 11 CNAs for 110 residents on the day shift, required 14 CNAs. -06/13/22 had 12 CNAs for 108 residents on the day shift, required 13 CNAs. -06/14/22 had 12 CNAs for 108 residents on the day shift, required 13 CNAs. -06/15/22 had 10 CNAs for 108 residents on the day shift, required 13 CNAs. -06/16/22 had 10 CNAs for 108 residents on the day shift, required 13 CNAs. -06/17/22 had 8 CNAs for 109 residents on the day shift, required 14 CNAs. -06/18/22 had 11 CNAs for 107 residents on the day shift, required 13 CNAs. During an interview with the surveyor on 06/29/22 at 10:21 AM, the Staffing and Scheduling Coordinator stated, "Unfortunately, when we get hit with call outs, we are close but not quite" in response to whether the facility met the staffing requirements. During an interview with the surveyor on 06/29/22 at 12:40 PM, the Regional Director of Operations stated, "There may be an occasional day where we have call outs and whatnot" when asked if the facility was meeting the staffing requirements. NJAC 8:39-5.1(a)	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
08004	A. Building B. Wing	9/6/2022

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 Reg. # 8:39-5.1(a) LSC	Correction Completed 08/24/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 7/1/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

EVENT ID: 2UGD12

STATE FORM: REVISIT REPORT (11/06)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315506	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 06/28/22 and 06/29/22 and Promedica Skilled Nursing and Rehabilitation - Washington Township was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Promedica Skilled Nursing and Rehabilitation - Washington Township is a single story, Type II Protected building that was built in May 2010. The facility is divided into 7 smoke zones.	K 000		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, in the presence of facility management, it was determined that the facility failed to provide a battery backup emergency light, above 1 of 1	K 291	1. No residents were affected by this practice. 2. All residents have the potential to be affected by this practice.	8/24/22

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

Electronically Signed | 07/22/2022

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K 291	Continued From page 1 emergency generator's transfer switch, independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was evidenced by the following: On 06/28/22 at 9:18 AM, in the presence of the facility's Maintenance Director (MD), a tour of the building was conducted. At 10:39 AM, an inspection was performed inside the main electrical room, where the generator's transfer switch was located. The surveyor observed one battery back up emergency light, inside the room, pointing towards the generator transfer switch. At this time, a request was made to the MD, to press the test button and activate the emergency light. When the MD performed the test, the emergency light did not function properly. The findings were verified and confirmed by the MD during the observations. The surveyor informed the Regional Director of Operations of the deficiency at the Life Safety Code exit conference on 06/29/2022 at 12:46 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	3. Batteries were ordered on 6/28/22 and were received on 6/30/22 and were replaced on 6/30/22 by Maintenance Director and battery back up is functioning as of 6/30/22. 4. Maintenance Director/Designee will conduct monthly checks for function. 5. Maintenance Director/Designee will report findings of monthly checks to QAPI for three months. After three months, QAPI team will review the need to continue monthly reporting/auditing and/or change to existing plan.	
K 912 SS=D	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating	K 912		8/24/22

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	315506	A. BUILDING **01** B. WING _____	**07/01/2022**

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PROMEDICA SKILLED NURSING & REHAB (WASHINGTON TWP)	**378 FRIES MILL ROAD** **SEWELL, NJ 08080**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 912	Continued From page 2 plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, in the presence of facility management, it was determined that the facility failed to ensure that 1 of 14 electrical outlets, located next to a water source, was equipped with proper working Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: On 06/28/2022, during the survey entrance, a request was made to the Maintenance Director (MD) to provide a copy of the facility layout, which identified the various rooms in the facility. Starting at 9:18 AM, in the presence of the facility's MD, a tour of the building was conducted. During the tour, the surveyor tested fourteen (14) electrical outlets, located in wet areas with a Ground-Fault Circuit Interrupter (GFCI) tester to de-energize the outlets. At 11:13 AM, an inspection was performed, inside the bathroom of resident room [redacted]. The surveyor used a GFCI tester to de-energize the GFCI electrical outlet in the bathroom and the GFCI outlet did not de-energize, as required by code. The GFCI tester identified the GFCI outlet	K 912	1. No residents were affected by this practice. 2. All residents have the potential to be affected by this practice. 3. Licensed Electrician was called and replaced GFCI in Room #[redacted] on 7/6/22. Maintenance Director audited all other GFCI with no further issues noted. 4. Maintenance Director/Designee will conduct 5 random audits weekly for GFCI function. 5. Maintenance Director/Designee will report findings of weekly checks to QAPI for three months. After three months, QAPI team will review the need to continue monthly reporting/auditing and/or change to existing plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315506	A. BUILDING **01** B. WING _____	**07/01/2022**

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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K 912	Continued From page 3 with having the hot and neutral reversed. During an interview with the Life Safety Code Inspector, the MD confirmed the findings, at the time that the referenced observation occurred. The surveyor informed the Regional Director of Operations of the deficiency at the Life Safety Code exit conference on 06/29/2022 at 12:46 PM. NJAC 8:39 -31.2 (e) NFPA 99	K 912		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a	K 918		8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315506	A. BUILDING **01** B. WING _____	**07/01/2022**

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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K 918	Continued From page 4 program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview, in the presence of facility management, it was determined that the facility did not ensure a remote manual stop station for 1 of 1 generator, which was provided in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice could potentially affect all residents and was evidenced by the following: During the building tour on 06/28/22 at 10:34 AM, in the presence of the facility's Maintenance Director (MD), an inspection was performed, outside of the building, where the exterior diesel emergency generator was located. At that time, the surveyor asked the MD, "Where is the remote emergency shut off for the generator?" The MD opened one of the metal cabinet housing doors of the generator. The surveyor observed that the emergency shut off button was part of the generator's control panel, rather than in a remote location away from the generator, to prevent inadvertent or unintentional operation of the	K 918	1. No residents were affected by this practice. 2. All residents have the potential to be affected by this practice 3. Licenses Electrician Installed Generator stop switch on July 26, 2022. 4. Maintenance Director/Designee will conduct testing of the switch as necessary. 5. Maintenance Director/Designee will report to QAPI any identified concerns related to generator switch.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315506	A. BUILDING **01** B. WING _____	**07/01/2022**

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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K 918	Continued From page 5 emergency generator. An interview was conducted during the observation with the MD, at which time he confirmed the exterior generator did not to have a remote manual stop station, consistent with the observation. The surveyor informed the Regional Director of Operations of the deficiency at the Life Safety Code exit conference on 06/29/2022 at 12:46 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918		

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 01 - MANOR CARE WASHINGTON TWP. B. Wing (Y2)	9/6/2022 (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 Reg. # NFPA 101 LSC K0291	Correction Completed 08/24/2022	ID Prefix Reg. # NFPA 101 LSC K0912	Correction Completed 08/24/2022	ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 08/24/2022
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
7/1/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO