STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315009	A. BUILDING _____ B. WING _____	01/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUNNELLS CENTER FOR REHABILITATION & HEALTHCARE	40 WATCHUNG WAY BERKELEY HEIGHTS, NJ 07922

(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 000	INITIAL COMMENTS Survey Date: 1/19/22 Census: 215 Sample: 35 + 3 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based off observation, interview, and record review it was determined that the facility failed to maintain respect and dignity for a resident prior to providing incontinence care. This deficient practice was identified for one of three residents, (Resident #43) reviewed for respect and dignity and was evidenced by the following: On 01/10/22 at 10:17 AM, the surveyor walked by Resident #43's room and observed the resident's Certified Nursing Aide (CNA) in the room with the resident. Resident #43's bed was closest to the	F 557	ID Prefix Tag F557 Element 1: The nursing staff immediately provided Resident #43 with the privacy necessary to show respect and maintain dignity during the completion of incontinence care. The Facility Educator immediately educated the direct care staff for Resident #43 on 1/10/22 about the importance of providing privacy during care. Element 2: Resident MDS assessments will be	2/11/22

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

Electronically Signed | 01/31/2022

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 557	Continued From page 1 door in the room. The surveyor observed that the door to the resident's room was open, the resident's privacy curtain was drawn open, and the resident's [redacted]. The surveyor observed a white sheet placed just below the resident's [redacted]. At that time, the surveyor made the CNA aware that [redacted] care was going to be observed. The CNA walked out of the room to gather supplies. The resident remained uncovered with his/her [redacted] The CNA did not close the door to the resident's room or pull the privacy curtain before exiting the resident's room. The surveyor stood between the resident and the hallway to obstruct the view of the resident's [redacted] At 10:21 AM, the CNA entered the resident's room and walked over to the resident. At that time, the surveyor interviewed the CNA who stated that privacy was maintained by closing the door to the resident's room and the privacy curtain. The CNA acknowledged that she had walked out of the room and left the resident's [redacted]. At 10:55 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that the resident was [redacted] and had [redacted] The LPN further stated that the resident could make his/her needs known by speaking very slowly but could not speak clearly. At 11:03 AM, the LPN further stated that privacy should be maintained for all resident's while providing [redacted] care. The LPN stated that staff should close the door to the resident's room and pull the privacy curtain closed for the resident	F 557	reviewed by each Unit Manager to identify all residents on each unit who are dependent for [redacted] care and have the potential to be affected by this deficient practice. Element 3: The Facility Educator will re-educate all Facility nursing staff on how to maintain dignity and respect for residents who are dependent for [redacted] care by 2/4/22. Unit Managers, Nursing Supervisors or designees will round daily to ensure privacy is being provided during [redacted] care for the dependent residents identified. Element 4: Each Unit Manager or designee will audit the care of 5 [redacted] residents per week on each unit who are dependent for [redacted] care x 4 weeks, then 4 residents per month x 4 months. The results of these audits will be submitted monthly to the DON for review at the monthly Nursing Professional Practice meeting and quarterly to the QAPI Committee for review and action, as appropriate. Element 5:	

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F 557	Continued From page 2	F 557		

when the resident was [redacted].

At 11:27 AM, the surveyor interviewed the resident's Registered Nurse/Unit Manager (RN/UM) who stated that privacy was maintained by closing the privacy curtain, shutting the door, and covering up [redacted]

At 11:47 AM, the surveyor interviewed the Director of Nursing (DON) who stated that privacy was maintained by pulling the privacy curtain and closing the bedroom door. The DON further stated that the resident should have been covered by the staff member before she walked out of the resident's room. The DON stated that the purpose for maintaining privacy was to maintain dignity for the resident.

The surveyor reviewed the medical record for Resident #43.

A review of the resident's Admission Record (an Admission Summary) reflected that the resident had resided at the facility for several years and had diagnoses which included but were not limited to [redacted] EX Order 26 § 4b1 [redacted]

A review of the resident's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted] indicated that the resident had [redacted] and was usually able to be understood when expressing himself/herself. A further review of the resident's MDS indicated that the resident had a Brief Interview for Mental Status (BIMS)

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F 557	Continued From page 3 score of [redacted] out of [redacted] which indicated the resident was [redacted]. Review of Section H0300 further indicated that the resident was occasionally [redacted]. A review of the facility's In-Service Record/Meetings Form dated 01/10/22 indicated that the CNA was in-serviced on, "Dignity-Providing privacy while giving care. A review of the facility's undated Quality of Life - Dignity Policy and Procedure indicated, "Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.	F 557		
F 584 SS=D	NJAC 8:39-4.1 (a) Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		2/11/22

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F 584	Continued From page 4 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation it was determined that the facility failed to: a.) maintain a resident's EX Order 26 § 4b1 in a clean and sanitary manner and, b.) maintain a resident's EX Order 2 in a clean and sanitary manner. This deficient practice was identified on 1 of 5 nursing units, for 1 of 35 residents reviewed, (Resident # 42) for cleanliness of EX Order 26 § 4b1, and for 1 of 5 residents reviewed, (Resident #15) who were receiving EX Order 26 § 4b1 . The deficient practice was evidenced by the following:	F 584	ID Prefix Tag F584 Element 1: The facility housekeeping staff was immediately notified and cleaned the EX Order 26 § 4b1 of Resident #42 and the EX Order 2 of Resident #15 to provide a safe, clean, comfortable and homelike environment. The Housekeeping staff and frontline nursing staff for residents #42 and #15 were inserviced on 1/6/22 the process to ensure the EX Order 26 § 4b1 and EX Order 26 § 4b1 are maintained in a clean and sanitary manner. Element#2:	

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F 584	Continued From page 5 1. On 01/04/22 at 10:02 AM, the surveyor observed Resident #43 glide up to the front of the nursing station while seated in his/her [EX Order 26 § 4b1] [redacted]. The surveyor observed that the residents [EX Order 26 § 4b1] was covered in yellow, brown, and white caked on dust and debris. The resident spoke [redacted] and was able to tell the surveyor his/her name. On 01/05/22 at 12:21 PM, the surveyor observed the resident laying in bed in his/her room. The surveyor exited the resident's room and observed the residents [redacted] wheelchair in the hallway, in the same condition as the day prior. Caked on yellow, white, and brown debris covered the legs, parts of the seat, and the bottom base of the wheelchair. On 01/06/22 at 10:51 AM, the surveyor observed the residents [EX Order 26 § 4b1] in the hallway outside of the resident's room. The surveyor observed that the residents [redacted] was covered in yellow, brown, and white caked on dust and debris. At 11:50 AM, the surveyor interviewed the daytime Housekeeper (HK) for [redacted] who stated that she was not responsible for cleaning the resident's wheelchairs. At 11:56 AM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated that if observed a resident's wheelchair was soiled, she would clean it. The CNA further stated that she believed each CNA made rounds throughout their shift to make sure the resident's rooms and their wheelchairs were clean. The CNA did not speak to the cleanliness of Resident	F 584	Facility MDS assessments will be reviewed by each Unit Manager to identify all residents on each unit who have a motorized wheelchair and residents who have continuous [EX Order 26 § 4b1] orders that require use of a [EX Order 26 § 4b1] pole and have the potential to be affected by this deficient practice. Element #3: The Director of Housekeeping will develop a protocol for equipment cleaning with a schedule and a log by 2/4/22. The cleaning schedules for the [redacted] and [redacted] wheelchairs will be included in this protocol, which will be developed by 2/4/22. Housekeeping staff and nursing staff will be educated on the new protocol by 2/11/22. Element #4: Each Unit Manager or designee will conduct an audit of all [redacted] and [redacted] on each unit weekly x 4 weeks and then monthly x 4 months. The results of these audits will be submitted monthly to the DON for review at the monthly Nursing Professional Practice meeting and quarterly to the QAPI Committee for review and action, as appropriate. Element #5:	

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F 584	Continued From page 6 #43's wheelchair. At 12:00 PM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that she honestly did not know if there was a schedule in place for cleaning the resident's wheelchairs. The LPN further stated that if the wheelchair was visibly soiled, the staff would clean the wheelchair for the resident. At 12:03 PM, the LPN observed the residents [redacted] in the presence of the surveyor and stated that the residents [redacted] needed to be cleaned. The LPN further stated that the bottom portion of the residents [redacted] was dusty and layered in a brownish colored debris. At 1:16 PM, the surveyor interviewed the Housekeeping Director (HKD) who stated that there was a cleaning schedule in place for cleaning the resident's wheelchairs and the facility staff tried to clean the resident's wheelchairs at least once a month. On 01/11/22 at 11:11 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the residents motorized wheelchair was cleaned on 01/6/22. The DON further stated that the resident's wheelchairs were cleaned monthly by the nighttime HK and porter and as needed by either the housekeeping or nursing staff. On 01/11/22 at 11:12 AM, the surveyor interviewed the Administrator who stated that the wheelchairs were power washed monthly and there was no Supervisor on the 3:00 PM to 11:00 PM shift who checked to see if the wheelchairs	F 584		

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F 584	Continued From page 7	F 584		

were cleaned. The Administrator further stated that the facility did not have a Policy and Procedure in place for cleaning the wheelchairs.

A review of the facility's Wheelchair Cleaning Logs dated [redacted] indicated that the wheelchairs on [redacted] had been cleaned. A further review of the facility's Wheelchair Cleaning Logs for the months of [redacted] and December 2021 did not indicate a specific numerical date in which the wheelchairs were cleaned. The surveyor was not provided with a Wheelchair Cleaning Log for the month of [redacted]

2. On 01/04/22 at 10:21 AM, the surveyor Observed Resident #15 laying in bed with his/her eyes closed. The surveyor observed a [redacted] in the resident's room. The bottom of the [redacted] was observed to have crusted layers on brownish, tan colored splatter throughout.

On 01/05/22 at 12:23 PM, the surveyor observed the [redacted] in the resident's room in the same condition as the day prior. The bottom of the [redacted] was observed to have crusted layers on brownish, tan colored splatter throughout.

On 01/06/22 at 10:57 AM, the surveyor observed that the bottom portion of the resident's [redacted] had crusted layers of brownish, tan colored spillage throughout.

At 11:50 AM, the surveyor interviewed the HK for [redacted] who stated that she cleaned all the resident's rooms on the unit. The HK stated that it

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F 584	Continued From page 8	F 584		

was her responsibility to clean the resident's tables, dressers, bathrooms, and floors. The HK further stated that she was responsible for cleaning the EX Order 26 § 4b1 in the resident's rooms.

At 11:56 AM, the surveyor interviewed the resident's CNA who stated that her responsibility for cleaning a resident's room was she would sweep the floors, remove soiled linen, and take out the trash when full. The CNA further stated that she believed each CNA during their shift would make rounds to make sure the resident's rooms were clean. The CNA stated that she thought it was the nurse's responsibility to clean the EX Order 26 § 4b1 in the resident's room because the nurses were responsible for administering the EX Order 26 § 4b1 .

At 12:00 PM, the surveyor interviewed the resident's LPN who stated that the housekeeping staff were responsible for cleaning the EX Order 2 in the resident's rooms.

At 12:04 PM, the surveyor entered Resident #15's room with the residents LPN. The LPN looked at the EX Order 26 § 4b1 and stated that the bottom of the pole had beige colored spillage on it that was from the resident's EX Order 26 § 4b1

At 1:16 PM, the surveyor interviewed the facility's HKD who stated that the housekeeping staff were responsible for cleaning the trash, mopping, and disinfecting the resident's rooms and bathrooms, cleaning high touch areas such as door handles, and doorknobs. The HKD further stated that the housekeepers were responsible for cleaning the toilets in the resident's bathrooms, sweeping the floors, and replenishing the supplies on the unit.

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F 584	Continued From page 9 The HKD stated that the housekeeping staff were responsible for cleaning spillage on the EX Order 2 [redacted] in the resident's rooms. The HKD stated that he follows up with his staff and checks three to five resident rooms daily to make sure that the rooms were cleaned. The HKD explained to the surveyor that when he checked the resident's rooms, he looks for overall cleanliness and checking that the EX Order 26 § 4b1 were clean would be something he would look for. On 01/11/22 at 11:36 AM, the surveyor interviewed the Director of Nursing (DON) who stated that Resident #15's EX Order 26 § 4b1 [redacted] yesterday and she observed that there was EX Order 26 § 4b1 throughout the EX Order [redacted] On 01/11/22 at 11:37 AM, the surveyor interviewed the Administrator who stated that it was housekeeping's responsibility to clean the EX Order 26 § 4b1 in the resident's rooms. The Administrator further stated that the facility had no Policy and Procedure for cleaning the EX Order 2 [redacted]	F 584		
F 658 SS=D	NJAC 8:38-4.1(a) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 658	ID Prefix Tag F658	2/11/22

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F 658	Continued From page 10 and review of pertinent facility documentation, it was determined that the facility failed to follow physician's orders by administering as needed EX Order 26 § 4b1 based on [redacted] parameters for the prescribed [redacted] and [redacted] in accordance with professional standards of practice. This deficient practice was identified for 1 of 2 residents (Resident #154) reviewed for [redacted] Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." The evidence was as follows:	F 658	Element #1: The Facility Educator immediately re-educated the staff responsible for the care of Resident #154 on the process of [redacted] assessments and [redacted] medication parameters. The Unit Manager immediately notified the MD of Resident #154 about the use of the [redacted] medication outside of the medication parameters. Element #2: Resident medication orders will be reviewed by each Unit Manager to identify residents on each unit who receive PRN [redacted] medication and have the potential to be affected by this deficient practice. Element #3: The Facility Educator will re-educate nurses by 2/4/22 about the importance of matching the [redacted] medication administered with the resident□s reported [redacted]. Each Unit Manager will also label the PRN [redacted] medication bingo-cards that were identified in Element #2 with the correct [redacted] for that particular medication by 2/4/22. (Example [redacted] The label on the bingo-card will be an additional reminder of the [redacted] parameters for that medication. Facility Educator will place a notice of [redacted] parameters on each medication cart to clarify the definition of [redacted]. Element #4: Each Unit Manager or designee will audit 5 residents who receive PRN [redacted] [redacted] medications weekly x 4 weeks and 5	

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F 658	Continued From page 11 On 1/3/22 at 12:46 PM, the surveyor observed Resident #154's door closed. The resident was on transmission-based precautions for [redacted] and had not responded to surveyor knocking. The surveyor reviewed the medical record for Resident #154. A review of the Admission Record face sheet (admission summary) reflected that the resident was re-admitted to the facility in October 2021, with diagnoses which included EX Order 26 § 4b1 [redacted]. A review of the active Order Summary Report (OSR) reflected a physician's order (PO) dated 11/20/21, for [redacted] milligram (mg) tablet, a [redacted]; to give one tablet by mouth every [redacted] hours as needed for severe [redacted]. A further review revealed PO dated 11/20/21, for [redacted], a [redacted]; to give [redacted] A PO dated [redacted], indicated to [redacted]. A review of the corresponding electronic Medication Administration Record (eMAR) for [redacted] reflected that the resident was administered [redacted] out of the prescribed parameters [redacted] on the following dates and time: [redacted]	F 658	residents monthly x 4 months for compliance with medication orders matching [redacted] stated. The results of these audits will be submitted monthly to the DON for review at the monthly Nursing Professional Practice meeting and quarterly to the QAPI Committee for review and action, as appropriate. Element #5:	

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F 658		F 658		

Continued From page 12

6:33 PM.
Pain Leve[redacted].

A review of the corresponding eMAR for [redacted] reflected that the resident was administered [redacted EX Order 26 § 4b1] out of the prescribed parameters [redacted] on the following dates and time:

[redacted] Level [redacted]
Pain Level [redacted].
[redacted] Level [redacted]
Pain Level [redacted]

A review of the corresponding eMAR for [redacted] reflected that the resident was administered [redacted EX Order 26 § 4b1] out of the prescribed parameters on the following dates and time:

[redacted] Level [redacted]

On 1/10/22 at 10:03 PM, the surveyor observed Resident #154 lying in bed. The resident stated that he/she had frequent [redacted] and received [redacted EX Order 26 § 4b1] and another medication that he/she could not recall the name. The resident stated that he/she could take the medication every [redacted] hours as needed.

On 1/10/22 at 11:00 AM, the surveyor interviewed the resident's medication nurse for the day who was the Registered Nurse/Unit Manager (RN/UM)

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F 658	Continued From page 13 who stated that she just administered the resident an EX Order 26 § 4b1 for a [redacted] of a EX Ord. The RN/UM stated that the resident also received [redacted] as needed and had routine EX Order 26 § 4b1 EX Order 26 § 4b1 [redacted]. The RN/UM stated that she administered the EX Order 26 § 4b1 instead of the EX Order 26 § 4b1 because the EX Order 26 § 4b1 relieved the resident's [redacted] better. On 1/10/22 at 11:39 AM, the surveyor interviewed the Director of Nursing (DON) who stated that [redacted] medication was administered according to the [redacted] l and the PO. If the resident was asking for a [redacted] medication that did not correlate with the [redacted], the nurse would need to communicate that to the Physician. The DON stated that you would expect to see documentation from the nurse regarding this in the Progress Notes. On 1/10/22 at 12:08 PM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA), Vice President Clinical, and survey team acknowledged that Resident #154 was receiving EX Order 26 § 4b1 and EX Order 26 § 4b1 outside of the ordered parameters. The DON confirmed that medications should only be administered in accordance with the PO. NJAC 8:39- 11.2(b)	F 658		
F 684 SS=E	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	F 684		2/11/22

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F 684	Continued From page 14 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 pertinent facility documentation it was determined that the facility failed to: a.) document and carry out a Physician's Order (PO) for a [redacted] culture within an appropriate time frame and b.) notify the resident's physician that staff was unable to obtain the [redacted]. This deficient practice was identified for 1 of 35 residents, (Resident #84) reviewed for quality of care and was evidenced by the following: On 1/05/22 at 11:44 AM, the surveyor was approached by an [redacted] resident, Resident #34 who was the roommate of Resident #84. Resident #34 stated that his/her roommate was recently admitted to the hospital. Resident #34 stated that he/she was very close with his/her roommate and they looked after one another like family. Resident #34 further stated that his/her roommate, Resident #84 had become [redacted] in the [redacted] and when that happened, the resident was [redacted] by facility staff. The surveyor reviewed the medical record for Resident #84. A review of Resident #84's Admission Record (an Admission Summary) reflected that that resident was a [redacted] resident at the facility and had diagnoses which included but were not	F 684	ID Prefix Tag F684 Element #1: The Unit Manager immediately notified Resident #84□s MD about the lab [redacted] that had not been collected. The nurses for Resident #84 were educated to carry out Physician lab orders in a timely manner and to notify the Physician if the specimens could not be collected or could not be collected within a reasonable time frame. Element #2: Any resident that requires a specimen collection by a nurse has the potential to be affected by this deficient practice. Element #3: The Facility Educator will educate all nurses to document all lab orders received in the unit 24-hour report and to continue carrying the orders over to the next day until the [redacted] are collected and results received or the order is discontinued by the Physician. The Unit Managers will report on the status of all lab orders at the morning clinical meeting. Element #4: Unit Managers will audit 5 random lab orders weekly x 4 weeks then 10 random lab orders monthly x 4 months for timely collection of specimens and timely reporting of results to the Physician. The	

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F 684	Continued From page 15 limited to EX Order 26 § 4b1 [redacted] A review of the resident's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 10/21/21 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted] which indicated the resident was EX Order 26 § 4b1. A review of the resident's Progress Notes (PN) dated [redacted] and timed at 23:10 (11:10 PM) written by the Registered Nurse (RN) reflected that the resident had [redacted]. The RN called the resident's physician to notify him of the change in resident's status and received new orders for a EX Order 26 § 4b1 and a [redacted] and [redacted]. A review of the resident's [redacted] Order Summary Report (OSR) did not reflect a PO for the EX Order 26 § 4b1 [redacted]. A review of the resident's laboratory results, did not indicate that EX Order 26 § 4b1 was obtained from the resident and sent to the lab for processing. A review of the Laboratory Requisition Form dated [redacted] reflected that the RN put in a request for a EX Order 26 § 4b1 and culture to be obtained for the resident. The [redacted] was never obtained and sent to the laboratory.	F 684	results of these audits will be submitted monthly to the DON for review at the monthly Nursing Professional Practice meeting and quarterly to the QAPI Committee for review and action, as appropriate. Element #5:	

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A review of an additional Laboratory Requisition Form dated [redacted] reflected that the RN made an additional request for a [redacted] to test for [redacted] be obtained for the resident. The [redacted] was never obtained and sent to the laboratory.

A review of the resident's PN from [redacted] did not indicate that the resident's physician was made aware that the [redacted] sample was not obtained for the resident. This reflected a seven-day delay in treatment for obtaining the [redacted] sample for the resident.

A further review of the resident's January 2022 OSR reflected a PO dated [redacted] for [redacted].

A further review of the resident's PN's dated 12/30/21 and timed at 22:28 (10:28 PM) written by the Licensed Practical Nurse (LPN) indicated that the resident was in no distress. The 12/30/21 PN indicated that the Nursing Supervisor attempted to obtain [redacted] and was unable to do so. The PN further indicated that the resident would be provided with [redacted] and the nurse would try to obtain the [redacted] later in the shift.

A continued review of the resident's PN from 12/30/21 to 1/2/22 did not reflect that [redacted] was obtained or that the resident's physician was notified that the Nursing Supervisor was unable to obtain [redacted] by way of [redacted] for the Resident #86.

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A review of the resident's Care Plan (CP) revised 12/13/21 indicated a focus area that the resident had EX Order 26 § 4b1 related to EX Order 26 § 4b1 and was at EX Order 26 § 4b1. The goal of the resident's CP was that the resident would remain free from signs and symptoms of EX Order through the next review date. The interventions in the resident's CP indicated to monitor and document EX Order 26 § 4b1 and report significant changes to the resident's physician.

On 01/10/22 at 10:44 AM, the surveyor interviewed the resident's Registered Nurse/Unit Manager (RN/UM) who stated that the resident's primary nurse was not working that day. The RN/UM stated that the resident was and had diagnoses of EX Order 26 § 4b1 and EX Order 26 § 4b1 The RN/UM told the surveyor that the resident was sent out to the hospital because the resident's EX Order 26 § 4b1, and the resident became which was different from his/her baseline. The RN/UM stated that prior to being sent to the hospital the resident had been complaining of EX Order 26 § 4b1. The RN/UM stated that she thought the resident's physician ordered a EX Order sample for but the staff was unable to obtain the EX Order. The RN/UM did not mention if the was ever obtained. The RN/UM further stated that she was unsure of why the staff were unable to obtain the EX Order sample and would have to find out. The RN/UM stated that if the physician ordered labs, they were usually done the following morning and if the nurse was unable to obtain the physician ordered EX Order 26 § 4b1, the physician should have been notified and it should be documented in the resident's medical record.

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F 684	Continued From page 18 At 11:53 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the resident was [redacted], very social, [redacted] care, and made [redacted] his/her priority. The DON further stated that prior to the resident's hospitalization the resident became [redacted]. The DON told the surveyor that when a physician ordered laboratory work to be done, the expectation was to follow the PO. The DON stated that if the staff was unable to obtain the physician ordered lab [redacted], the staff would have to let the physician know and then document that the physician was notified in the resident's medical record. On 01/11/22 at 11:46 AM, the surveyor interviewed the Vice President of Clinical Operation (VP) who stated that it wasn't until [redacted] that the resident's [redacted] was attempted to be obtained. The VP did not speak to the [redacted] sample or notification of the physician. At 11:49 AM, the DON stated that when labs were ordered for a resident, the nurse would write a physician's order for the laboratory [redacted] and document in the laboratory portal to make the lab technician aware. The DON further stated that it was the nurses working at the facility's responsibility to obtain the [redacted] samples, not the laboratory technicians. At 1:02 PM, the surveyor placed a call to the RN who wrote the PN dated [redacted] and timed at 23:10 (11:10 PM) for the [redacted] after speaking with the resident's physician, but the RN was unavailable for an interview.	F 684		

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F 684	Continued From page 19 At 1:24 PM, the surveyor conducted an interview with the resident's physician over the telephone who stated that if he gave orders for laboratory [redacted] to be obtained, it was his expectation that they would be done for the resident. The physician further stated that he expected the nurses would notify him of the laboratory results and he further expected to be notified if the labs were unable to be obtained. The resident's physician further stated that he did not recall being notified that the resident's [redacted] were not obtained as ordered. A review of the facility's Physician Notification of Change in Resident/Patient Condition Policy and Procedure dated 12/20/21 indicated, "Our facility shall promptly notify the resident, his or her attending physician, and the representative (sponsor) of changes in the resident's condition and/or status." NJAC 8:39-27.1(a)	F 684		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		2/11/22

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F 688	Continued From page 20 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based off observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to: a.) place a splinting device on a resident who had a Physician's Order (PO) for one and b.) maintain accurate and consistent accountability for the use of the [redacted] device for the months of [redacted]. This deficient practice was identified for 1 of 4 residents, (Resident #43) reviewed for position and mobility. The deficient practice was evidenced by the following: On 01/04/22 at 10:02 AM, the surveyor observed Resident #43 glide to the front of the nurse's station on the [redacted] unit in his/her [redacted]. The surveyor further observed that the resident had a splinting device secured around on his/her [redacted] The surveyor attempted to interview the resident; the resident softly told the surveyor his/her name. On 01/05/22 at 12:21 PM, The surveyor observed the resident lying in bed in his/her room. The surveyor observed a [redacted] over the resident's bed. The surveyor further observed that the resident was not wearing a [redacted] on his/her [redacted] On 01/06/22 at 10:53 AM, the surveyor observed	F 688	ID Prefix Tag F688 Element #1: The nurse immediately applied the [redacted] to Resident #43. Director of Rehab was notified on 1[redacted] that Resident #43 did not have the [redacted] applied consistently and re-evaluated the resident□s condition. A new [redacted] order was placed in Resident #43 Treatment Administration Record requiring a signature daily from the nurse responsible for applying the [redacted]. The nursing staffs responsible for the care of Resident #43 were educated on the procedure for applying [redacted] as ordered. Element #2: Facility MDS assessments will be reviewed by each Unit Manager by 2/4/22 to identify all residents on each unit who have [redacted] orders and have the potential to be affected by this deficient practice. Element #3: The Director of Nursing and Director of Rehab will update the facility□s [redacted] Care Policy by 2/4/22 to reflect who is responsible for putting the [redacted] on the resident and how the [redacted] will be monitored or accounted for while in use by a resident. Nurses will be educated on the updated policy by 2/11/22. Each Unit Manager will review Rehab [redacted]	

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F 688	Continued From page 21 the resident sitting upright in bed watching television. The surveyor observed that the residents [redacted] was not placed in a [redacted] device. The resident's [redacted] was observed to be formed in a [redacted] and was placed at the resident's side. At 1:36 PM, the surveyor observed the resident in bed watching television. The surveyor observed that the resident was not wearing his/her [redacted]. The surveyor attempted to interview the resident and asked the resident where his/her [redacted] was. The surveyor could not understand the resident when he/she spoke. The resident pointed and showed the surveyor that his/her [redacted] was located on the dresser next to the resident's bed. The residents [redacted] remained curled in [redacted] On 01/10/22 at 10:03 AM, The surveyor observed the resident in his room, lying in bed. The surveyor observed the resident's [redacted] under a sheet. The resident's [redacted] was observed laying on the floor by the resident's closet. At 10:23 AM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated that the resident wore a [redacted]. The CNA told the surveyor that she got the resident up out of bed on [redacted] and [redacted] and on those days, she would put the [redacted] on the resident's [redacted]. The CNA further stated that on the days she did not put the splint on the resident, the therapist would. The CNA never mentioned that the resident would remove the [redacted]. At 10:55 AM, the surveyor interviewed the	F 688	Recommendations for all resident□s identified in Element #2 and transcribe or update orders as necessary in the resident□s TAR to require nurses to sign for the application and removal of TAR. The nurse may delegate the task to an appropriately trained nursing assistant; however the nurse is ultimately responsible for monitoring the application and removal of the [redacted]. Element #4: All Unit Managers will obtain a weekly list of [redacted] every Monday from the Director of Rehab. Each Unit Manager will audit all [redacted] orders on their unit weekly x 4 weeks and then monthly x 4 months. The audit will include reviewing the Physician Order for accuracy, reviewing the resident TAR for monitoring of application and removal and assessing the resident for compliance with the [redacted]. The results of these audits will be submitted monthly to the DON for review at the monthly Nursing Professional Practice meeting and quarterly to the QAPI Committee for review and action, as appropriate. Element #5:	

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resident's Licensed Practical Nurse (LPN) who stated that she regularly took care of the resident and she never put the EX Order 26 § 4b1 on the resident. The LPN stated that the resident was [redacted], did not [redacted] peak clearly, had EX Order 26 § 4b1 [redacted]. The LPN was unsure if the resident had a contracture upon surveyor inquiry and stated that the resident did not wear a EX Order 26 § 4b1. The LPN further stated that if the resident wore a [redacted] there would be a PO for the use of the [redacted]. The LPN reviewed the POs for the resident in the presence of the surveyor and identified that there was a PO for the use of the [redacted] The LPN further reviewed the [redacted] Treatment Administration Record in the presence of the surveyor and identified that there was no place for her to sign for the use of the EX Order 26 § 4b1.

At 11:25 AM, the surveyor interviewed the Registered Nurse/Unit Manager who stated that the resident was [redacted], had a EX Order 26 § 4b1 [redacted], and wore a [redacted]. The RN/UM further stated that it was the CNA's or the nurse's responsibility to place the EX Order 26 § 4b1 on the resident and then the nurse would sign for the application of the device on the TAR. The RN/UM stated that sometimes the resident would put the [redacted] on himself/herself. The RN/UM told the surveyor that the therapy department was not responsible for putting the [redacted] on the resident but would educate the nursing staff on how to apply it if needed. The RN/UM never mentioned that the resident would remove the [redacted].

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At 11:46 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the person responsible for putting the [redacted] on the resident was the [redacted] nursing aide and the primary nurse would sign for the accountability of putting the hand splint on the resident in the TAR. The DON did not speak to who would place the hand splint on the resident when the restorative nursing aide had off from work.

At 12:20 PM, the surveyor interviewed the Director of Rehab (DR) who stated that Resident #43 wore the splint to his/her [redacted], and it was the restorative nursing aide's responsibility to put the [redacted] on the resident in the morning and document that she put it on and took it off the resident. The DR further stated that the resident would sometimes remove his/her [redacted]

At 12:33 PM, the surveyor asked the Administrator if the restorative nursing aide was available for an interview and was told that she had off from work. The Administrator stated that she was unsure who was responsible for putting the [redacted] on the resident when the restorative nursing aide was off from work, but she would find out.

At 12:40 PM, the Administrator stated that it was the nurse's responsibility to put the [redacted] on the resident when the restorative nursing aide had off work

The surveyor reviewed the medical record for Resident #43.

A review of the resident's Admission Record (an

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Admission Summary) reflected that the resident had resided at the facility for several years and had diagnoses which included but were not limited to EX Order 26 § 4b1 [redacted].

A review of the resident's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted] indicated that the resident had unclear speech and was usually able to be understood when expressing himself/herself. A further review of the resident's MDS indicated that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted] which indicated the resident was EX Order 26 § 4b1. A review of Section G0400 - Functional Limitation in Range of Motion indicated that the resident had limited range of motion in one EX Order 26 § 4b1.

A review of the resident's January 2022 Order Summary Report (OSR) reflected a PO dated [redacted] for resting hand EX Order 26 § 4b1. ON after AM care. Off at PM care.

A review of the November 2021 TAR and December 2021 TAR did not reflect a PO for the nurses to sign for the accountability for the [redacted] EX Order 26 § 4b1. A review of the January 2022 TAR reflected a PO dated 01/10/22 for nurses to sign for the accountability of the resting EX Order 26 § 4b1 to be applied after AM care and removed after PM care.

A review of the resident's [redacted] Restorative Nursing Program Sheet indicated

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hand splint to prevent contracture on after AM care, off before PM care. A further review of the [redacted] Restorative Nursing Program Sheet reflected that the restorative nursing aide did not sign for the use of the [redacted] on [redacted]

A review of the resident's December 2021 Restorative Nursing Program Sheet indicated [redacted] to prevent [redacted] on after AM care, off before PM care. A further review of the December 2021 Restorative Nursing Program Sheet reflected that the restorative nursing aide did not sign for the use of the [redacted] on [redacted]

A review of the resident's [redacted] Restorative Nursing Program Sheet indicated hand splint to prevent contracture on after AM care, off before PM care. A further review of the [redacted] Restorative Nursing Program Sheet reflected that the restorative nursing aide did not sign for the use of the [redacted] on [redacted]

A review of the resident's undated Care Plan (CP) reflected a focus area that the resident had a diagnosis of [redacted] and needed a lot of help with care in the morning. The goal of the residents CP was for the staff to continue to provide the resident with help and the resident would not sustain injuries or feel unsafe. The interventions for the resident's CP included that the resident had a [redacted] to be put on after AM care and removed after PM care to prevent further [redacted] and [redacted]

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F 688	Continued From page 26 The resident's CP did not reflect that the resident would remove his/her [EX Order 26 § 4b1]. On 01/11/22 at 11:27 AM, the surveyor interviewed the Vice President of Clinical Operations who stated that she interviewed the resident and the resident stated that sometimes he/she would remove the [EX Order 26 § 4b1] during the day and the residents care plan was updated to reflect that the resident had this behavior. A review of the facility's undated [EX Order 26 § 4b1] [redacted] are Policy did not reflect who was responsible for putting the [redacted] on the resident or how the [EX Order 26 § 4b1] was monitored or accounted for while in use for a resident. NJAC 8:39-27.1(a)	F 688		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning 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, record review, and review of pertinent facility documentation, it	F 695	ID Prefix Tag 695 Element #1:	2/11/22

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F 695	Continued From page 27 was determined that the facility failed to obtain the appropriate physician orders for the care of a resident with a [redacted] This deficient practice was identified for 1 of 1 residents (Resident # 210) reviewed for respiratory care. This deficient practice was evidenced by the following: On 1/3/22 at 1:00 PM, the surveyor observed Resident # 210 inside his/her room. The resident was observed with a EX Order 26 § 4b1. The resident was able to speak. The EX Order 26 § 4b1 dressing was [redacted]. On 1/4/22 at 10:45 AM, the surveyor observed the resident in his/her room. The resident did not wish to speak with the surveyor. The surveyor reviewed the medical record for Resident #210. A review of the resident's Admission Record reflected that the resident had diagnoses which included but were not limited to EX Order 26 § 4b1 [redacted] A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted] reflected that the resident had a Brief Interview for Mental Status (BIMS) of [redacted] out of [redacted] which indicated the resident was EX Order 26 § 4b1. Further review of the resident's MDS, section	F 695	The Unit Manager immediately contacted Respiratory Company to receive recommendations for [redacted] care for Resident #210. The recommendations were communicated to the Physician for Resident #210 and orders for tracheostomy care were obtained and transcribed to Resident #210's Treatment Administration Record on 1/10/22.The nurses for Resident #210 were educated by the Facility Educator on 1/10/22 regarding the new orders for care of the resident□s tracheostomy. Element #2: Facility MDS assessments were reviewed on 1/10/22 to identify any other resident that could have been affected. New admissions to the facility will be reviewed by the DON, ADONs and Unit Managers at morning clinical meeting to identify any new residents with a tracheostomy that has the potential to be affected by this deficient practice. Element #3: Effective 1/17/22, all new admission charts and readmission charts will be reviewed by the DON, ADON and Unit Manager at morning clinical meeting to identify any new residents with a tracheostomy. Resident orders will be reviewed to confirm appropriate tracheostomy care orders are in the resident□s Treatment Administration Record and a consult requested from Respiratory Company. The Unit Managers will review orders for all residents on their unit with a tracheostomy for tracheostomy care orders and suctioning orders by 2/4/22.	

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F 695	Continued From page 28 O-Special Treatments, Procedures, and Programs indicated the resident received EX Order 26 § 4b1 care. A review of the resident's electronic Order Summary Report (OSR) reflected the following discontinued physician's order dated : - "to change inner # 4 daily and as needed everyday shift for change inner #4. - suction every shift and as needed for suction. - care every shift." Further review of the electronic January 2022 OSR did not reflect physician orders for the care of the resident's Review of the December 2021 and January 2022 electronic Medication Administration Record (eMAR) and Treatment Administration Record (eTAR) reflected there was no documented evidence to ensure the daily care of the resident's care was completed. A review of the resident's individualized comprehensive care plan date initiated 7/14/21, reflected a focus area that the resident has a EX Order 26 § 4b1 related to EX Order 26 § 4b1 The goal of the resident's care plan was that the resident will have EX Order 26 § 4b1 through the review date and will have no complications resulting from EX Order 26 through the review date. The interventions for the resident's care plan indicated to ensure that EX Order 26 § 4b1 are secured at all times; monitor/document for EX Order 26 § 4b1	F 695	Element #4: Each Unit Manager will conduct an audit weekly x 4 weeks and then monthly x 4 months to reconcile all tracheostomy orders with recommendations noted by the Respiratory Care Therapist to ensure appropriate care orders and suctioning orders are in place for each resident on their unit with a Each Unit Manager will notify the appropriate Physician as necessary for updated orders. The results of these audits will be submitted monthly to the DON for review at the monthly Nursing Professional Practice meeting and quarterly to the QAPI Committee for review and action, as appropriate.	

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EX Order 26 § 4b1 Reassure that help is available immediately; provide paper and pencil if needed. Work with resident to develop communication system that will work in an emergency; Reassure resident to EX Order 26 § 4b1 EX Order 26 § 4b1 If able to breathe spontaneously, elevate head of bed 45 degrees and stay with resident. Obtain medical help immediately; use universal precautions as appropriate.

On 1/10/22 at 11:21 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) for the [redacted] unit. The ADON stated that the resident has a EX Order 26 and a EX Order 26 § 4b1 due to mouth cancer and recent surgery for the EX Order 26 § 4b She further stated that the nurses do the EX Order 26 § care for the resident.

On that same date and time, the surveyor together with the ADON reviewed the electronic January 2022 OSR which indicated that the physician orders for the care for the resident's EX Order 26 § 4b1 were discontinued on [redacted] and there were no active physician orders for the care of the EX Order 26 § 4b1. The ADON stated she would have to "look into" why the resident did not have active physician orders for care of the EX Order 26 § 4b1.

On 1/10/22 at 12:49 PM, the ADON stated that "the resident likes to do his/her EX Order 26 care

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F 695	Continued From page 30 him/herself, the nurses sometimes do it. But yes, he/she should have physician orders for tracheostomy care." On 1/10/22 at 1:11 PM, the surveyor met with the administrative team and discussed the above concerns. On 1/11/22 at 11:04 AM, the Director of Nursing (DON) stated that the resident was readmitted to the facility in October 2021 and the [redacted] orders "were not put into" the electronic medical record. The DON stated the resident should have had physician orders for the care of the [redacted] and that the nurses ensured the resident's trach care by "visible inspection and by talking with him/her." She further stated that the resident was seen monthly by an outside [redacted] company. The DON stated that the [redacted] care notes were not in the resident's medical record "we are getting that now. I can't speak to anything until I see the documentation. He/she was last seen on 12/31/21. He/she is seen monthly." There was no additional information provided. A review of the facility's [redacted] Care policy revised on 11/12/21, indicated that "[redacted] and [redacted] shall be performed as necessary to maintain a clear airway and to [redacted]. [redacted] and [redacted] shall be performed by a Registered Nurse or a Licensed Practical Nurse." NJAC 8:39-11.2 (b); 27.1(a)	F 695		
F 698 SS=E	Dialysis CFR(s): 483.25(l)	F 698		2/11/22

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F 698	Continued From page 31 §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation it was determined that the facility failed to: a.) receive a Physician's Order (PO) for a change in a resident's [EX Order 26 § 4b] schedule and b.) plot medications to be administered according to the resident's [EX Order 26 § 4b] schedule. This deficient practice was identified for 1 of residents, (Resident #15) reviewed for [EX Order 26 § 4b] and was evidenced by the following: On 1/04/22 at 10:26 AM, the surveyor observed Resident #15 lying in bed. The resident closed his/her eyes when the surveyor entered the resident's side of the room. The surveyor asked the resident if he/she went to [EX Order 26 § 4b] and the resident stated, "no." The surveyor did not attempt to further interview the resident because the resident's body language indicated that he/she did not want to further communicate with the surveyor. The surveyor reviewed the medical record for Resident #15. A review of the resident's Admission Record (an Admission Summary) reflected that the resident resided at the facility for approximately half a year and had diagnoses which included but were not limited to [EX Order 26 § 4b1]	F 698	ID Prefix Tag 698 Element #1: The Unit Manager immediately confirmed that the current Physician Order for Resident #15's [EX Order 26 § 4b] days and time were correct, as the Resident returned from prio[EX Order 26 § 4b] days and time. The Facility Educator educated the Unit Managers from Resident #15□s original unit and new unit about the process of giving report when a resident is transferred between units to ensure residents are getting appropriate care. The Facility Educator educated the nurses responsible for the care of Resident #15 about the process of documenting medications not given in the Medication Administration Record and when to notify the Physician to have the orders changed. Element #2: Facility MDS assessments will be reviewed by each Unit Manager by 2/4/22 to identify all residents on each unit who receive dialysis treatments and have the potential to be affected by this deficient practice. Element #3: Facility Educator will educate all nurses by 2/4/22 about the requirement of having a Physician□s Order outlining the days, time and place that a resident will be	

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F 698	Continued From page 32 EX Order 26 § 4b1 . A review of the resident's most recent significant change Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted] indicated the resident had a Brief Interview for Mental Status (BIMS) score of EX Or [redacted] out of [redacted] which indicated the resident was EX Order 26 § 4b1 . A further review of the resident's MDS, Section O - Special Treatments, Procedures, and programs reflected that the resident was on EX Order 26 § 4b [redacted]. A review of the resident's [redacted] MAR reflected a PO dated [redacted] for EX Order 26 § 4b [redacted] every [redacted]. On 01/10/22 at 10:11 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that for the past two weeks, the resident's EX Order 26 § 4b [redacted] schedule had changed for him/her to be picked up from the facility at [redacted] instead of [redacted] on [redacted]. The LPN told the surveyor that as of tomorrow [redacted] the resident would be going back to his/her regular scheduled EX Order 26 § 4b [redacted] schedule of [redacted] The LPN stated that when the resident went to EX Order 26 § 4b [redacted] early in the morning, he/she would return to the facility around [redacted]. This indicated the resident was out of the facility for approximately six hours. The LPN stated that when the resident left for EX Order 26 § 4b [redacted] at [redacted] she was done with her shift at [redacted], so she did not know when the resident was returning to the facility. The LPN stated that the resident's medications should be scheduled to be administered according to the resident's EX Order 26 § 4b [redacted] schedule. The LPN was unaware if the resident's medication times had	F 698	receiving dialysis treatments. Facility Educator will educate all nurses by 2/4/22 about making sure that medication times for dialysis residents are plotted during times that the resident is consistently in the facility and not scheduled to be at dialysis. Education will include the procedure to document a medication not given in the resident□s administration record due to the resident being at a dialysis appointment, which includes calling the Physician and changing the times of the medications effected. Element #4: Assistant Directors of Nursing will each audit 2 resident dialysis charts weekly x 4 weeks and then 4 charts monthly x 4 months for an accurate Physician Order, appropriate medication times and completed communication forms to/from the dialysis center. The results of these audits will be submitted monthly to the DON for review at the monthly Nursing Professional Practice meeting and quarterly to the QAPI Committee for review and action, as appropriate.	

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changed to reflect the change in the resident's EX Order 26 § 4b schedule.

At 11:21 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that the resident's EX Order 26 § 4b schedule had changed because the resident had tested positive for COVID-19. The RN/UM further stated that she assumed the resident's medications were changed according to the resident's EX Order 26 § 4b schedule.

At 11:50 AM, the surveyor interviewed the Director of Nursing (DON) who stated that medications should be plotted when the resident was in the building, not when the resident was at EX Order 26 § 4b. The DON further stated that if a resident's EX Order 26 § 4b schedule changed, the medication times should also be changed.

A review of the [redacted] MAR reflected a PO dated [redacted] for strict droplet isolation for [redacted] days and to notify the Infectious Disease care for changes in clinical status every shift. This indicated that the resident was COVID-19 positive and needed additional infection control measures in place.

A further review of the resident's [redacted] MAR reflected a PO dated [redacted] for the supplement medication, EX Order 26 § 4b1 [redacted] The medication was plotted to be administered at [redacted] The nurses had signed that the resident was administered the EX Order 26 § 4b1 [redacted] on Thursday [redacted],

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F 698	Continued From page 34 and Thursday 12/30/21. A further review of the [redacted] MAR revealed a PO dated [redacted] for the medication, EX Order 26 § 4b1 [redacted] The medication was plotted to be administered at [redacted] and [redacted] The nurses had signed that the resident was administered the medication [redacted] on [redacted]. A further review of the [redacted] MAR reflected a PO dated [redacted] for the medication, EX Order 26 § 4b1 [redacted] The medication was plotted to be administered at [redacted]) and [redacted] The nurses had signed that the resident was administered the medication EX Order 26 § 4b1 [redacted] on [redacted]. A further review of the December 2021 MAR revealed a PO dated [redacted] for the supplement, [redacted] The supplement was plotted to be administered at [redacted] and [redacted]. The nurses had signed that the resident was administered the EX Order 26 § 4b1 at [redacted]) o [redacted] A review of the [redacted] MAR reflected a PO dated [redacted] for EX Order 26 § 4b1 in the [redacted] for a [redacted] The medication was plotted to be administered at [redacted]. The nurses had signed that the resident was	F 698		

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F 698	Continued From page 35 administered the EX Order 26 § 4b1 at [redacted] PM) on [redacted] and [redacted] A further review of the [redacted] MAR reflected a PO dated [redacted] for the supplement medication EX Order 26 § 4b1 [redacted] give EX Order 26 § 4b1 in the evening as a supplement. The medication was plotted to be administered at [redacted]). The nurses had signed that the resident was administered EX Order [redacted] at [redacted]) on [redacted] A further review of the [redacted] MAR reveled a PO dated [redacted] for the medication, EX Order 26 § 4b1 [redacted] he medication was plotted to be administered at [redacted]). The nurses had signed that the resident was administered EX Order 26 § [redacted] on [redacted] A further review of the [redacted] MAR reflected a PO dated [redacted] for the medication, EX Order 26 § 4b1 [redacted] The medication was plotted to be administered at [redacted]) and [redacted] The nurse signed that the medication EX Order 26 § 4b1 was administered at [redacted] on [redacted] A further review of the [redacted] MAR revealed a PO dated [redacted] for the supplement EX Order 26 § 4b1 [redacted] The supplement was plotted to be administered at [redacted]	F 698		

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PM). The nurses had signed that the resident was administered the EX Order 26 § 4b1 at [redacted]

A further review of the [redacted] MAR reflected a PO dated 1[redacted] for the medication, EX Order 26 § 4b1, give three (3) capsules via [redacted] three times a day every [redacted], [redacted] The medication was plotted to be administered at [redacted] The nurses had signed that the resident was administered the EX Order 26 § 4b1 at [redacted].

The resident's [redacted] chair time had changed to [redacted] pick up from the facility on [redacted], this indicates the resident would not have been back at the facility for approximately five to six hours [redacted] Therefore, Resident #15 would not have been in the facility [redacted] to have been administered his/her medications.

A review of the resident's undated Care Plan (CP) indicated a focus area that the resident was on [redacted] related to EX Order 26 § 4b1. The goal of the resident's [redacted] was the resident would have immediate intervention if complications from [redacted] occurred and the resident would show no complications from [redacted] through the next review date. The intervention on the resident's CP did not include scheduling the resident's medication according to [redacted] times.

On 01/11/22 at 11:30 AM, the surveyor conducted a follow up interview with the DON who stated

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F 698	Continued From page 37 that on 12/23/21 the resident tested positive for [EX Order 26 § 4b1] and his/her [EX Order 26 § 4b] chair time changed to 3:30 PM. At 11:33 AM, the surveyor interviewed the Vice President of Clinical Operations (VP) who stated that when the resident's [EX Order 26 § 4b] chair time changed, there was no PO to reflect the change in time, and she was unaware of when the resident went back to his/her normal schedule of [redacted] pick up from the facility. The VP further stated that the facility had no policy and procedure for residents on [EX Order 26 § 4b]. A review of a typed statement provided by the DON indicated that the resident, "was diagnosed [redacted] [EX Order 26 § 4b] center asked to keep [gender redacted] days the same and change chair time to [redacted] NJAC 8:39-27.1(a)	F 698		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		2/11/22

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F 755	Continued From page 38 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide appropriate pharmaceutical services which included ensuring accurate administering and reconciliation of all drugs, in accordance with professional standards. This deficient practice was identified for 3 of 4 residents (Resident #47, #156 and #812) during the medication administration observation with 2 of 2 nurses during the medication observation pass. Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care	F 755	ID Prefix Tag F755 Element #1: 1. The Unit Manager notified the physician on 1/12/22 and received a new physician for resident #182 order to match the dosing of the medication order to the medication tablets sent by pharmacy, instructing to give EX Order 26 § 4b1 [redacted] which wasn't available. Nurse administering the medication was educated by the Facility Educator on 1/12/22 to match the medication available with the physician's order and what to do if they do not match. 2. The DON notified the physician and received a new physician order to match the dosing of the medication order to the medication tables sent by pharmacy, for	

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F 755	Continued From page 39 supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." The evidence was as follows: 1. On 1/6/2022 at 10:42 AM, the surveyor conducted a medication pass observation in the presence of a second surveyor with the Licensed Practical Nurse (LPN #1). The surveyors with the LPN #1 observed on the electronic Medication Administration Record (eMAR) for Resident #812 a single order for EX Order 26 § 4b1 [redacted] LPN #1 removed two (2) bingo cards (a method of packaging medication doses within clear or light resistant bubbles or blister pack done by the provider pharmacy) from the medication cart with the resident's name on the top right-hand corner. One (1) of the bingo cards for Resident #812 was for EX Order 26 § 4b1 and the other bingo card was for EX Order 26 § 4b1 Each bingo card had a supplementary note that read EX Order 26 § 4b1 [redacted]. The PO had no supplementary	F 755	resident #47 instructing to give EX Order 26 § 4b1 [redacted] Nurse administering the medication was educated by the Facility Educator on 1/12/22 to match the medication available with the physician□s order and what to do if they do not match. 3. LPN #2 notified the physician on 1/11/22 and received a new physician order to match the form of the medication order to the capsules being administered to resident #156. LPN #2 was educated by the Facility Educator on 1/12/22 that the form of the medication administered must match the form of the medication ordered and what to do if they do not match. Element #2: Any resident with medication orders have the potential to be affected by these deficient practices. Element #3: The Facility Educator will educate all nurses by 2/4/22 that the medication administered to the resident must match the medication that is ordered, including the number of tablets that are given to achieve the ordered dose and the form of the medication (tab, cap). Education will include instructions to compare the medications that are delivered from pharmacy with medication orders in the resident□s medical record and what to do if the two do not match. The shipping manifest for the medication delivery will be forwarded to the Unit Manager after reconciliation is complete and will then be used to audit the process. Element #4:	

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F 755	Continued From page 40 instructions. On 1/6/22 at 11:22 AM, the surveyor interviewed LPN #1 who stated that she administered EX Order 26 § 4b [redacted] acknowledged that the PO should match what was being administered. LPN #1 added that there should be two (2) PO; one for EX Order 26 § 4b1 [redacted] that she would sign on the eMAR to reflect the medications she was administering. LPN #1 stated she would inform the Unit Manager (UM) to reconcile the discrepancy between the PO and the medication being administered. On 1/6/2021 at 12:01 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that the night nurse received the medications from the pharmacy and reconciled those medications with the PO. The RN/UM further stated if the PO does not match the medication being sent by the pharmacy then they called the pharmacy or the physician and clarified the PO. The RN/UM added that the nurse passing the medication should also call the pharmacy if the PO does not match with the medications being administered. The RN/UM stated that sometimes the pharmacy called when the medication sent was different from the order and instructed the nurse to correct the PO with the physician. The RN/UM confirmed that medications must be administered as ordered. The surveyor reviewed the medical record for Resident #182 A review of the resident's Admission Record (an admission summary) reflected that the resident	F 755	Each Unit Manager will conduct an audit of 25 random medications from the shipping manifests every week x 4 weeks and then 25 medications monthly x 4 months to ensure the medications delivered match the medication orders. The results of these audits will be submitted monthly to the DON for review at the monthly Nursing Professional Practice meeting and quarterly to the QAPI Committee for review and action, as appropriate.	

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was admitted to the facility with diagnoses which included [redacted].

A review of the current Order Summary Report (OSR) reflected an order dated 12/27/21 with a start date of 12/28/21, for EX Order 26 § 4b1 [redacted] There were no supplementary notes associated with the PO.

On 1/10/22 at 11:00 AM, the surveyor conducted an interview with the Assistant Director of Nursing (ADON) who stated that medications being administered must match the PO on the eMAR. The ADON further stated that the physician can be contacted to clarify the PO to reflect the medication being dispensed by the provider pharmacy.

On 1/10/22 at 2:30 PM, the surveyor interviewed the Consultant Pharmacist (CP) via telephone who stated that PO must match what was being administered by the nurses. CP further stated if a PO was for EX Order 26 § 4b1 and the pharmacy sent EX Order 26 § 4b1 and the label indicated to administer both to equal [redacted]; then the PO should be changed to match the medication that was being dispensed from the pharmacy and administered by the nurses.

On 1/11/22 at 12:16 PM, the Director of Nursing (DON) acknowledged that LPN #1 should have administered the medication as prescribed by the physician.

On 1/11/22 at 1:52 PM, the surveyor in the presence of the survey team interviewed the Licensed Nursing Home Administrator (LNHA), DON, and Vice President Clinical (VPC). The

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VPC stated that when the nurses received a medication from the pharmacy, they were to make sure that the medication matched what was ordered by the physician. The DON further clarified that if there was a discrepancy between the PO and the bingo card, then the physician should be called to clarify the PO.

2. On 1/6/22 at 11:03 AM, the surveyor conducted a medication pass observation in the presence of a second surveyor with LPN #1. The surveyors with LPN #1 observed on the eMAR for Resident #47 a PO for EX Order 26 § 4b1 [redacted]. LPN #1 removed a bingo card from the medication cart with the resident's name on the top right-hand corner for EX Order 26 § 4b1 tablets that were cut in half. The bingo card had a supplementary note for EX Order 26 § 4b which indicated EX Order 26 § 4b1 were dispensed. The PO had no supplementary instructions.

On 1/6/22 at 11:22 AM, the surveyor and LPN #1 reviewed the eMAR which revealed a PO dated 7/27/21, for EX Order 26 § 4b1 by mouth one time a day. LPN #1 stated that the pharmacy had already cut the EX Order 26 § 4b1 to make the EX Order 26 § 4b1. The surveyor asked LPN #1 if the PO and eMAR should match the medication being administered to Resident #47. LPN #1 acknowledged that the PO and eMAR should match the medication administered. LPN #1 stated that she would inform the UM to reconcile the discrepancy between the PO and the medication being dispensed and administered.

On 1/6/2021 at 12:01 PM, the surveyor

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interviewed the RN/UM who stated the night nurse received the medications from the pharmacy and reconciled those medications with the PO. The RN/UM further stated if the PO does not match the medication being sent by the pharmacy then they should call the pharmacy or the physician and clarify the PO. The RN/UM added that the nurse passing the medication should also call the pharmacy if the PO does not match with the medications being administered. The RN/UM confirmed that medications must be administered as ordered.

The surveyor reviewed the medical record for Resident #47.

A review of the current OSR reflected an order dated [redacted] and a start date of [redacted] for EX Order 26 § 4b1; give [redacted] There were no additional supplementary notes associated with the medication order.

On 1/10/22 at 11:00 AM, the surveyor interviewed the ADON who confirmed that medications being administered must match the PO on the eMAR. The ADON stated that the physician should be contacted to clarify the PO to reflect the medication being dispensed by the provider pharmacy.

On 1/10/22 at 2:30 PM, the surveyor interviewed the CP via telephone who confirmed that PO must match what is being administered by the nurses.

On 1/11/22 at 12:16 PM, the DON acknowledged that LPN #1 should have administered the medication as prescribed by the physician.

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On 1/11/22 at 1:52 PM, the surveyor in the presence of the survey team interviewed the LNHA, DON, and VPC. The VPC stated that when the nurses received a medication from the pharmacy, they were to make sure that the medication matched what was ordered by the physician. The DON further stated that if there was a discrepancy then the physician should be called to clarify the PO.

3. On 1/10/22 at 9:09 AM, the surveyor conducted a medication pass observation in the presence of a second surveyor with LPN #2. The surveyors with the LPN #2 observed on the eMAR for Resident #156 a PO for EX Order 26 § 4b1 [redacted] LPN #2 removed a bottle of EX Order 26 § 4b [redacted] from the medication cart to administer to Resident #156. LPN #2 stated that the EX Order 26 § 4b1 [redacted] was an over the counter (OTC) medication and was obtained by the facility as a house stock product.

On 1/10/22 at 10:30 AM, the surveyors with LPN #2 reviewed the eMAR for Resident #156 which revealed a PO with a start date [redacted], for EX Order 26 § 4b1 [redacted]; give one tablet by mouth once daily for [redacted]. LPN #2 stated the capsule formulation was the only available item in his cart. LPN #2 acknowledged the PO indicated to administer EX Order 26 § 4b1 [redacted] and that he had administered the capsule. LPN#2 also acknowledged that the PO should match the medication administered. LPN #2 stated that he would have to call central supply to see if they had the tablet formulation. LPN #2 stated that he could also call the prescriber to

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request for a change of formulation to the capsule because the resident was able to swallow the [redacted]

On 1/6/2021 at 12:01 PM, the surveyor interviewed with the RN/UM who stated that OTC medications were the facility's house stock medications and can be ordered from central supply. The RN/UM added that for house stock medications, the nurses can check other medication carts for availability. The RN/UM further stated that the physician can be contacted, and a request made for an alternative medication if a medication was not available.

The surveyor reviewed the medical record for Resident # 156.

A review of the resident's Admission Record reflected that the resident was admitted to the facility with diagnoses which included [redacted]

A review of the current OSR reflected an order dated [redacted] with a start date of [redacted], for EX Order 26 § 4b1 [redacted] by mouth one time a day for [redacted].

On 1/10/22 at 11:00 AM, the surveyor interviewed the ADON who confirmed that medications being administered must match the PO on the eMAR. The ADON further stated that the physician should be contacted to clarify the PO to reflect the medication being dispensed by the provider pharmacy.

On 1/10/22 at 2:30 PM, the surveyor interviewed

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the CP via telephone who confirmed that PO must match what was being administered by the nurses.

A review of the house stock item list provided by the LNHA revealed that EX Order 26 § 4b1 [redacted] was not on the list.

On 1/11/22 at 12:16 PM, the DON acknowledged that the nurses should administer a medication as prescribed by the physician.

On 1/11/22 at 1:52 PM, the surveyor in the presence of the survey team interviewed the LNHA, DON, and VPC. The VPC stated that when the nurses received a medication from the pharmacy, they were to make sure that the medication matched what was ordered by the physician. The DON further clarified that if there was a discrepancy between the PO and the bingo card, then the physician should be called to clarify the PO.

A review of the facility's "Medication Administration Policy" dated revised 12/20/21, included prior to administering the first dose of a new medication, the nurse will verify the order was correctly transcribed by comparing with the physician's order ...check the transcribed order on MAR for the dose, time and route of administration ...compare medication order on the MAR three (3) times with label on medication (taking out of drawer before opening and compare label again).

A transcription of medication policy was requested, but the facility was unable to provide a policy.

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F 759 SS=D	NJAC 8:39-11.2(b); 29.2(a)(b)(d); 29.4(b) Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication observation on 1/6/22 and 1/10/22, the surveyor observed two (2) nurses administer medications to four (4) residents. There were 33 opportunities, and two (2) errors were observed which calculated to a medication administration error rate of 6.06 %. This deficient practice was identified for 1 of 4 residents (Resident #47), that were administered medications by 1 of 2 nurses and was evidenced by the following: 1. On 1/6/22 at 11:03 AM, the surveyor conducted a medication pass observation in the presence of a second surveyor. The surveyor observed the Licensed Practical Nurse (LPN) preparing to administer ten (10) medications to Resident #47 which included EX Order 26 § 4b1 [redacted]. The LPN stated that EX Order 26 § 4b1 was an over the counter (OTC) medication and was obtained by the facility as a house stock product and stored in the original	F 759	ID Prefix Tag F759 Element #1: The Facility Educator educated the nurse on 1/6/22 who committed errors during medication pass to review the errors that occurred and to review the proper procedure for administration of medication to ensure that al medication will be administered with an error rate of less than 5%. Element #2: Unit Managers will review all resident medication orders to identify all residents with orders for EX Order 26 § 4b1 and EX Order 26 § 4b1 and have the potential to be affected by this deficient practice. Element #3: The Facility Educator or designee will re-educate facility nurses on the medication administration policy by 2/4/22. Education will include how to properly administer polyethylene glycol powder according to the manufacturer□s instructions, why altering the dose is	2/11/22

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F 759	Continued From page 48 container in the medication cart. The LPN also stated that according to the electronic Medication Administration Record (eMAR) for Resident #47, Clearlax was the OTC medication ordered by the physician. The LPN poured the EX Order 26 § 4b1 into the cap of the manufacturer's bottle and then put the powder into a clear plastic cup. The surveyors had not observed the LPN measure the amount of powder in the cap. The LPN stated that the resident did not like cold water so she would use tap water in the resident's room to dilute the powder. On 1/6/22 at 11:22 AM, the LPN confirmed that she was going to administer the ten (10) medications to Resident #47. The surveyor in the presence of another surveyor, stopped the LPN and asked her to review the medications she was about to administer. The surveyor asked the LPN how she measured the EX Order 26 § 4b1 [redacted]. The LPN replied that she thought there should have been a measuring device to accompany the EX Order 26 § 4b1. Then the LPN poured the powder from the clear plastic cup back into the EX Order 26 § 4b1 manufacturer's cap and the surveyors were able to visualize that the powder did not reach the indicated measuring line. The LPN proceeded to pour the powder into a teaspoon which yielded a teaspoonful of EX Order 26 § 4b1 [redacted]. The surveyor asked the LPN to review the directions for use on the EX Order 26 § 4b1 manufacturer's bottle which revealed: "the bottle top is a measuring cap marked to contain 17 grams of powder when filled to the indicated line (white section on cap)." The LPN had to read the instructions on the manufacturers' bottle because she did not understand the indicated measuring line and the surveyor had to point out where the measuring line was indicating on the cap for 17	F 759	incorrect and the correct procedure to follow when a resident refuses the medication. Education will also include when therapeutic substitutions are appropriate, confirming the correct form of the medication prior to administration and what to do if the medication is not available as ordered. Element #4: The Facility Educator or designee will execute a medication pass on 5 nurses per week x 4 weeks and then 10 nurses per month x 4 months in order to audit the proficiency of the medication administration education. Nurses who receive 5% error rate or greater will be re-educated in medication administration and be referred to the consultant pharmacist for a follow-up medication pass. The results of these audits will be submitted monthly to the DON for review at the monthly Nursing Professional Practice meeting and quarterly to the QAPI Committee for review and action, as appropriate.	

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F 759	Continued From page 49 GM to be measured. (ERROR#1) The LPN further stated if she gave the full amount of [EX Order 26 § 4], Resident #47 would refuse to take the full amount of [EX Order 26 § 4b1] because of the taste. The LPN then measured again the Clearlax to the indicated [EX Order 26 § 4b1]. On 1/6/22 at 11:45 AM, the surveyor in the presence of another surveyor observed the LNP add four ounces of tap water to the [EX Order 26 § 4b1] o Resident #47. The resident took his/her medications by drinking the entire amount of liquid that contained the [EX Order 26 § 4b1]. On 1/6/22 at 11:46 AM, the surveyor interviewed Resident #47 who stated that he/she took the pills the nurses brought by drinking the water with the [EX Order 26 § 4b] in it. The resident added that he/she was not bothered by the taste of the water with the [EX Order 26 § 4b]. On 1/6/2021 at 12:01 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that [redacted] must be administered as instructed on the eMAR and physician order (PO). The RN/UM also stated that he/she would follow the measurement instructions on the manufacturer's bottle. The RN/UM stated that medications should always be offered regardless of previous refusals and any refusals or if the resident did not take the medication in full, there would be documentation on the eMAR and electronic Progress Notes (ePN). In addition, the RN/UM stated that the physician would need to be notified of the refusals.	F 759		

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The surveyor reviewed the medical record for Resident #47.

A review of the resident's Admission Record (an admission summary) reflected that the resident was admitted to the facility in [redacted] with diagnoses which included EX Order 26 § 4b1 [redacted].

A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 10/12/21, reflected that the resident had a brief interview for mental status (BIMS) score of [redacted] out of [redacted] indicating that the resident had an [redacted].

A review of the resident's [redacted] eMAR had not reflected any refusals of [redacted].

On 1/10/22 at 11:00 AM, the surveyor interviewed Assistant Director of Nursing/Registered Nurse (ADON) who stated that she was the facility educator. The ADON/RN stated that the nurses were to document any refusals of medications and contact the physician. The ADON further stated that if a nurse was unsure how to administer a medication or measure a medication, then the nurse can ask the UM, the other ADON, or her. In addition, the ADON stated that the nurses were to administer the medications according to the physician's order. The ADON also stated that new nurses were observed for medication administration after shadowing an experienced nurse and each nurse was observed at least once a year.

On 1/10/22 at 2:30 PM, the surveyor interviewed the consultant pharmacist (CP) via telephone who stated that he thought the nurses would know

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how to measure EX Order 26 § 4b1 in the cap.

On 1/11/22 at 12:16 PM, the Director of Nursing (DON) acknowledged that the nurses should administer a medication as prescribed by the physician.

A review of the facility's "Medication Administration Policy" dated revised 12/20/21, included prior to administering the first dose of a new medication, the nurse will verify the order was correctly transcribed by comparing with the physician's order ...check the transcribed order on MAR for the dose, time and route of administration ...compare medication order on the MAR three (3) times with label on medication (taking out of the drawer, before opening and compare label again).

A review of the manufacturer specifications for Clearlax powder included to follow the directions for use to "the bottle top is a measuring cap marked to contain 17 grams of powder when filled to the indicated line (white section on cap)."

2. On 1/6/22 at 11:03 AM, the surveyor conducted a medication pass observation in the presence of a second surveyor. The surveyor observed the LPN preparing to administer ten (10) medications to Resident #47. The surveyor observed the LPN read the eMAR for a PO for EX Order 26 § 4b1 [redacted] was an OTC medication and was obtained by the facility as a house stock product. The LPN added

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that the EX Order 26 § 4b1 was the medication to be administered.

On 1/6/22 at 11:22 AM, the LPN confirmed that she was going to administer the ten (10) medications to Resident #47. The surveyor in the presence of another surveyor stopped the LPN and asked her to review the medications she was about to administer. The surveyors with the LPN reviewed the eMAR which revealed a PO for EX Order 26 § 4b1; apply to the lower back topically in the morning for [redacted] management. The LPN stated that the RN/UM had advised her in the past to substitute EX Order 26 § 4b1 [redacted] was not in stock. The LPN confirmed EX Order 26 § 4b1 [redacted] was not the correct medication; it was not the same as EX Order 26 § 4b1 ointment. The LPN stated that she would speak with the RN/UM to obtain the EX Order 26 § 4b1 ointment. The LPN had not administered the EX Order 26 § 4b1 after surveyor inquiry. (ERROR#2)

On 1/6/22 at 11:47 AM, the surveyor interviewed Resident #47 who stated that he/she took pills for EX Order which helped relieve the EX Order 26 § 4b1. The resident added that the nurses also put something on his/her EX Order 26 § 4b1. The resident stated that he/she thought the medication on the back was a patch but was unsure and thought it could also have been an ointment or cream. The resident added that today the nurse had not done that yet.

On 1/6/2021 at 12:01 PM, the surveyor interviewed the RN/UM who stated that medications can be ordered from central supply. The RN/UM added that for house stock medications, the nurses can check other

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medication carts for availability. The RN/UM further stated that the physician can be contacted, and a request made for an alternative medication if a medication was not available.

The surveyor reviewed the medical record for Resident #47.

A review of the resident's Admission Record reflected that the resident was admitted to the facility in [redacted] with diagnoses which included EX Order 26 § 4b1 [redacted]

A review of the most recent quarterly MDS dated 10/12/21, reflected that the resident had a BIMS score of [redacted] out of [redacted], indicating that the resident had an EX Order 26 § 4b1.

On 1/10/22 at 11:00 AM, the surveyor interviewed the ADON who stated that medications were to administered according to PO and must match the eMAR. The ADON also stated that if a house stock medication was not available in the cart, then central supply can be called to restock the missing house stock/OTC medication. The ADON/RN further stated that the physician can also be contacted for a substitution.

A record review of the house stock item list provided by the and Licensed Nursing Home Administrator (LNHA) revealed that EX Order 26 § 4b1 [redacted] was on the list and EX Order 26 § 4b1 was not on the list.

On 1/10/22 at 2:30 PM, the surveyor interviewed the CP via telephone who stated that he was not aware of any substitutions for OTC medications. The CP further stated that EX Order 26 § 4b1

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cannot be substituted for a EX Order 26 § 4b1 because it is not the same medication.

On 1/11/21 at 10:00 AM, the surveyor interviewed a Pharmacy Representative (PR) from the facility's provider pharmacy who provides the medications to the facility via telephone. The PR stated that a physician's order for EX Order 26 § 4b1 for Resident #47 had an order date of 0 and was filled for a EX Order 26 § 4b1 with refill dates of . The PR further stated there were no issues with availability for EX Order 26 § 4b1

On 1/11/22 at 12:16 PM, the DON acknowledged that the nurses should administer a medication as prescribed by the physician.

On 1/11/22 at 1:52 PM, the surveyor in the presence of the survey team asked the LNHA, the DON, and Vice President Clinical (VPC) asked what the process receiving and administering medications. The VPC responded that when the nurses received a medication from the pharmacy, they were to make sure that the medication matched what was ordered by the physician. The DON further stated that if there was a discrepancy, then the physician should be called to clarify the physician order.

A review of the manufacturer's specifications for EX Order 26 § 4b1 reflected that the medication is a prescription medication.

A review of the manufacturer's specifications for EX Order 26 § 4b1 reflected that the medication was an OTC medication containing EX Order 26 § 4b1 as the

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F 759	Continued From page 55 main ingredient. NJAC 8:39-11.2(b), 29.2(d)	F 759		
F 760 SS=E	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, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure that a physician's order was clarified with the physician to prevent an antipsychotic medication (Zyprexa) being administered in excess of the recommended manufacturer's total daily dosage and increased the [redacted] dosage by doubling the total daily dose from [redacted] to [redacted] (fifteen days). This deficient practice was identified for 1 of 5 residents (Resident #70) reviewed for unnecessary medications and the evidence was as follows: On 1/3/22 at 12:30 PM, the surveyor observed Resident #70 walking in the hallway. The resident was dressed and appeared groomed. The resident informed the surveyor that he/she was walking to their room. The surveyor reviewed the medical record for Resident #70. A review of the Admission Record face sheet (an admission summary) reflected that the resident was re-admitted to the facility in [redacted] with diagnoses which included [redacted]	F 760	ID Prefix Tag F760 Element #1: The nurse for Resident #70 clarified the recommendation for Zyprexa with the Psychiatric NP on 1/6/22 and carried out new Physician Orders. The NP and the Physician were both made aware that the antipsychotic medication was administered in excess of the recommended manufacturer□s total daily dosage. The Unit Manager who carried out the original telephone order was re-educated by the Director of Nursing on the procedure for taking telephone orders and reading back the orders. The Unit Manager was also educated to ask for clarification if a new order exceeds the manufacturer□s recommended daily dose or if the increase in the medication dosage seems excessive. Education also included making the ordering clinician aware of all doses being administered to the resident, not just the new orders, to prevent excessive dosing. Element #2: Unit Managers will review all resident medication orders by 2/4/22 to identify	2/11/22

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F 760	Continued From page 56 EX Order 26 § 4b1 A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool, dated 10/11/21, reflected a brief interview for mental health status (BIMS) score of EX O out of , which indicated fully EX Order 26 § 4b1 . A review of the Order Summary Report (OSR) reflected a physician's order (PO) dated for EX Order 26 § 4b1 give one tablet by mouth at bedtime for EX Order 26 § 4b1 A further review of the OSR reflected an additional PO dated and discontinued for EX Order 26 § 4b1 ; give one tablet by mouth in the morning related to EX Order 26 § 4b1 A review of the corresponding December electronic Medication Administration Record (eMAR) indicated it was discontinued on A further review of the OSR reflected a PO dated for EX Order 26 § 4b1 give by mouth two times a day related to EX Order 26 § 4b1 . A review of the EX Order 26 § 4b1 Follow-up Form dated reflected that the resident was seen today for EX Order 26 § 4b1 EX Order 26 § 4b1 with a recommendation/plan to start EX Order 26 § 4b1 . A review of the electronic Progress Notes (ePN)	F 760	those residents receiving antipsychotic medications and have the potential to be affected by this deficient practice. Element #3: The Facility Educator will educate facility nurses by 2/4/22 that all changes to antipsychotic medication orders must be documented on the unit 24-hour report and reported by the Unit Managers at the morning clinical meeting for review. Any orders that do not appear to have an appropriate readback to the ordering clinician will be clarified with that clinician by the Unit Manager. A log will be maintained by the Director of Nursing on all antipsychotic medication order changes reviewed at morning clinical meeting to be used to audit this process. Element #4: The Director of Nursing, or designee, will audit all antipsychotic medication order changes weekly x 4 weeks and then 10 random antipsychotic medication order changes monthly x 4 months to ensure the orders are appropriate for each medication. The results of these audits will be submitted monthly to the DON for review at the monthly Nursing Professional Practice meeting and quarterly to the QAPI Committee for review and action, as appropriate. Element #5:	

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reflected a Health Status Note dated [redacted] that this writer spoke to the [redacted] Nurse Practitioner [redacted] NP) who requested the [redacted] order be discontinued and new order written for [redacted] twice a day; author Care Manager/Coordinator.

A review of the corresponding eMARs reflected that in December, the resident received a total of [redacted] on [redacted] and a total of [redacted] from [redacted] through [redacted] which was double the original daily total dose of [redacted]

A review of the resident's individualized care plan had a focused area dated revised [redacted] included that the resident has [redacted] The resident experiences [redacted] and believes that a [redacted] caused [him/her] to have a [redacted], that [he/she] [redacted] and that [he/she] [redacted] [his/her] fingers, but they still work. Interventions included to administer medications as ordered. Monitor/document for side effects and effectiveness.

On 1/6/22 at 12:11 PM, the surveyor observed the resident in bed. The resident stated that his/her "brain is empty and has no thoughts". The resident indicated that one of his/her medications was recently changed, but he/she was unsure which medication was changed including if it was a medication that they received in the morning or at night. The resident stated that the unit manager (Care Manager/Coordinator) knew what medication was changed, but she was not at the facility today.

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On 1/6/22 at 12:14 PM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated that the resident was pleasant and not usually in bed. The CNA stated that the resident was walking around earlier and probably returned to his/her room for lunch. The CNA stated that she had not noticed in the past few weeks any changes in the resident's mood, behavior, or routine.

On 1/6/22 at 12:17 PM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that the resident was very pleasant but also had periods of [redacted]. The resident would either stay in their room by themselves or was out socializing with others depending on the day. The LPN stated that she was unaware of a medication change, but the [redacted] NP visited the resident frequently and would be the one to change his/her [redacted] medications. The LPN stated that the unit manager (Care Manager/Coordinator) communicated with the [redacted] NP and was responsible for changing those medications in the electronic Medical Record. The LPN stated that the unit manager was currently on a leave from the facility.

On 1/6/22 at 12:43 PM, the surveyor interviewed the Psych NP via telephone who stated that he last saw the resident on 12/21/21 for increased [redacted] and increased their [redacted] in the morning and [redacted] at night, to [redacted] twice a day for a total of [redacted] a day. When questioned, the Psych NP stated that the manufacturer's maximum dosage per day for [redacted] When questioned how many milligrams of [redacted] the resident was supposed to be receiving daily, the [redacted] NP confirmed [redacted] in total. At this time, the

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F 760		F 760		

Continued From page 59

surveyor informed the [redacted] NP that when reviewing the resident's medical record, the resident was receiving [redacted] a day. The [redacted] NP could not speak further.

On 1/6/22 at 1:01 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the process for receiving [redacted] orders would be that the [redacted] or [redacted] NP would make a recommendation either written or verbal and the nurse would call the resident's primary care physician to obtain the order and input the PO into the electronic Medical Record. The nurse should read back the order to the prescriber at the time to verify the order is correct and clarify the order if needed. The Consultant Pharmacist (CP) came to the facility monthly to review all the residents' medications and looked for any discrepancies or concerns. At this time, the surveyor reviewed the [redacted] Follow-up Form from [redacted] as well the PO with the corresponding eMARs with the DON who confirmed that the resident had been and still was receiving since [redacted] more than [redacted]. The surveyor informed the DON that they spoke with the [redacted] NP who confirmed that the resident should only be receiving [redacted] a day. The DON stated that she would follow-up with the [redacted] NP to clarify the orders.

On 1/6/22 at 1:25 PM, the surveyor interviewed the CP via telephone who stated that he had not been at the facility yet to review the resident's December physician orders. When the surveyor asked what the manufacturer's maximum dosage for [redacted] was per day, the CP stated that the total was [redacted]. When asked if a resident's total [redacted] administered daily increased in double

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F 760	Continued From page 60 from [redacted], if that would be something he would look at and question, the CP confirmed yes. On 1/10/22 at 9:33 AM, the surveyor re-interviewed the DON who stated that she followed-up with the [redacted] NP after surveyor inquiry and confirmed that the resident was supposed to be receiving [redacted]. A review of the facility's "Verbal Orders" policy dated revised 12/9/21 included that the nurse receiving verbal order must write it on the physician's order sheet as "v.o." (verbal order) or "t.o." (telephone order). The nurse transcribing the verbal order must read the order back to the physician to ensure that the information is clearly understood and correctly transcribed. A review of the [redacted] manufacturer's specifications included for dosage and administration for [redacted] in adults when dosage adjustments are necessary, dose increments/decrements of [redacted] (every day) are recommended.. [redacted] is not indicated for use in doses above [redacted]. NJAC 8:39-11.2(b); 29.2(d)	F 760		
F 761 SS=D	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	F 761		2/11/22

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F 761	Continued From page 61 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 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, record review, and review of other pertinent facility documentation, it was determined that the facility failed to a.) identify and remove expired medications from an active medication cart and b.) maintain a completed temperature log for a medication storage refrigerator. This deficient practice was identified for 1 of 5 observed medication carts ([redacted] and 1 of 3 observed medication storage rooms [redacted]) and was evidenced by the following: 1. On 1/10/22 at 9:53 AM, the surveyor interviewed the Licenced Practical Nurse/Unit Manager (LPN/UM) regarding the process for checking medication storage. The LPN/UM stated that the nurses and her were responsible for checking medication storage to ensure there	F 761	ID Prefix Tag F761 Element #1: The expired medications found in the active medication cart were immediately removed and appropriately discarded by the ADON on 1/10/22. The medications found in the refrigerator without a completed temperature log were also immediately removed and appropriately discarded by the Unit Manager on 1/10/22. The nurses assigned to the active medication cart specified were educated by the Facility Educator on 1/10/22 to check for expired medications at the start of their shift. The 11-7 nurse on the unit with the incomplete temperature log was educated on 1/11/22 by the Facility Educator about the	

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F 761	Continued From page 62 were no expired medications or items. The LPN/UM further stated that expired medications and items were given back to central supply to discard. On 1/10/22 at 10:01 AM, the surveyor in the presence of a second surveyor and LPN #1 inspected medication cart two (2) on [redacted]. The cart contained the following expired medications: [redacted] 11/21 house stock [redacted] 10/21 house stock On 1/10/22 at 10:09 AM, LPN #1 confirmed [redacted] and [redacted] medications were expired. The LPN stated that all nurses on all shifts were supposed to check the expiration date prior to administering the medications. On 1/10/22 at 2:30 PM, the surveyor interviewed the Consultant Pharmacist (CP) via telephone who confirmed that he conducted unit inspections at the facility which included indentifying expired medications. On 1/11/22 at 11:07AM, the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA), Vice President Clinical (VPC), and survey team acknowledged that there should not have been expired medications on the medication cart. The DON further stated that the facility utilized a Unit Inspection Audit tool once a week. A review of the facility provided "Storage of Medications" policy dated revised 12/10/21 included the facility shall not use discontinued, outdated or deteriorated drugs or biological's. All such drugs shall be returned to the dispensing	F 761	importance of and rationale for being compliant with checking the refrigerator temperature and documenting the results. Element #2: All residents receiving medications have the potential to be affected by this deficient practice. Element #3: The 11-7 Nursing Supervisor, or designee, will orient the 11-7 nurses by 2/4/22 about the updated Refrigerator Log and the requirements to document refrigerator temps on it every night. The Facility Educator or designee will educate facility nurses on all shifts to inspect medication carts at the beginning of every shift for expired medications by 2/4/22. The Unit Managers, during morning rounds will inspect one medication or treatment cart per day for expired medications and check the refrigerator log for completion. Element #4: The Unit Managers on each unit will conduct an audit on one random medication cart weekly x 4 weeks and then 3 medication or treatment carts monthly x 4 months. The Unit Managers will also conduct an audit of the unit refrigerator log weekly x 16 weeks. The results of these audits will be submitted monthly to the DON for review at the monthly Nursing Professional Practice meeting and quarterly to the QAPI Committee for review and action, as appropriate. Element #5:	

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F 761	Continued From page 63 pharmacy or destroyed. 2. On 1/10/22 at 10:56 AM, the surveyor in the presence of LPN #2 inspected the [redacted] medication storage room. The surveyor observed the "Med Room Temp Log" for the unit's medication refrigerator was not completed since 1/6/22. The surveyor observed at this time, that resident medications were being stored inside of it. At this time, the surveyor interviewed the LPN who stated that she could not speak to why the temperatures were not recorded since 1/6/22 or who was responsible for taking the temperature of the medication storage refrigerator. On 1/10/22 at 11:09 AM, the surveyor interviewed the DON who stated that the Unit Manager (UM) on each unit was responsible for checking the medication storage refrigerator, as well as the CP. The temperature log was completed by the UM in the mornings, Monday through Friday. The DON could not speak to who was responsible for completing the medication refrigerator temperature logs on the weekends. On 1/10/22 at 11:18 AM, during a follow-up interview with the DON, she informed the surveyor that the 11-7 shift nursing staff was responsible for recording the medication storage refrigerator temperatures in the medication storage room. In addition, the DON stated that the UM was responsible for verifying that it was done by the 11-7 shift nursing staff Monday	F 761		

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through Friday, and that the Nursing Supervisor was responsible for making sure it was done on the weekends. The DON further stated, "The UM and the Nursing Supervisor did "spot checks" on different areas on the units; but did not necessarily check the medication storage refrigerator temperature logs each day."

On 1/10/22 at 11:30 AM, the surveyor interviewed the [redacted] Registered Nurse/UM (RN/UM) who stated that the 11-7 shift nursing staff were responsible for checking and documenting temperatures for the medication storage refrigerator in the medication storage room. The RN/UM confirmed that she was responsible Monday through Friday for ensuring the temperatures for the medication storage refrigerator were completed. The RN/UM could not speak to who was responsible for checking the temperatures on the weekends. The RN/UM stated, "I do check the temperatures in the morning, but I'm on the cart today and didn't get to do most of the stuff I was supposed to do." The RN/UM stated if the "Med Temp Log" was not signed, then she would think the nursing staff "forgot" to do it and would question why it was not done.

At this time, the surveyor showed the RN/UM the "Med Temp Log" for her unit that had not been completed since 1/6/22. The RN/UM confirmed that the temperature log was incomplete and that the temperatures should be taken daily. The surveyor asked the UM if the temperatures were not done, how did she know the temperatures were maintained for the days the temperature log was not completed? The RN/UM replied, "I would check the thermometer myself. Then I would "look" at the medications to see if they were still

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good; for example, insulin, if it was cloudy, then it would be no good." When questioned, the RN/UM could not speak to the acceptable temperature ranges for the medication storage refrigerator.

On 1/10/22 at 1:04 PM, the surveyor asked the LNHA what the medication storage refrigerator temperature range should be, and she responded, "It should be below 40 degrees."

On 1/10/22 at 2:30 PM, the surveyor interviewed the CP via telephone who stated that he completed monthly unit inspections and looked for expired medications and proper medication storage. The CP would also check the medication refrigerators on the units for the same issues. The CP stated that all refrigerated medications should be stored between 36 to 46 degrees Fahrenheit (F), and the CP thought it was noted on the log that the nurses checked daily. The CP was unaware of any problems with medication storage refrigerator temperature logs at the facility. The CP stated the medication refrigerator temperature logs should be completed daily to ensure the temperatures were correct. The CP stated he was at the facility last week to do the checks.

On 1/11/22 at 11:09 AM, DON in the presence of the LNHA, VPC, and survey team stated that [redacted] nursing unit was using the wrong temperature log recording sheet. The DON provided a new recording sheet labeled "Med Room Temp Log" which included on the sheet "temperature ranges 36-46 Degrees F, Check Refrigerator every day. If out of range, NOTIFY YOUR SUPERVISOR." The DON stated that she had called the 11-7 LPN, who stated that she had

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F 761	Continued From page 66 checked the medication storage refrigerator temperatures each night, but she did not document on the temperature log. A review of the facility provided "Storage of Medications" policy dated 12/10/21 included in #2 "The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner." NJAC: 8-39 - 29.4(g)(h)	F 761		
F 836 SS=E	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the	F 836		2/11/22

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F 836	Continued From page 67 basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility provided documentation, the facility failed to a.) ensure that [redacted] care was provided in a timely manner for 1 of 10 residents (Resident #43) reviewed for [redacted] care, b.) maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey for 23 of 23-day shifts and 1 of 14 overnight shifts reviewed and c.) ensure call bells were answered timely for 1 of 35 residents (Resident #154) reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift.	F 836	ID Prefix Tag F836 Element #1: Incontinence care was immediately provided to resident #43. Resident #154 was assisted with adl's and assisted out of bed. C.N.A.□s on floor were in-serviced on answering call bells in a timely fashion. Staffing was immediately reviewed as was the projected staffing needs by the DON, staffing coordinator, and LNHA. Element #2: All residents have the potential to be affected by this deficient practice. Element #3: Staff re-in-serviced on answering call bells in a timely fashion. Current staffing interventions in place were reviewed. Interventions in place include job fairs with on the spot hiring scheduled monthly, staff wages were increased, bonus structure in place. In addition, facility is in contract with 6 staffing agencies, administrative team is assigned to non-clinical tasks thus relieving clinical, clinical administrative team (DON, ADON, Unit Managers/supervisors) are assigned as needed for clinical tasks. Facility has teamed up with nursing schools to aide in recruitment, facility leadership is on NJ	

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F 836	Continued From page 68 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. 1. On 01/10/22 at 10:21 AM, the surveyor observed CNA #1 perform [redacted] care on Resident #43. When CNA #1 removed the resident's [redacted], the surveyor observed that the adult [redacted] was [redacted]. The surveyor further observed that the sheet underneath where the resident was laying was covered in [redacted]. The resident's [redacted] had seeped through his/her [redacted] onto the bedsheets. At that time, CNA #1 acknowledged that the resident's [redacted] was [redacted]. The surveyor observed that the resident's skin was [redacted] After [redacted] care was performed the surveyor interviewed CNA #1 who stated that it was her first time changing the resident that day because she had a lot of other hard work to do, the facility was short staffed, and the last time the resident was changed was probably between 6:00 AM and 7:00 AM that morning. CNA #1 stated that she had many other residents on her assignment, had to make rounds, change other residents, and pass out breakfast trays. On 1/10/22 at 11:03 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN)	F 836	state DOH waiting list to become c.n.a. instructors. Element #4: Unit manager/designee will conduct 5 call bell audits to monitor response time weekly x4 weeks, then 10 audits monthly x 4 with findings reported to the DON/designee for review at the monthly nursing professional practice meeting and quarterly to QAPI team for review and action as appropriate. Monthly projected schedule will continue to be monitored by DON/Administrator/designee for early recognition of potential staffing inadequacies. Upon assessment of needs staffing agencies are contacted to aide in filling available shifts. Staff is offered overtime and bonuses. Weekly schedule will also continue to be reviewed for any staffing deficiencies and interventions in place will be utilized. Monthly the DON/designee schedule will be audited and intervention effectiveness appraised, with findings reported to QAPI team for review and action as appropriate.	

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who stated that the CNA had 14 residents on her assignment that day. The LPN further stated that the CNAs were expected to make rounds and take care of the residents on their assignment who were total care first. The LPN stated that the Resident #43 was total care and [redacted] of [redacted]

At 11:27 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM #1) who stated that the CNAs shift started at 7:00 AM and it was their job responsibility was to check on the residents at least every two hours and as needed to provide regular incontinence care for the residents. The RN/UM #1 further stated that the purpose of performing regular scheduled [redacted] care was to prevent skin breakdown and make the residents feel good about themselves.

At 11:49 AM, the surveyor interviewed the Director of Nursing (DON) who stated that incontinence rounds should be performed every two hours and as needed to prevent skin breakdown.

The surveyor reviewed the medical record for Resident #43.

A review of the resident's Admission Record (an admission summary) reflected that the resident had resided at the facility for [redacted] and had diagnoses which included [redacted]

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A review of the resident's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 10/5/21, reflected that the resident had unclear speech and was usually able to be understood when expressing himself/herself. A further review of the resident's MDS indicated that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted] which indicated the resident was [redacted]. Review of Section H [redacted]

A review of the facility's "Incontinence Care Policy and Procedure" dated 08/9/21 indicated that it was their policy that residents who were incontinent would be kept clean and dry.

2. The surveyors entered the facility on 01/3/22 to conduct a recertification survey. On [redacted] and the surveyors observed three to six Certified Nursing Aides (CNA)s working on each of the five units throughout the facility. These CNAs were responsible for providing direct care to the residents who resided at the facility.

A review of the "Nurse Staffing Report" completed by the facility for the weeks of 12/19/21 to 12/25/21 and 12/26/21 to 1/1/22, the staffing to ratios that did not meet the 1 CNA to 8 residents for the day shift or the total staff for residents on overnight shifts were as follows:

12/19/21 had 11 CNAs for 220 residents on the day shift, required 28 CNAs.
12/20/21 had 21 CNAs for 220 residents on the day shift, required 28 CNAs.
12/21/21 had 19 CNAs for 219 residents on the

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day shift, required 28 CNAs.
12/22/21 had 19 CNAs for 219 residents on the day shift, required 28 CNAs.
12/23/21 had 19 CNAs for 219 residents on the day shift, required 28 CNAs.
12/24/21 had 21 CNAs for 218 residents on the day shift, required 28 CNAs.
12/25/21 had 13 CNAs for 217 residents on the day shift, required 28 CNAs.
12/26/21 had 11 CNAs for 216 residents on the day shift, required 27 CNAs.
12/27/21 had 19 CNAs for 216 residents on the day shift, required 27 CNAs.
12/28/21 had 20 CNAs for 216 residents on the day shift, required 27 CNAs.
12/29/21 had 24 CNAs for 215 residents on the day shift, required 27 CNAs.
12/30/21 had 22 CNAs for 215 residents on the day shift, required 27 CNAs.
12/31/21 had 15 CNAs for 214 residents on the day shift, required 27 CNAs.
12/31/21 had 15 total staff for 214 residents on the overnight shift, required 16 total staff.
01/01/22 had 20 CNAs for 214 residents on the day shift, required 27 CNAs.

On 01/3/22, the facility census (number of residents who resided at the facility) was 214. There were 19 CNAs who worked the 7:00 AM - 3:00 PM shift that day. This indicated that each CNA had approximately 214/ (divided by) 19 = (equals) 11 residents on their care assignment.

On 01/4/22 the facility census was 215. There were 21 CNAs who worked the 7:00 AM - 3:00 PM shift. This indicated that each CNA had approximately 10 residents on their care assignment.

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On 01/5/22 the facility census was 214. There were 17 CNAs who worked the 7:00 AM - 3:00 PM shift. This indicated that each CNA had approximately 13 residents on their care assignment.

On 01/6/22 the facility census was 214. There were 19 CNAs who worked the 7:00 AM - 3:00 PM shift. This indicated that each CNA had approximately 11 residents on their care assignment.

On 01/7/22 the facility census was 215. There were 18 CNAs who worked the 7:00 AM - 3:00 PM shift. This indicated that each CNA had approximately 12 residents on their care assignment.

On 01/8/22 the facility census was 213. There were 12 CNAs who worked the 7:00 AM - 3:00 PM shift. This indicated that each CNA had approximately 18 residents on their care assignment.

On 01/9/22 the facility census was 213. There were 13 CNAs who worked the 7:00 AM - 3:00 PM shift. This indicated that each CNA had approximately 16 residents on their care assignment.

On 01/10/22 the facility census was 214. There were 19 CNAs who worked the 7:00 AM - 3:00 PM shift. This indicated that each CNA had approximately 11 residents on their care assignment.

On 01/11/22 the facility census was 214. There were 24 CNAs who worked the 7:00 AM - 3:00 PM shift. This indicated that each CNA had

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approximately 9 residents on their care assignment.

3. On 1/10/22 at 10:00 AM, the surveyor observed Resident #154 lying in bed. The resident informed the surveyor that he/she has to wait a long time for staff to come into his/her room for assistance. The resident stated that he/she was dependent on staff for help and at times has called on his/her cell phone the lobby Receptionist to ask them to contact the nursing unit to send staff to their room for assistance. The surveyor asked the resident to press their call bell and observed the following:

At 10:03 AM, the resident hit their call bell and a red light on the call bell system lit.

At 10:21 AM, the resident repeatedly hit a tap bell located on their tray table. The red light on the call bell system was still observed lit.

At 10:30 AM, the resident again repeatedly hit their tap bell. The red light on the call bell system was still observed lit.

At 10:31 AM, the surveyor observed a green light on the call bell system lit and an intercom system was activated, but no staff communicated.

At 10:35 AM, the surveyor observed a green light on the call bell system lit and an intercom system was activated. A voice was heard over the intercom that asked the resident if he/she was okay. The resident responded "yes". The resident identified the speaker to be the Registered Nurse/Unit Manager (RN/UM #2).

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At 10:36 AM, the surveyor observed the resident's red call bell light located outside their room in the hallway turned off.

On 1/10/22 at 10:37 AM, the surveyor interviewed RN/UM #2 who confirmed that she was the person who called over the intercom to Resident #154's room. RN/UM #2 stated that anyone can answer a call bell. A paging system at the nurse's station activated when a resident pressed the call bell and the light outside their room lit to let staff know assistance was required. RN/UM #2 stated that if the resident's call bell was not operating correctly, the resident would also be given a tap bell to ring. RN/UM #2 when questioned what was an acceptable call bell response time, she responded "two to three minutes". The RN/UM informed the surveyor that the unit today had only five Certified Nursing Aides (CNAs) and two nurses including herself for a census of 52 residents.

On 1/10/22 at 10:45 AM, the surveyor observed Resident #154 out of bed in their EX Order 26 § 4b1 with CNA #2 exiting the room. At this time, the surveyor interviewed CNA #2 who stated that she was not the resident's CNA, but she had just assisted the resident out of bed. At this time, CNA #2 showed the surveyor her assignment for the day, which revealed that she had twelve assigned residents for that shift.

On 1/10/22 at 10:52 AM, the surveyor interviewed CNA #3 who stated that she was Resident #154's assigned aide for the day, but she was assisting another resident when the call bell was on. The CNA stated that she had ten assigned residents for today's shift, but she usually had twelve assigned residents for the day shift. When

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F 836	Continued From page 75 asked, the CNA stated that if she was assisting a resident and another resident's call bell was on, she would ask another CNA for assistance answering the call bell. A review of the [redacted] "Runnells Center for Rehabilitation & Healthcare 7-3 Assignment Sheet" dated 1/10/22 provided by RN/UM #1 included "WE CARE - Call Bells Are Responded to by Everyone IMMEDIATELY Within 3 Minute". On 1/11/22 at 12:14 PM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON), Vice President Clinical, and survey team acknowledged that a resident waiting over thirty minutes for a call bell response was unacceptable. NJAC 8:39-5.1(a)	F 836		
F 880 SS=E	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	F 880		3/18/22

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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 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.

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F 880	Continued From page 77 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility staff failed to a.) appropriately don (put on) and doff (remove) Personal Protective Equipment (PPE), in accordance with Centers for Disease Control and Prevention (CDC) guidelines, before and after exiting a resident's room who was on Transmission Based Precautions (TBP) due to being a Person Under Investigation (PUI) for 1 resident on 1 of 5 units, (Resident #20), b.) appropriately perform hand hygiene and wear PPE at the appropriate time on 1 of 5 units by staff in the nursing department and recreation department, and c.) appropriately disinfect multiuse medical equipment for 1 of 4 nurses during the medication pass. These deficient practices were evidenced by the following: CDC COVID-19 Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes updated 9/10/2021, "Managing Residents with Suspected or Confirmed SARS-CoV-2 Infection" reflects that healthcare personnel caring for residents with suspected SARS-CoV-2 infection should use full	F 880	ID Prefix Tag F880 Element #1 (a) The Infection Preventionist immediately educated LPN #1 regarding the required use of full PPE when caring for a resident on Transmission Based Precautions due to Person Under Investigation (PUI) status and the correct procedure for donning and doffing PPE. LPN #1 was able to verbalize correct use of PPE and provide return demonstration of donning and doffing of PPE. (b) The Infection Preventionist immediately educated the Recreation Aide and the C.N.A. from 3West in proper use of gloves and hand hygiene. Recreation Aide and C.N.A. were able to verbalize correct use of gloves and both successfully completed a Hand Washing Competency at that time. (c) The Infection Preventionist immediately educated LPN #2 on cleaning of the pulse oximeter with 70% isopropyl alcohol before and after use on a resident. Resident #156 was provided with hand hygiene and will continue to be monitored for signs and symptoms of infection. Element #2	

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F 880	Continued From page 78 PPE (gowns, gloves, eye protection, and NIOSH approved N95 or equivalent higher-level respirator). In addition, the healthcare personnel are to remove gloves, gown, and dispose into a trash receptacle. Then the healthcare provider may exit the patient room and then perform hand hygiene. According to the U.S. CDC guidelines for Hand Hygiene in Healthcare Settings Hand Hygiene Guidance, updated 1/30/20, included Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: " Immediately before touching a patient " Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices " Before moving from work on a soiled body site to a clean body site on the same patient " After touching a patient or the patient's immediate environment " After contact with blood, body fluids, or contaminated surfaces " Immediately after glove removal Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and, in the absence of a sink, are an effective method of cleaning hands. According to the U.S. CDC guidelines for Transmission-Based Precautions dated 1/7/2016, indicated to "Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the	F 880	All residents receiving care from staff have the potential to be affected by this deficient practice. Element #3: A Directed Plan of Correction (DPOC) will be completed as required. All facility staff will complete the Nursing Home Infection Preventoinist Training Course Module 7 (Hand Hygiene), Module 6A (Principles of Standard Precautions) and Module 6b (Principles of transmission based precautions). Additionally, front line staff will view videos: Keep COVID-19 Out! and Use PPE Correctly for COVID-19. The topline staff and infection preventoinist will also complete the Nursing Home Infection Preventoinist Training Course: Model 1 (Infection prevention and control program), Module 5 (Outbreaks) and Module 4 (Infection Surveillance). A Root Cause Analysis indicated that a lack of knowledge on the part of the LPNs, the C.N.A. and the Recreation Aide led to these deficient practices. Therefore, (a) The Infection Preventoinist or designee will educate the nursing staff on the donning and doffing of PPE and emphasize the circumstances when full PPE is required by 2/4/22. (b) The Infection Preventionist will educate the nursing staff and Recreation Staff on the correct use of gloves and proper hand hygiene technique by 2/4/22. (c) The Infection Preventoinist will educate the facility nurses on the process and rationale of cleaning the pulse oximeter with 70% isopropyl alcohol before and after use on a resident. Element #4:	

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F 880	Continued From page 79 patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain [redacted]." 1. On 1/4/22 at 10:09 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that Resident #20 was a PUI and had been placed on TBP because yesterday the resident's roommate had tested [redacted] and was transferred to the [redacted] unit. On 1/4/22 at 10:12 AM, the surveyor observed a bin, filled with PPE, and a Stop sign outside the door to Resident #20's room. The Stop sign indicated that there were "airborne precautions" and everyone must clean their hands, don a fit tested N95 mask, gown, and gloves before entering the room, as well as doff when exiting the room. On 1/4/22 at 10:14 AM, the surveyor observed the Licensed Practical Nurse (LPN#1) preparing medications at the medication cart in the hallway, in front of Resident #20's open doorway. The LPN#1 was wearing a surgical mask and goggles. The surveyor observed, from the hallway, the LPN#1 walk into the resident's room with medications in a cup, hand the medications to the resident who then swallowed the medications with water provided by the nurse. The LPN#1 was observed inside the room for less than 5 minutes. Then, the LPN#1 performed hand hygiene at the sink in the resident's room near the door and walked out of the room to the medication cart in the hallway in front of the resident's open doorway. At that time, the surveyor interviewed the LPN#1,	F 880	(a) The Infection Preventionist will conduct PPE Donning and Doffing competencies on 5 nurses weekly x 4 weeks and then 10 competencies monthly x 4 months. (b) The Infection Preventionist will make rounds to conduct 5 random audits weekly x 4 weeks and then 20 random audits monthly x 4 months on various nursing units to observe for appropriate use of gloves. Hand washing competencies will be performed on 5 front line staff members weekly x 4 weeks and then 20 staff members monthly x 4 months. (c) The Infection Preventionist will make rounds to conduct 5 random audits weekly x 4weeks and then 20 random audits monthly x 4 months on various nursing units to observe for appropriate cleaning of pulse oximeter devices. The results of these audits will be submitted monthly to the DON for review at the monthly Nursing Professional Practice meeting and quarterly to QAPI Committee for review and action, as appropriate.	

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at the medication cart, who stated that she was an agency nurse and worked on the unit frequently. The LPN#1 stated that the resident was alert and oriented and was on TBP because the resident had been exposed to the roommate who had [redacted]. The LPN#1 stated that she was wearing a surgical mask and goggles and did not think she had to wear a gown and gloves when entering the resident's room because she was just giving the resident medications. The LPN#1 added that if a resident was COVID-19 positive then she would have to wear a N95 mask (a NIOSH-approved particulate filtering facepiece respirator), gown and gloves in addition to goggles but if a resident was a PUI she did not think she had to wear a N95 mask, gown, and gloves. The LPN#1 added that she was unsure if she was right or wrong. The LPN#1 also stated that she thought this was a "COVID-free unit", which meant that she did not have to wear a N95 mask.

On 1/4/22 at 10:17 AM, the surveyor observed, from the hallway, Resident #20 in their room sitting in a wheelchair with an overbed table in front that had a disposable tray containing breakfast. The surveyor, from the hallway, was able to speak with the resident who stated that he/she was finishing his/her breakfast and that he/she was told to stay in his/her room by the nurse. The resident stated that he/she would rather be out in the dayroom. The resident added that some of the staff wore gowns and gloves when they came into the room, but some did not. The resident then stated that he/she preferred not to talk further.

On 1/4/22 at 10:19 AM, the surveyor further interviewed the RN/UM who stated that any

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resident on PUI was on TBP and that required the staff to wear full PPE. The RN/UM explained that full PPE meant that a N95 mask, face shield or goggles, gown and gloves were to be donned before entering the room of a resident who was a PUI, and the gown and gloves were to be doffed before exiting and hand hygiene was to be performed. The RN/UM added that all staff were to be wearing a mask and face shield or goggles at all times in the building but before entering the room of a resident on PUI, the staff had to wear a N95 mask.

The surveyor reviewed the medical record for Resident #20.

A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted] reflected the resident had a brief interview for mental status (BIMS) score of [redacted] out of [redacted] indicating that the resident had an [redacted]

A review of the Order Summary Report revealed a physician's order (PO) dated [redacted] for "Isolation for droplet precautions related to exposure to [redacted] for 14 days."

A review of the interdisciplinary care plan (IDCP) revealed a focus area dated as initiated 1/4/22 was that the resident required care and isolation precautions specifically related to COVID-19 exposure. The intervention indicated to ensure that the resident stayed in their room, away from other people as much as possible with contact and droplet precautions.

A review of the resident's and the LPN#1

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vaccination status provided by the Licensed Nursing Home Administrator (LNHA) indicated that the resident and LPN#1 had been fully vaccinated.

On 1/11/22 at 9:39 AM, the surveyor, in the presence of another surveyor, interviewed the Registered Nurse/Assistant Director of Nursing/Infection Preventionist of Nursing (RN/ADON/IP) who explained that staff working on the red zones, which had the COVID-19 positive were expected to wear full PPE, which included a N95, face shield/goggles, gown and gloves. In addition, the RN/ADON/IP stated that any staff member going into a room designated as a PUI were also expected to wear full PPE. The RN/ADON/IP further explained that a resident who was considered a PUI was any resident exposed to COVID 19 or a non-vaccinated new admission. The RN/ADON/IP added that staff that had to care for residents that were considered "clean" or in a green zone, which meant that the residents had not been exposed, were expected to wear either a KN95 face mask or surgical mask and face shield or goggles. The RN/ADON/IP further explained that all staff were expected to don full PPE when they stepped into a PUI room for any reason, whether to deliver trays, provide medications or care for the resident, and doff the gown and gloves before exiting the room. The RN/ADON/IP added that she provided in services on infection control, as well as another ADON, to all staff. The RN/ADON/IP acknowledged that the LPN should have donned a N95 mask, gown and gloves, in addition to the goggles that she was already wearing, upon entry to Resident #20's room and doffed the PPE before exiting.

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On 1/11/22 at 11:07 AM, the survey team met with the Administrative team. The LNHA stated that the LPN#1 had not been scheduled to return to work after 1/6/22 and would have to receive additional in-servicing on PPE usage, infection control and quarantine.

A review of an In-service Record/Meetings sign-in form titled "Infection Control, Proper use of PPE" dated 1/3/2022 provided by the LNHA reflected that the LPN was instructed by the ADON.

There was no policy provided by the facility reflecting donning and doffing of PPE.

On 1/14/22 at 11:26 AM, the surveyor interviewed the LNHA via telephone who stated that there was no policy for donning and doffing and that was a procedure that was followed.

2. On 1/4/22 from approximately 10:15 AM to 11:00 AM, the surveyor, in the presence of another surveyor observed the Recreation Aide (RA) pushing a cart on wheels that contained supplies for coffee and tea down the hallway on the [redacted] unit. The RA was outside in the hallway on the [redacted] unit wearing gloves. The surveyor observed the RA pour coffee into Styrofoam cups and enter resident rooms on the low side of the unit to provide coffee to the residents while wearing the same gloves. The RA did not remove gloves and perform hand hygiene in-between resident rooms. The RA was observed wearing the same gloves on the high side of the unit pouring coffee and entering resident rooms to bring the poured cups of coffee into resident rooms on the high side of the unit.

On 1/6/22 from approximately 10:39 AM to 11:03

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AM, the surveyor, in the presence of another surveyor who were performing a medication pass with a LPN in the hallway, observed the Recreation Aide (RA) pushing a cart on wheels that contained supplies for coffee and tea down the hallway on the [redacted] unit. The surveyors observed the RA pour coffee into a styrofoam cup, went into room [redacted] and hand the cup to an unsampled resident. The RA continued to pour coffee and/or tea and bring the poured cups into rooms [redacted] bed [redacted] and bed [redacted]

During that time, the surveyor, in the presence of another surveyor, interviewed the RA who stated that this was her usual routine to deliver coffee every morning. The RA stated that she would normally do this in the day room but due to the current situation, group activities were being limited so she was doing more serving room to room.

During the interview, an unsampled resident approached the RA and the RA poured a cup of coffee and handed it to an unsampled resident in the hallway. The RA had then stated that she had completed that hallway.

On 1/10/22 at 9:52 AM, the surveyor observed a Certified Nursing Assistant (CNA) walking in the hallway wearing gloves on the [redacted] unit. The surveyor observed the CNA enter room [redacted]. She spoke with the resident then she came out of the room wearing the same gloves.

At that time, the surveyor observed the CNA remove her gloves in the hallway and discard the gloves inside a clear plastic bag that was tied to a cart on wheels. The CNA did not perform hand hygiene after removing the gloves. The surveyor

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F 880	Continued From page 85 interviewed the CNA who could not speak to what she should do after removing gloves. At that same time, the Registered Nurse Unit Manger (RN/UM) instructed the CNA to wash her hands. The CNA re-entered room [redacted] to wash her hands at the sink near the door. The CNA turned the water on, applied soap to her hands and immediately placed her hands under the running water for less than 15 seconds. The surveyor inquired if she hand training when to put on and remove gloves and what to do after removing gloves. The CNA stated, "yes. Oh yes, I should have washed my hands. I forgot." On 1/10/22 at 10:21 AM, the surveyor, in the presence of another surveyor, interviewed the RA who stated that "it is not our process to change gloves because my hands are clean after I washed them. I wash my hands and put on gloves, so my hands are clean. I did that kind of impulsively. I did not go into any COVID rooms. I don't normally wear gloves to hand out coffee. So, I did on 1/4/22 impulsively. Yes, there has been training whenever they do training. But you know; I don't know. I just hand the coffee out. You know what I'm saying. You only have to change your gloves and do hand hygiene if COVID; that would be a lot of work for just handing out coffee." The surveyors had not observed the RA perform hand hygiene at any time. On 1/10/22 at 1:10 PM, the survey team met with the administrative staff and discussed the above observations and concerns. On 1/11/22 at 10:00 AM, the surveyor, in the	F 880		

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presence of another surveyor interviewed the RA who stated that she had not changed gloves or performed hand hygiene while giving out coffee because she didn't think she had to. The RA stated that "would be a lot of work" to use hand sanitizer in between every resident that she served coffee to. The RA stated that she does receive infection control in services from the RN/ADON/IP.

On 1/11/22 at 11:07 AM, the survey team met with the administrative team. The administrative team acknowledged that staff should not be wearing gloves in the hallway.

There was no policy provided by the facility reflecting donning and doffing of PPE.

On 1/14/22 at 11:26 AM, the surveyor interviewed the LNHA via telephone who stated that there was no policy for donning and doffing and that was a procedure that was followed.

Review of the facility's "Handwashing/Hand Hygiene" dated 1/22/21 provided by the Director of Nursing indicated that "all personal shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections ...all personal shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors ...employees must wash their hands for at least 20 seconds using antimicrobial or non-antimicrobial soap and water under the following directions ...after removing gloves or aprons ...in most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an

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alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following ...after removing gloves ...hand hygiene is always the final step after removing and disposing of personal protective equipment ...the use of gloves does not replace handwashing/hand hygiene." The procedure for washing hands indicated to "vigorously lather hands with soap and rub them together, creating friction to all surfaces, for at least twenty (20) seconds under a moderate stream of running water, at a comfortable temperature ...rinse hands thoroughly

3. On 1/6/2022 at 9:07 AM, during the medication pass, the surveyor in the presence of another surveyor, observed the LPN#2 obtain the oxygen level of an unsampled resident's blood by using a [redacted]).

On 1/6/22 at 9:23 AM, during the medication pass, the surveyor in the presence of another surveyor observed the LPN#2 obtain the oxygen level of Resident #156 by using the same pulse oximeter that was used on the unsampled resident. The surveyors had not observed the LPN#2 clean the pulse oximeter device.

On 1/6/22 at 9:26 AM, the surveyor, in the presence of another surveyor, interviewed the LPN#2 who stated that he was supposed to clean all equipment in between residents. The LPN#2 acknowledged that he had not cleaned the pulse oximeter device in between the two residents. The LPN#2 added that he should have cleaned the pulse oximeter with an alcohol wipe. At that time, the LPN removed an alcohol wipe from the

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F 880	Continued From page 88 medication cart and cleaned the pulse oximeter device. On 1/11/22 at 11:07 AM, the survey team met with the administrative team. The DON stated that the LPN#2 was supposed to clean the pulse oximeter with an alcohol wipe in between residents. The DON stated that the LPN#2 was in-serviced on proper cleaning of the pulse oximeter on 1/10/22. A review of the manufacturer's specifications for the cleaning of the pulse oximeter was provided by the DON which reflected that the pulse oximeter sensor was to be cleaned with a 70% isopropyl alcohol solution and allowed to air dry.	F 880		
F 919 SS=D	NJAC 8:39-19.4(a)(l)(n) Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was identified that the facility failed to maintain a functioning call bell system. This deficient practice was identified on 2 of 5 nursing units ([redacted] West and [redacted]) and for 2 of 35 residents	F 919	ID Prefix Tag F919 Element #1: the call bells for resident #27 and #38 were repaired Element #2: all residents have the potential of being	2/11/22

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F 919	Continued From page 89 (Resident #27 and Resident #38) reviewed and was evidenced by the following: 1. On 1/5/22 at 11:39 AM, the surveyor observed Resident #38 seated in a wheelchair in his/her room. The resident stated that his/her call bell had not been working for a couple of days and the facility gave him/her a tap bell to use. The surveyor observed the tap bell on the residents overbed table. On 1/6/22 at 12:07 PM, the surveyor stood outside of Resident #38's room and observed the call bell light blinking over the door to the residents room. On 1/6/22 at 12:09 PM, the surveyor observed the resident and his/her friend in the resident's room. The resident's friend stated that they had called the maintenance department to notify them that the call bell was not working. The surveyor observed a tap bell on the overbed table in the resident's room On 1/6/22 at 1:39 PM, the surveyor stood outside of Resident #38's room and observed the call bell light blinking over the door to the residents room. On 1/10/22 at 9:30 AM, the surveyor stood outside Resident #38's room and observed the call light above the resident's door blinking. The surveyor entered the resident's room. On 1/10/22 at 9:32 AM, the surveyor interviewed the resident's roommate who stated that the call bell was, "shorted out" on Resident #38's side. On 1/10/22 at 9:33 AM, the surveyor interviewed	F 919	affected Element #3: md or designee audited all resident room calls bells to ensure they are in working order. We created a new Maintence request log that includes the request, the date, time, who made the request and who was the request assigned too and status of the request. If it was not corrected the md was responsible for follow up to ensure all request are being processed in a timely fashion and if a task requires additional steps he will address. Element #4: md or designee will audits weekly times three months ans then monthly times 3 months all call bells and ensure all maintenance request are completed. All findings will be addressed and report to monthly qapi meeting	

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the resident who stated that the call bell was not working. The resident stated, "Problem with it for a long time. Think that it's fixed but then it's not. It needs to be fixed because what if I fell or something? No one would be able to come. They gave me this little bell, but no one will hear that."

On 1/10/22 at 9:40 AM, the surveyor interviewed the resident's Certified Nursing Aide (CNA #1) with the assistance of the Assistant Director of Nursing (ADON) who acted as a translator. CNA #1 stated that it was her first time working with the resident and that the call bell was flashing above the resident's door. CNA #1 further stated that she tried to turn the call bell off, but it wasn't working.

On 1/10/22 at 9:46 AM, the surveyor interviewed the Registered Nurse/Unit Manger (RN/UM #1) who was passing medications to the resident that day. RN/UM #1 stated they noticed last week the residents call bell was not working, maintenance knew about it, and was working on it. RN/UM #1 further stated that she thought the plan was to get a new one for the resident. RN/UM #1 stated that the process for notifying the maintenance department when something broke was to text them from her personal cell phone or page them.

On 1/10/22 at 12:24 PM, the surveyor interviewed the Maintenance Director (MD) who stated that if a nurse identified that something was broken and needed to be fixed for a resident, they would call the Receptionist at the front desk, the Receptionist would document the concern, and the maintenance department would follow up first thing in the morning the next day. The MD further stated that he delegates to his maintenance staff to fix the concern unless there was an

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emergency. The MD stated that he was unaware that Resident #38's call bell was not functioning.

The surveyor reviewed the facility's Maintenance Work Order in the presence of the MD. A review of the Maintenance Work Order indicated a written request dated 01/6/21, to fix the call bell in the resident's room.

On 01/11/22 at 11:16 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the call bell for Resident #38 was fixed on 01/6/21 but continued to malfunction.

On 1/11/22 at 11:17 AM, the Licensed Nursing Home Administrator (LNHA) stated that there was no documentation indicating that the call bell was fixed.

The surveyor reviewed the medical record for Resident #38.

A review of the resident's Admission Record (an admission summary) indicated that the resident had resided at the facility for about a year and had diagnoses which included EX Order 26 § 4b1 [redacted].

A review of the resident's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 10/21/21, reflected the resident had a Brief Interview of Mental Status (BIMS) score was [redacted] out of [redacted] which indicated the resident was EX Order 26 § 4b1 [redacted].

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F 919	Continued From page 92 2. On 1/3/22 at 12:32 PM, the surveyor interviewed Resident #27 in his/her room. The resident stated that their call bell was not working, and they had informed maintenance, but it still was not repaired. The surveyor reviewed the medical record for Resident #27. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility in [redacted] with diagnoses which included [redacted EX Order 26 § 4b1]. A review of the most recent quarterly MDS dated 12/30/21, reflected that the resident had a BIMS score was [redacted EX O] out of [redacted] which indicated a fully [redacted EX Order 26 § 4b1]. On 1/10/22 at 10:26 AM, the surveyor was unable to speak with the resident because the CNA #2 was rendering care, however the resident called out from behind the curtain that the call bell was still not working. At this time, CNA #2 confirmed that the resident's call bell was not working, and that the facility had provided the resident a tap bell to ring if needed. When the surveyor asked if CNA #2 was aware if maintenance had come to look at the call bell, the CNA replied she was unsure. The surveyor then asked CNA #2 to press the call bell and the CNA confirmed that she had. The surveyor did not observe the light illuminated outside the resident's door as expected.	F 919		

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On 1/10/22 at 10:32 AM, the surveyor interviewed RN/UM #2 who stated that the process for when something was broken or not working, was to call the front desk and they would call maintenance. The nurse or whoever called the front desk would not document the call. RN/UM #2 stated that she was aware Resident #27's call bell was not working since last week. Maintenance had come to check it and they were unable to fix it, so they had given the resident a tap bell temporarily.

On 1/10/22 at 11:04 AM, the surveyor interviewed the MD who stated that he was responsible for everything related to maintenance, electric, sheetrock, and plumbing. The MD stated that the facility procedure for a work order was for staff to call the front desk and the Receptionist would write down the request on a log; then he would obtain the log and assign the work to his staff. The MD confirmed that everything should be documented on the log, both the request and that the work had been completed. The MD further stated a call bell repair would be considered an emergency. The MD stated extra supplies of call bells were kept on hand in the key room.

On 1/10/22 at 11:18 AM, the MD and the surveyor toured the key room which contained numerous replacement call bells.

On 1/10/22 at 11:21 AM, the surveyor interviewed the facility's front desk Receptionist who confirmed that she kept a log of the maintenance requests. At that time, the Receptionist provided a copy of the Maintenance Request Log dated 1/3/22 through 1/5/22.

On 1/10/22 at 11:40 AM, the surveyor reviewed the Maintenance Request Log dated 1/3/22,

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F 919	Continued From page 94 which revealed two separate notations indicating Resident #27's call bell was not working and needed to be checked by maintenance. A review of the facility's Answering the Call Bells Policy and Procedure dated 8/8/21 indicated staff was to report all defective call bells to the Supervisor promptly. The facility's Answering Call Bell Policy and Procedure did not speak to malfunctioning call bells. NJAC 8:39-31.8(c)9	F 919		

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S 000	Initial Comments THE FACILITY WAS 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 interviews, 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 and night shift as mandated by the State of New Jersey. This was evident in CNA staffing for 13 of 14-day shifts and in total staff for 1 of 14-night shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated)	S 560	ID Prefix Tax S560 Element #1 Staffing was immediately reviewed as was the projected staffing needs by the DON, staffing coordinator, and LNHA. Element #2 All residents have the potential to be affected by this deficient practice. Element #3 Current staffing interventions in place were reviewed. Interventions in place include job fairs with on the spot hiring scheduled monthly, staff wages were	2/11/22

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

Electronically Signed | 01/31/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22001L	A. BUILDING: _____ B. WING _____	01/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
RUNNELLS CENTER FOR REHABILITATION & HEALT	40 WATCHUNG WAY BERKELEY HEIGHTS, NJ 07922

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S 560	Continued From page 1 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 12/19/21 through 12/25/21 and 12/26/21 through 1/01/22, the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift, and total staff to 14 residents for the night shift as documented below: - 12/19/21 had 11 CNAs for 220 residents on the day shift, required 28 CNAs. - 12/20/21 had 21 CNAs for 220 residents on the day shift, required 28 CNAs. - 12/21/21 had 19 CNAs for 219 residents on the day shift, required 28 CNAs. - 12/22/21 had 19 CNAs for 219 residents on the day shift, required 28 CNAs. - 12/23/21 had 19 CNAs for 219 residents on the	S 560	increased, bonus structure in place. In addition, facility is in contract with 6 staffing agencies, administrative team is assigned to non-clinical tasks thus relieving clinical, clinical administrative team (DON, ADON, Unit Managers/supervisors) are assigned as needed for clinical tasks. Facility has teamed up with nursing schools to aide in recruitment, facility leadership is on NJ state DOH waiting list to become c.n.a. instructors. Element #4 Monthly projected schedule will continue to be monitored by DON/Administrator/designee for early recognition of potential staffing inadequacies. Upon assessment of needs staffing agencies are contacted to aide in filling available shifts. Staff is offered overtime and bonuses. Weekly schedule will also continue to be reviewed for any staffing deficiencies and interventions in place will be utilized. Monthly the DON/designee schedule will be audited and intervention effectiveness appraised, with findings reported to QAPI team for review and action as appropriate. Element #5	

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S 560	Continued From page 2	S 560		

day shift, required 28 CNAs.
- 12/24/21 had 21 CNAs for 218 residents on the day shift, required 28 CNAs.
- 12/25/21 had 13 CNAs for 217 residents on the day shift, required 28 CNAs.
- 12/26/21 had 11 CNAs for 216 residents on the day shift, required 27 CNAs.
- 12/27/21 had 19 CNAs for 216 residents on the day shift, required 27 CNAs.
- 12/28/21 had 20 CNAs for 216 residents on the day shift, required 27 CNAs.
- 12/29/21 had 24 CNAs for 215 residents on the day shift, required 27 CNAs.
- 12/30/21 had 22 CNAs for 215 residents on the day shift, required 27 CNAs.
- 12/31/21 had 15 CNAs for 214 residents on the day shift, required 27 CNAs.
- 12/31/21 had 15 total staff for 214 residents on the overnight shift, required 16 total staff.
- 01/01/22 had 20 CNAs for 214 residents on the day shift, required 27 CNAs.

On 1/10/22 at 9:45 AM, the surveyor interviewed the Staffing Coordinator (SC) who stated that she/he is responsible for the staffing of Nurses, CNA's, and Unit Clerks on all units of the facility. The SC added that the facility is using six different agencies for staffing at this time. If a staff member calls out, the staff member will call and notify the staffing Coordinator first during day shift, and on the evening and night shifts will notify the Nursing Supervisor on call. The SC stated that she/he uses a "special cellphone" specifically designated to be used for facility staffing. The SC indicated that the cellphone had all staff contacts and is passed on to the Nursing Supervisors when the SC leaves the facility for the day or is unavailable. The Nursing Supervisors will call the SC first for current

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S 560	Continued From page 3	S 560		

staffing updates, and can also call nursing agencies if needed. The SC stated that staffing is done according to facility census and availability, and the staff is offered incentive bonuses. The SC said that the required staff to resident ratio should be day shift 8 residents to 1 CNA, evening shift 10 residents to 1 CNA, and on night shift 14 residents to 1 CNA. The SC stated that the day shift (7:00 AM-3:00 PM) had been the most challenging to staff according to the required ratio. The SC also added that he/she communicates daily with administration regarding staffing and is making all attempts necessary to meet the required ratios. The SC stated that to help with staffing numbers the facility advertised on an employment website and was planning a job fair in the near future.

On 1/11/22 at 9:17 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), and the Vice President of Clinical (VP) who stated that they are aware of the state requirement ratios for staffing. The VP stated that the required staff to resident ratio should be eight residents to one CNA for the day shift, 10 residents to one CNA for the evening shift, and 14 residents to one CNA on the night shift. The LNHA stated that the facility "is doing their best" to meet and maintain the staffing requirements. The LNHA also added that the staff was offered incentive bonuses for overtime, and their regular staff were given a salary increase competitive to the surrounding facilities. The VP stated that the rate increase for their regular staff caused a 25% increase in retention of their regular staff.

On 1/11/22 at 9:36 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the required staff to resident ratio should be eight residents to 1 CNA for the day shift, 10 residents

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S 560	Continued From page 4 to 1 CNA for the evening shift, and 14 residents to 1 CNA on the night shift. The DON stated that the day shift had been the most challenging to staff according to the requirements. The DON stated that during a recent staff meeting, the CNA's stated that "there is too much work to do on the day shift." The DON stated that Administration, Unit managers, and Nursing Supervisors had provided assistance on the units when the staffing numbers were low. The DON stated that monetary incentive bonuses are offered to both regular and agency staff. The DON also added that the facility does have a policy for Emergency staffing.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315009 Y1	A. Building B. Wing Y2	3/25/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RUNNELLS CENTER FOR REHABILITATION & HEALTHCARE	40 WATCHUNG WAY BERKELEY HEIGHTS, NJ 07922

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 F0557	Correction	ID Prefix F0584	Correction	ID Prefix F0658	Correction
Reg. # 483.10(e)(2)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	02/11/2022	LSC	02/11/2022	LSC	02/11/2022
ID Prefix F0684	Correction	ID Prefix F0688	Correction	ID Prefix F0695	Correction
Reg. # 483.25	Completed	Reg. # 483.25(c)(1)-(3)	Completed	Reg. # 483.25(i)	Completed
LSC	02/11/2022	LSC	02/11/2022	LSC	02/11/2022
ID Prefix F0698	Correction	ID Prefix F0755	Correction	ID Prefix F0759	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(f)(1)	Completed
LSC	02/11/2022	LSC	02/11/2022	LSC	02/11/2022
ID Prefix F0760	Correction	ID Prefix F0761	Correction	ID Prefix F0836	Correction
Reg. # 483.45(f)(2)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.70(a)-(c)	Completed
LSC	02/11/2022	LSC	02/11/2022	LSC	02/11/2022
ID Prefix F0880	Correction	ID Prefix F0919	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.90(g)(2)	Completed	Reg. #	Completed
LSC	03/18/2022	LSC	02/11/2022	LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/19/2022	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
22001L Y1	A. Building B. Wing Y2	3/25/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RUNNELLS CENTER FOR REHABILITATION & HEALTHCARE	40 WATCHUNG WAY BERKELEY HEIGHTS, NJ 07922

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 02/11/2022	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 1/19/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315009	A. BUILDING **01** B. WING _____	**01/19/2022**

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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 01/18/22 and 01/19/22, was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy This building is a 4-story building that was built in the 60's, It is composed of Type I fire resistant construction. The facility is divided into 10- smoke zones The generator does approximately 80 % of the building. The building's fire sprinkler system utilizes an electric fire pump. The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions.	K 000		

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

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K 000	Continued From page 1 The facility has 300 certified beds, at the time of survey the census was 215.	K 000		
K 281 SS=D	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview from 01/18/22 to 01/19/22, it was determined that the facility failed to provide automatic emergency illumination that would automatically operate along a means of egress. This deficient practice was observed in 1 of 9 wings of the facility and evidence by the following: During a tour of the building from approximately 9:00 AM to 1:00 PM, in the presence of the facility's Maintenance Director and Administrator it was determined that the 3rd floor west-wing, resident rooms 304 to 319 corridor, did not have any emergency lighting. The 3 upper wall switches shut all the lights off, leaving no continuous emergency lighting. Based on observation and interview, the facility failed to provide emergency illumination that would operate automatically along the means of egress and the required illuminance with two lamps energized during emergencies in accordance with NFPA 101, 2012 Edition, Section	K 281	K281 1) Emergency lighting in corridor of rooms 304-319 West were installed. East stairways of #1, #2, #3 emergency lightings are on and working efficiently. 2) All residents have the potential of being affected by this deficient practice. 3) Administrator or designee will re-educate Maintenance staff on the requirement to provide emergency illumination that would automatically operate along a means of egress. 4) Maintenance Director or designee will conduct audits of facility emergency lighting weekly times 4 then monthly times 2. Results of these audits will be forwarded to the Quality Assurance Performance Improvement committee monthly to ensure ongoing compliance. Any findings identified will be immediately corrected.	2/1/22

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K 281	Continued From page 2 19.2.8 7.8, 7.8.1.1, 7.8.1.2, 7.8.1.4 and 7.9.2.1. On 01/19/22, the surveyor observed outside the exit/egress doors outside # 2 and # 3 stairwell's,that no emergency light over the door was provided on the exterior of the building. Based on observation and interview on 01/19/21, in the presence of the Administrator and Maintenance Director, it was determined that the facility failed to ensure that the means of egress were provided with continuous lighting. While touring the building from 09:00 AM, to 01:00 PM, the surveyor observed that the East-stairwells, marked # 1, 2 and 3, were provided with wall lighting that was not on at the time of the observations. The Maintenance Director stated he was not sure why the fixtures were not on. The facility's Administrator was informed of the finding's, during the building tour and at the Life Safety Code survey exit on 01/19/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.8, 7.8.1.1, 7.8.1.2	K 281		
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 on 01/19/22, it was determined that the facility failed to provide	K 291	K291 1) Facility installed an operational battery	2/1/22

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K 291	Continued From page 3 an operational battery backup emergency light above the emergency generator's transfer switches, 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 for 2 of 2 transfer switches, observed by the following: 1. At 11:28 AM, the surveyor, Administrator and the Maintenance Director, observed in the electrical closet transfer switch outside the kitchen, for the generator marked C003, that no emergency lighting was provided. 2. At 11:38 AM, the surveyor, Administrator and the Maintenance Director, observed in the main electrical closet transfer switch for the generator marked ATS-2, that no emergency lighting was provided. This finding was verified by the Administrator and the Maintenance Director at the time of observation. The Administrator was notified of the above findings at the Life Safety Code exit conference on 01/19/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	backup emergency light above the emergency generator transfer switches outside the kitchen for the generator marked c003 and one in the main electrical closet transfer switch for the generator marked Ats-2. 2) All residents have the potential of being affected by this deficient practice. 3) Administrator or designee will re-educate Maintenance staff on the requirement to provide an operational battery backup emergency light above the emergency generator's transfer switches, independent of the building's electrical system and emergency generator. 4) Maintenance Director or designee will conduct random audits of battery backup emergency lights to ensure functionality and operational. Audits will be conducted weekly times 4 then monthly times 2. Results of these audits will be forwarded to the Quality Assurance Performance Improvement committee monthly to ensure ongoing compliance. Any findings identified will be immediately corrected.	
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.	K 293		2/1/22

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K 293	Continued From page 4 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation on 01/19/22, in the presence of the Maintenance Director and Administrator, it was determined that the facility failed to ensure that illuminated exit signs were illuminated at all times, to clearly identify the exit access path. This deficient practice was evidenced for 2 of 24 exit signs by the following: 1. On 01/19/22 at 10:51 AM, the surveyor, Administrator and the Maintenance Director observed the ceiling mounted exit sign by stairwell #2 by resident room [redacted] was not illuminated. 2. On 01/19/22 at 11:48 AM, the surveyor, Administrator and the Maintenance Director observed the ceiling mounted exit sign by stairwell #3 on the ground floor, was not illuminated. Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2	K 293	K293 1) batteries were replaced in both emergency exit signs by stairway #2 near resident room [redacted] and exit sign by stairway #3 on ground floor. 2) All residents have the potential of being affected by this deficient practice. 3) Administrator or designee will re-educate Maintenance staff on the requirement to ensure that exit signs are installed and illuminated. 4) Maintenance Director or designee will conduct random audits of illuminated exit signs to ensure proper functionality. Audits will be conducted weekly times 4 then monthly times 2. Results of these audits will be forwarded to the monthly Quality Assurance Performance Improvement committee to ensure ongoing compliance. Any findings identified will be immediately corrected.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315009	A. BUILDING **01** B. WING _____	**01/19/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUNNELLS CENTER FOR REHABILITATION & HEALTHCARE	**40 WATCHUNG WAY** **BERKELEY HEIGHTS, NJ 07922**

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K 293	Continued From page 5 The facility Administrator was informed of the findings during the Life Safety Code survey exit conference at 1:46 PM on 01/19/22. NJAC 8:39 -31.1 (c) NFPA Life Safety Code 101	K 293		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 01/19/22, the facility did not provide complete sprinkler coverage as required by Centers for Medicare/Medicaid Services regulation § 483.90(a) physical environment. Also, the facility failed to install the sprinkler system in accordance with the requirements of NFPA 101, 2012 Edition,	K 351	K351 1) Sprinkler heads were installed in kitchen janitor closet and in [redacted] unit manger office closet. 2) All residents have the potential of being affected by this deficient practice.	2/8/22

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K 351	Continued From page 6 Section 19.3.5, 4.6.12 and 9.7, NFPA 13, 2012 Edition, Section 6.2.7.1, 8.1, 8.1.1, 8.5.2.1, 8.5.5, 8.5.5.2 8.15.7, 8.15.7.1 and 8.15.7.5. The lack of sprinkler coverage could delay or prevent the extinguishment of a fire in this area. This deficient practice was evidenced by the following: 1. At 11:08 AM, the surveyor, in the presence of the Administrator and the Maintenance Director observed that the kitchen janitors closet approximately 3' x 2' was observed to have no fire sprinkler coverage. 2. At 12:07 PM, the surveyor, in the presence of the Administrator and the Maintenance Director observed that the [redacted] unit managers office closet approximately 3' x 3' was observed to have no fire sprinkler coverage. An interview was conducted with the Maintenance Director who stated and agreed that the above areas of the building, did not have any fire sprinkler coverage. The Administrator was informed of the deficiencies at the Life Safety Code exit conference on 01/19/22.	K 351	3) Administrator or designee will re-educate Maintenance staff on the requirement to provide complete sprinkler coverage. 4) Maintenance Director or designee will conduct random audits of facility to ensure proper sprinkler coverage. Audits will be conducted weekly times 4 then monthly times 2. Results of these audits will be forwarded to the monthly Quality Assurance Performance Improvement committee to ensure ongoing compliance. Any findings identified will be immediately corrected.	
K 363 SS=E	NJAC 8:39-31.2(e) Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for	K 363		2/1/22

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K 363	Continued From page 7 at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview from 1/18/22 to 1/19/22, the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient	K 363	K363 1) The facility repaired doors to ensure proper latching on rooms: 208w, 212w, 214w, 216w, 217w, 313 w, 316 w, 318 w, 327 w, 343 w, 346 w, 202 e, and e 215.	

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K 363	Continued From page 8 practice of not ensuring that room doors will close and latch restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was observed in 13 of 40 resident room door's and was evidenced by the following: From 1/18/22 to 1/19/22, during the building tour from 9:00 AM, to 1:00 PM, the surveyor, in the presence of the Administrator and the Maintenance Director observed that the doors to resident rooms did not latch into the door frame in the following room numbers: [redacted] An interview was conducted with the Maintenance Director who stated and confirmed that the above resident room doors, had hardware issues that prevented the doors from latching into there frame's properly. The Administrator was informed of the finding at the Life Safety Code exit conference on 1/19/22.	K 363	2) All residents have the potential of being affected by this deficient practice. 3) Administrator or designee will re-educate Maintenance staff on the requirement to ensure proper door latching. 4) Maintenance Director or designee will conduct random audits of facility to ensure proper door latching. Audits will be conducted weekly times 4 then monthly times 2. Results of these audits will be forwarded to the monthly Quality Assurance Performance Improvement committee to ensure ongoing compliance. Any findings identified will be immediately corrected.	
K 374 SS=D	NJAC 8:39-31.1(c), 31.2(e) Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors	K 374		2/8/22

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K 374	Continued From page 9 are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility provided documentation from 1/18/22 to 1/19/22, it was determined that the facility failed to provide smoke barrier wall doors that completely closed to resist the passage of smoke, flame or gases during a fire in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.7, 19.3.7.1, 19.3.7.8, 8.5, 8.5.2, 8.5.4, 8.5.4.1. This deficient practice was observed for 2 of 8 sets of double smoke doors tested for closure and was evidenced by the following: 1. At 12:46 PM, the surveyor and the Maintenance Director observed the set of smoke-doors by resident room's [redacted] and [redacted] that when released from their hold open device. The left side door on the [redacted] side remained open approximately 1" allowing the passage of smoke, flame or gases to enter, compromising the integrity of the smoke zone. 2. At 1:18 PM, the surveyor and the Maintenance Director observed the set of smoke-doors by resident room's [redacted] and [redacted], that when released from their hold open device. The left side door on the [redacted] side remained fully open allowing the passage of smoke, flame or gases to enter,	K 374	K374 1) Facility repaired 1 inch gap by the smoke door next to room [redacted] and the mag lock attached to the smoked doors by room [redacted] when fire alarm goes off to release the door appropriately. 2) All residents have the potential of being affected by this deficient practice. 3) Administrator or designee will re-educate Maintenance staff on the requirement to provide smoke barrier wall doors that completely closed to resist the passage of smoke, flame or gases during a fire. 4) Maintenance Director or designee will conduct random audits to smoke barrier wall doors close completely. Audits will be conducted weekly times 4 then monthly times 2. Results of these audits will be forwarded to the monthly Quality Assurance Performance Improvement committee to ensure ongoing compliance. Any findings identified will be immediately corrected.	

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K 374	Continued From page 10 compromising the integrity of the smoke zone. This observation was due to an alarm activation in the building from a Maintenance worker spraying ceiling tiles. When the fire alarm was activated the door automatically should have closed to protect the smoke zone. The Administrator was notified of the finding at the Life Safety Code exit conference on 1/19/22. NJAC 8:39-31.2(e)	K 374		
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview from 1/18/22 to 1/19/22, in the presence of the facility Administrator and Maintenance Director, it was determined that the facility failed to ensure resident bathroom ventilation systems for 52 of 85 units were adequately maintained, in accordance with the National Fire Protection Association (NFPA) 90 A, B. This deficient practice was evidenced by the following: While touring the building from 1/18/22 to 1/19/22, from approximately 10:30 AM to 1:30	K 521	K521 1) Facility repaired bathroom ventilation system to ensure compliance and installed in accordance with the manufacturer's specifications. 2) All residents have the potential of being affected by this deficient practice. 3) Administrator or designee will re-educate Maintenance staff on the requirement to ensure HVAC system is	2/18/22

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K 521	Continued From page 11 PM, the surveyor, in the presence of the Administrator and Maintenance Director observed that the ventilation in the following resident room bathrooms did not function: [redacted] - 17 bathrooms shower room [redacted] - 17 bathrooms [redacted] - 17 bathrooms The surveyor requested that the Maintenance Director, confirm if the units were functioning by placing a piece of single-ply toilet tissue paper across the ceiling grills to confirm ventilation. When tested, the tissue did not hold in place. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation. At that time, the surveyor interviewed the Maintenance Director who confirmed that the exhaust vents in the above resident room bathrooms, were not functioning when tested. The Administrator was informed of this deficiency at the Life Safety Code exit conference on 01/19/22. NFPA 90 A NFPA 101-2012 -19.5.2.1 section 9.2.2 NFPA 101-2012- 19.5.2.1 Chapter 9.1 Utilities 9.2.1 NJAC 8:39-31.2(e)	K 521	installed per regulation and in accordance with the manufacturer's specifications. 4) Maintenance Director or designee will conduct random audits of facility to ensure ventilation system is operational and being used per manufacturer's specifications. Audits will be conducted weekly times 4 then monthly times 2. Results of these audits will be forwarded to the monthly Quality Assurance Performance Improvement committee to ensure ongoing compliance. Any findings identified will be immediately corrected	
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other	K 911		1/20/22

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K 911	Continued From page 12 List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on documentation review and interview, in the presence of the Maintenance Director, it was determined that the facility failed to ensure that electrical panels were up to code as per NFPA 99. This deficient practice was evidenced for 1 of 10 electrical panels observed by the following: On 1/19/22 at 10:32 AM, the surveyor and the Maintenance Director observed the west 248 electrical closet that the LPH2B Main Bk-A panel was missing the # 41 breaker and/or spacer. The # 41 open spacer in the panel, now could allow someone to touch the main breaker bar and get a shock. The door to the electrical room was locked at the time of the observation. The Maintenance Director confirmed the finding during the observation. The Administrator was informed of the finding at the Life Safety Code exit conference on 1/19/22. NFPA 99 NJAC 8:39-31.2(e)	K 911	K911 1) Facility replaced breaker #41 in electrical closet near 248west that has lph2b main bk-a panel . 2) All residents have the potential of being affected by this deficient practice. 3) Administrator or designee will re-educate Maintenance staff on the requirement to ensure to ensure that electrical panels were up to code as per NFPA 99 and operational. 4) Maintenance Director or designee will conduct random audits of facility to ensure functionality of electrical panels. Audits will be conducted weekly times 4 then monthly times 2. Results of these audits will be forwarded to the monthly Quality Assurance Performance Improvement committee to ensure ongoing compliance. Any findings identified will be immediately corrected.	
K 916 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator	K 916		2/1/22

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K 916	Continued From page 13 A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview conducted on 1/19/22, it was determined that the facility failed to ensure that the facility's emergency generator annunciator was functional as evidenced by the following: At 11:50 AM, in the presence of the facility's Maintenance Director where he stated the facility generator did not have a remote annunciator panel. The Administrator upon further investigation indicated that there was an annunciator panel at the nurse station. The annunciator panel at the first floor nurses station column was confirmed. The panel did not have any identification indicating what it was for or any labels as to what the eight panel lights would indicate if activated. There was a push button on the panel that did not activate the lights so there was no way to test the panel for activation. The unit failed to emit a visual and/or audible signal to verify its hardwired connection to the emergency generator. The Administrator was informed of this observation at the Life Safety Code exit conference on 1/19/22. NJAC 8:39-31.2(e)	K 916	K916 1) Contracted services repaired emergency generator annunciator panel. 2) All residents have the potential of being affected by this deficient practice. 3) Administrator or designee will re-educate Maintenance staff on the requirement to ensure that the facility's emergency generator annunciator is functional. 4) Maintenance Director or designee will conduct random audits of facility to ensure panel is functioning correctly. Audits will be conducted weekly times 4 then monthly times 2. Results of these audits will be forwarded to the monthly Quality Assurance Performance Improvement committee to ensure ongoing compliance. Any findings identified will be immediately corrected.	

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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
315009 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/25/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RUNNELLS CENTER FOR REHABILITATION & HEALTHCARE	40 WATCHUNG WAY BERKELEY HEIGHTS, NJ 07922

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0281	02/01/2022	LSC K0291	02/01/2022	LSC K0293	02/01/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	02/08/2022	LSC K0363	02/01/2022	LSC K0374	02/08/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0521	02/18/2022	LSC K0911	01/20/2022	LSC K0916	02/01/2022
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	
1/19/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO