STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CHILDRENS SPECIALIZED HOSPITAL MOUNTAINSIDE	150 NEW PROVIDENCE ROAD MOUNTAINSIDE, NJ 07092

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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		
F 000	INITIAL COMMENTS Survey Date: 6/27/23 Census: 45 Sample Size: 13 + 2 closed records + 6=21 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 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. 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 accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, for 12 of 21 residents, (Residents #2, #3, #11, #14, #21, #27, #28, #33, #36, #41, #44, and #48) reviewed, and was evidenced by the following: According to the Centers for Medicare & Medicaid Services (CMS) Minimum Data Set 3.0 Public	F 641	1. Twelve residents were found to have been affected by the deficient practice outlined in the CMS 2567. For the MDSs identified as inaccurate in the CMS 2567, a Correction File MDS will be submitted by the completion date. These are MDSs for Residents #2, #3, #11, #14, #21, #27, #28, #33, #36, #41, #44, and #48. 2. All residents have the potential to be affected by the deficient practice outlined in the CMS 2567.	7/31/23

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

Electronically Signed | 07/10/2023

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F 641	Continued From page 1 Reports page last modified 12/01/21, included that the MDS is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. Care Area Assessments (CAAs) are part of this process, and provide the foundation upon which a resident's individual care plan is formulated. MDS assessments are completed for all residents in certified nursing homes, regardless of the source of payment for the individual resident. MDS assessments are required for residents on admission to the nursing facility, periodically, and on discharge. All assessments are completed within specific guidelines and time frames. According to CMS Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.17.1, dated October 2019, included the following: SECTION I: ACTIVE DIAGNOSES Intent: The items in this section are intended to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status ... I: Active Diagnoses in the Last 7 Days ... Planning for Care This section identifies active diseases and infections that drive the current plan of care. Steps for Assessment There are two look-back periods for this section: Diagnosis identification (Step 1) is a 60-day	F 641	3. Education was created by the MDS Coordinator. All Physical Therapists (PT) and Occupational Therapists (OT) will receive this education by the completion date, or before their next shift. All MDSs will be audited for accuracy according to the Resident Assessment Instrument (RAI) Manual before submission by the MDS Coordinator or their designee. 4. Compliance for adhering to the RAI manual for all MDSs will be monitored by the MDS Coordinator, or designee, in the form of direct observation. All MDSs will be audited until 100% compliance has been maintained for four (4) consecutive weeks. Then five (5) observations per month until 100% compliance has been maintained for three (3) consecutive months. Audit reports will be submitted to the QAPI committee quarterly by the MDS Coordinator or designee.	

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look-back period.
Diagnosis status: Active or Inactive (Step 2) is a 7-day look-back period (except for Item I2300 UTI, which does not use the active 7-day look-back period).
1. Identify diagnoses: The disease conditions in this section require a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60 days. Medical record sources for physician diagnoses include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/problem list, and other resources as available. If a diagnosis/problem list is used, only diagnoses confirmed by the physician should be entered. Although open communication regarding diagnostic information between the physician and other members of the interdisciplinary team is important, it is also essential that diagnoses communicated verbally be documented in the medical record by the physician to ensure follow-up. Diagnostic information, including past history obtained from family members and close contacts, must also be documented in the medical record by the physician to ensure validity and follow-up.
2. Determine whether diagnoses are active: Once a diagnosis is identified, it must be determined if the diagnosis is active. Active diagnoses are diagnoses that have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period...
Check the following information sources in the medical record for the last 7 days to identify "active" diagnoses: transfer documents, physician progress notes, recent history and physical,

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recent discharge summaries, nursing assessments, nursing care plans, medication sheets, doctor's orders, consults and official diagnostic reports, and other sources as available ...
If a disease or condition is not specifically listed, enter the diagnosis and ICD code in item I8000, Additional active diagnosis ...
SECTION N: MEDICATIONS
Intent: The intent of the items in this section is to record the number of days, during the last 7 days (or since admission/entry or reentry if less than 7 days) that any type of injection, insulin, and/or select medications were received by the resident. In addition, an Antipsychotic Medication Review has been included. Including this information will assist facilities to evaluate the use and management of these medications. Each aspect of antipsychotic medication use and management has important associations with the quality of life and quality of care of residents receiving these medications.

1. On 6/15/23 at 10:44 AM, the surveyor observed Resident #2 lying on the bed supine (facing upward), with a NJ Exec Order 26.4b1 [redacted] NJ Exec Order 26.4b1 [redacted]

On 6/15/23 at 10:50 AM, the surveyor observed the NJ Exec Order 26.4b1 enter Resident #2's room.

The surveyor reviewed Resident #2's medical record.

The resident's Registration Form (RF; or face

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sheet; an admission summary) reflected that the resident was admitted to the facility and had a diagnosis of NJ Exec Order 26.4b1 [redacted]

The resident's most recent Comprehensive Minimum Data Set (CMDS) with an Assessment Reference Date (ARD) of [redacted], revealed a Cognitive Skills for Daily Decision-Making (CSDDM) assessment which indicated the resident's NJ Exec Order 26.4b1 [redacted].

The CMDS indicated the resident had active diagnoses that included, NJ Exec Order 26.4b1 [redacted]

Section G Functional Status of the CMDS revealed that [redacted] were coded a [redacted]

The CMDS Section H Bladder and Bowel indicated the resident was receiving NJ Exec Order 26.4b1 [redacted]

Further review of the resident's MDS reflected a previous quarterly MDS (qMDS) with an ARD of [redacted] Section G for [redacted] was coded [redacted]

On 6/26/23 at 11:48 AM, during an interview with the surveyor, Certified Nursing Assistant #1 (CNA #1) stated she was the aide assigned to Resident #2. CNA #1 informed the surveyor that Resident #2 used a [redacted] and the NJ Exec Order 26.4b1 and [redacted] was documented by her into the electronic Medical Record (eMR).

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On 6/27/23 at 9:33 AM, during an interview with the surveyor, Licensed Practical Nurse #1 (LPN #1) stated she was assigned to the team that cared for Resident #2 on that day. LPN #1 informed the surveyor that the resident NJ Exec Order [redacted] and was NJ Exec Order 26.4b1 and NJ Exec Order 26. The LPN informed the surveyor that the resident also received a NJ Exec Order 26.4b1 to encourage NJ Exec Order 26.

2. On 6/15/23 at 10:50 AM, the surveyor observed Resident #3 seated in a wheelchair, head tilted to the right with NJ Exec Order 26.4b1 [redacted] fitted with NJ Exec Order 26.4b1 [redacted]

The surveyor reviewed Resident #3's medical record.

The resident's RF reflected that the resident was admitted to the facility and had a diagnosis of static NJ Exec Order 26.4b1 [redacted]

The resident's most recent CMDS with an ARD of NJ Exec Order 26. revealed a CSDDM assessment which indicated the resident's NJ Exec Order 26.4b1 [redacted]

The CMDS also indicated the resident had active diagnoses that included, NJ Exec Order 26.4b1 [redacted]

Section G of the CMDS revealed that NJ Exec Order 26.4b1 [redacted] use was coded as NJ Exec O

The CMDS Section H indicated the resident was

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receiving NJ Exec Order 26.4b1.

Further review of the resident's MDS showed that on the following MDS assessments:

ARD NJ Exec Order 26 qMDS, Section G NJ Exec Order 26.4b1 use was coded NJ Exe
ARD NJ Exec Order 26 qMDS, Section G NJ Exec Order 26.4b1 use was coded NJ Exe
ARD NJ Exec Order 26 qMDS, Section G NJ Exec Order 26.4b1 use was coded NJ Exe

The resident's Nutritional Assessment dated NJ Exec Order 26 reflected the resident was on a NJ Exec Order 26.4b1

On 6/22/23 at 12:53 PM, the surveyor and the Dietetic Technician Registered (DTR) reviewed the Nutritional Assessment for Resident #3. The DTR confirmed Resident #3 was NJ Exec Order 26.4b1 and received NJ Exec Order 26.4b1 whose weight was monitored monthly.

On 6/26/23 at 11:52 AM, during an interview with the surveyor, CNA #1 stated she was the aide assigned to Resident #3. CNA #1 informed the surveyor that Resident #3 had a NJ Exec Order 2 and used a NJ Exec Orde; The NJ Exec Order 26.4b1 and NJ Exec Order 26 was documented by the her into the eMR.

3. On 6/15/23 at 11:11 AM, the surveyor observed Resident #11 lying in bed with the head of the bed elevated. Resident #11 had a NJ Exec Order 26.4b1 that was connected to a NJ Exec Order 26.4 and was receiving NJ Exec Order 26.4b1

On 6/22/23 at 9:52 AM, the surveyor reviewed

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Resident #11's medical record.

Resident #11's AR showed that the resident was admitted to the facility with diagnoses that included but was not limited to; NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1

The most recent qMDS with an ARD of NJ Exec Order 26. showed that Resident #11's CSDDM assessment was NJ Exec Order 26.4b1. The NJ Exec Order 26. qMDS showed on Section G, the resident was NJ Exec Order 26.4b1 on NJ Exec Order 26.4b. The section for NJ Exec Order 26.4b was coded incorrectly.

Further review of the MDS showed the following:

ARD of NJ Exec Order 26.4b CMDS: Section G NJ Exec Order 26.4 was coded NJ Exec
ARD of NJ Exec Order 26.4 qMDS: Section G NJ Exec Order 26.4b was coded NJ Exec
ARD of NJ Exec Order 26. qMDS: Section G NJ Exec Order 26.4b was coded NJ Exec

On 6/26/23 at 11:18 AM, the surveyor interviewed CNA #2 regarding the care of Resident #11. She stated that the resident was NJ Exec Order 26.4b1 and had to change the resident's NJ Exec Orde often because the resident had NJ Exec Order 26.4b1 frequently.

On 6/26/23 at 12:21 PM, in the presence of the survey team, the surveyor interviewed the MDS Coordinator/Registered Nurse (MDSC/RN) who confirmed that Section G NJ Exec Order 26.4b was coded

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incorrectly for Resident #11.

On 6/26/23 at 01:40 PM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA), Director Of Nursing #1 (DON#1), DON#2, MDSC/RN, and Director of Therapy (DoT) the concern regarding the incorrectly coded MDS.

4. On 6/19/23 at 11:17 AM, the surveyor observed Resident #21 ambulating and mopping the floor with a play mop in the resident's room with a staff member present.

The surveyor reviewed Resident #21's medical record.

Resident #21's AR showed that the resident was admitted to the facility with a diagnosis that included but was not limited to; NJ Exec Order 26.4b1 [redacted] and is associated with considerable risk of NJ Exec Order 26.4b1 [redacted]

Resident #21's Medication Administration Record for NJ Exec Order 26.4b1 [redacted] included the following orders:

NJ Exec Order 26.4b1 [redacted]
at 7:30 AM.
NJ Exec Order 26.4b1 [redacted] at 8 PM.

A review of Resident #21's developmental pediatric physician's note dated NJ Exec Order 2[redacted] included

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the following: Reason for Evaluation: Resident #21 ... with NJ Exec Order 26.4b1 [redacted] who is being seen for initial assessment and assessment of NJ Exec. Order 26:4.b.1. Medications: NJ Exec Order 26.4b1 g at night with added NJ Exec [redacted] daytime, as tolerated ...Plan: A prescription and written order were provided for NJ Exec Orde to change to NJ Exec Order 26 in am (morning) ...but keep NJ Exec Order 26.4b1 at bedtime for now ...

The most recent CMDS with an ARD of NJ Exec Order 2, showed that Resident #21's CSDDM assessment was NJ Exec Order 26.4b1. The CMDS showed on Section N for medications that the resident received an NJ Exec Order 26.4b1 7 (seven) days.

Further review of the CMDS indicated that Section I Active Diagnoses did not include NJ Exec Order 2 [redacted] which was the diagnosis indicated for the physicians order of NJ Exec Order 26.4b1.

Further review of the MDS showed the following:

ARD of NJ Exec Order 26.4b qMDS: Section N NJ Exec Order 26.4b1 7 days; Section I did not include diagnosis of NJ Exec Order 2 [redacted]

ARD of NJ Exec Order 26.4b qMDS: Section N NJ Exec Order 26.4b1 7 days; Section I did not include diagnosis of NJ Exec Order 2 [redacted]

ARD of NJ Exec Order 2 qMDS: Section N NJ Exec Order 26.4b1 7 days; Section I did not include diagnosis of NJ Exec Order 2 [redacted]

On 6/20/23 at 12:35 PM, the surveyor interviewed Registered Nurse #1 (RN #1) who stated that Resident #21 had a diagnosis of NJ Exec Order and that

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the resident had NJ Exec Order 26.4b1.

On 6/26/23 at 12:16 PM, the surveyor interviewed the MDSC/RN regarding Resident #21's MDS. The MDSC/RN stated that the resident was on an NJ Exec Order 26.4b1 and that the reason the resident was on the medication was that the resident had a diagnosis of NJ Exec Order. The surveyor asked the MDSC/RN the reason the diagnosis of NJ Exec Order was not listed on Resident #21's MDS. The MDSC/RN stated that the diagnoses listed on the MDS were the medical diagnoses that were in the resident's chart in the section of diagnoses. The surveyor asked the MDSC/RN if NJ Exec Order was a medical diagnosis. She stated "yes," and added that the diagnosis was documented in other sections of the medical chart.

On that same date and time, the surveyor then asked the MDSC/RN if the expectation would be to see the diagnosis on the MDS. The MDSC/RN stated "yes maybe". She then added that the diagnosis code was pulled directly from eMR, in the diagnosis section. She then stated that if the diagnosis was not coded in the diagnosis section of the eMR, then it would not go over to the MDS. She further stated that she could manually put in the diagnosis but that she was told not to put the diagnoses in. The surveyor then asked the MDSC/RN if Resident #21's NJ Exec Order diagnosis should have been listed in the MDS. She stated "yes."

On 6/26/23 at 01:40 PM, in the presence of the survey team, the surveyor notified the LNHA, DON #1 and #2, MDSC/RN and DoT the concern regarding the missing diagnosis associated with the use of the NJ Exec Order 26.4b1 in the

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MDS.

On 6/27/23 at 12:24 PM, in the presence of the survey team, the LNHA stated that the diagnosis of [redacted] was in Resident #21's [redacted] notes. The surveyor then asked the LNHA if the diagnosis of [redacted] should have been in Resident #21's MDS. The LNHA stated that he was not a MDS Coordinator and that he would have to look at the manual.

5. On 6/15/23 at 10:42 AM, the surveyor observed Resident #36 sitting up in bed watching television. Resident #36 had a [redacted] that was connected to a [redacted] and was receiving [redacted]

The surveyor reviewed Resident #36's medical record.

The AR showed that the resident was admitted to the facility with a diagnosis that included but was not limited to; [redacted]

The most recent qMDS with an ARD of [redacted], showed that Resident #36's CSDDM assessment was [redacted]. The [redacted] qMDS showed on Section G, the resident was coded [redacted] on [redacted] use. Section K Swallowing/Nutritional Status indicated the resident had a [redacted]. The sections for [redacted] and [redacted] were coded incorrectly.

Further review of the MDS showed the following:

ARD of [redacted] qMDS: Section G [redacted] and [redacted] use was coded [redacted] Section K-TF.

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F 641	Continued From page 12 ARD of NJ Exec Order 26.4b qMDS: Section G NJ Exec Order 26.4b was coded NJ Exec and NJ Exec Order was coded four (4) total dependence and (2) one person physical assist. Section K-TF. ARD of NJ Exec Order 26. CMDS: Section G NJ Exec Orde and NJ Exec Ord use was coded NJ Exec (total dependence/one person physical assist). Section K-TF. The section for NJ Exec Ord use was coded incorrectly for 3 (three) of 4 (four) MDS reviewed. The section for NJ Exec Orde was coded incorrectly for 2 (two) of 4 (four) MDS reviewed. On 6/26/23 at 11:21 AM, the surveyor interviewed CNA #2 regarding Resident #36's care. She stated that Resident #36 was NJ Exec Order 26.4b1 and that she would change the resident's NJ Exec Order 2 often. She added that the nurse would give the resident a NJ Exec Order 26.4b1. On 6/26/23 at 12:21 PM, in the presence of the survey team, the surveyor interviewed the MDSC/RN who confirmed that Section G NJ Exec Orde and NJ Exec O use was coded incorrectly for Resident #36 when it was coded NJ Exec On 6/26/23 at 01:40 PM, in the presence of the survey team, the surveyor notified the LNHA, DON #1 and #2, MDSC/RN and DoT the concern regarding the incorrectly coded MDS. 6. On 6/15/23 at 11:06 AM, the surveyor observed Resident #44 laying in a crib. Resident #44 had a NJ Exec Order 26.4b1 that was connected to a NJ Exec Order 26.4 r and had received NJ Exec Order 26.4b1 but the NJ Exec Order 26.4b1. The surveyor reviewed the medical records of Resident #44.	F 641		

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Resident #44's AR showed that the resident was admitted to the facility with a diagnosis that included but was not limited to; NJ Exec Order 26.4b1 [redacted] and NJ Exec Order 26.4b1

The most recent qMDS with an ARD of NJ Exec Order 26, showed that Resident #44's CSDDM was not assessed. The NJ Exec Order 26 qMDS showed on Section G, the resident was coded NJ Exec Order 26.4b1 use. Section K indicated the resident had a NJ Exec. The sections for NJ Exec Order and NJ Exec O use were coded incorrectly.

Further review of the MDS showed the following:

ARD of NJ Exec Order 26 qMDS: Section G NJ Exec Ord use was coded NJ Exec and NJ Exec Order was coded NJ Exec O Section K-TF.
ARD of NJ Exec Order 26.4b CMDS: Section G NJ Exec Ord use was coded NJ Exec and NJ Exec Orde was coded NJ Exec Section K-TF.
The section for NJ Exec Ord use was coded incorrectly for 3 (three) of 3 (three) MDS reviewed.
The section for NJ Exec Orde was coded incorrectly for 1 (one) of 3 (three) MDS reviewed.

On 6/26/23 at 11:22 AM, the surveyor interviewed CNA #2 regarding Resident #44's care. She stated that Resident #44 was NJ Exec Order 26.4b1 and that she would change the resident's NJ Exec Orde often. She added that the nurse would give the resident a NJ Exec Order 26.4b1 and that the resident had a NJ Exec Order 26.4b1 that the nurse changed.

On 6/26/23 at 12:21 PM, in the presence of the survey team, the surveyor interviewed the MDSC/RN who confirmed that Section G NJ Exec Orde

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and [NJ Exec Or] use was coded incorrectly for Resident #44 when it was code[NJ Exec O]
7. On 6/15/2023 at 11:57 AM, the surveyor observed Resident #41 seated in [NJ Exec. Order 26.4] wheelchair inside their room with a [NJ Exec Order 26.4b1] attached to an [NJ Exec Order 2]. The resident was [NJ Exec Or] to the surveyor's questions.

On 6/19/23 at 11:29 AM, the surveyor observed the three facility staff transfer the resident from bed to a [NJ Exec Order 26] wheelchair with the use of the mechanical mobility tool as a lift. The three staff were the Nurse Extern (NE), RN #2, and CNA #3.

On 6/19/23 at 11:37 AM, the surveyor interviewed CNA#3. The CNA informed the surveyor that Resident#41 was [NJ Exec Order 26.4b1], and required total assistance with ADL, and on [NJ Exec O]. She further stated that the resident was [NJ Exec Order 26.4b1] and that [NJ Exec Order 26.4b1] care was provided as needed. She indicated that the resident was [NJ Exec O] and on a [NJ Ex] for [NJ Exec Order 26.4b1]

The surveyor reviewed Resident #41's medical record.

The resident's RF reflected that the resident was admitted to the facility and had a diagnosis of [NJ Exec Order 26.4b1]

The resident's most recent qMDS with an ARD of [NJ Exec Order 2] reflected that the CSDDM indicated that the resident's [NJ Exec Order 26.4b1]. Section G of the qMDS revealed that the [NJ Exec Order] and [NJ Exec O] use were coded as [NJ] 8. Section O Special Treatments, Procedures, and Programs in the qMDS revealed that the resident had no

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NJ Exec Order 26.4b1 and was not assessed, and no information.

Further review of the resident's MDS showed that on the following MDS assessments:

ARD NJ Exec Order 26 CMDS= NJ Exec O use was coded NJ Exec and no NJ Exec Order 26.4b1 information
ARD NJ Exec Order 26.4 qMDS= NJ Exec O use was coded NJ Exec and no NJ Exec Order 26.4b1 information

On 6/26/23 at 8:55 AM, the AVP of Access Management & Regulatory Affairs (AVPAMRA) in the presence of the LNHA, and the survey team provided a copy of the resident's Immunization Information System and revealed that the resident received the NJ Exec Order 26.4b1 dated NJ Exec Order 26.4b1 (dose one) NJ Exec Order 26.4b1 (dose two), NJ Exec Order 26.4b1 (dose three), and NJ Exec Order 26.4b1 (dose four).

A review of the resident's electronic medical record revealed that there was no evidence that the resident had been administered the NJ Exec Order 26.4b1. The provided list of residents with NJ Exec Order 26.4b1 by DON#2 did not include the resident's name.

8. On 6/19/2023 at 11:43 AM, the surveyor observed Resident #14 seated in a NJ Exec Order 26 wheelchair inside their room with a padded headboard, lap tray, and leg rest. The resident was NJ Exec Order 26.4b1 to the surveyor's questions.

The surveyor reviewed Resident #14's medical record.

The resident's RF reflected that the resident was

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admitted to the facility and had a diagnosis of NJ Exec Order 26.4b1

The resident's Progress Note (PN) dated NJ Exec Order 26 by the Medical Doctor (MD) with a date of service of NJ Exec Order 26 included past medical history diagnoses that were not limited to NJ Exec Order 26.4b1

The resident's most recent CMDS with an ARD of NJ Exec Order 26 reflected that the CSDDM indicated that the resident's NJ Exec Order 26.4b1. Section G of the CMDS revealed that the NJ Exec Order use was coded as NJ Exec.

Further review of the resident's MDS showed that on the following MDS assessments:

ARD NJ Exec Order 26 qMDS NJ Exec Order use was coded NJ Exec
ARD NJ Exec Order 26.4 qMDS= NJ Exec Order use was coded NJ Exec
ARD NJ Exec Order 26.4 qMDS= NJ Exec Order use was coded NJ Exec

On 6/21/23 at 9:56 AM, the surveyor interviewed the MDSC/RN in the presence of another surveyor, DON#1 and #2. The MDSC/RN informed the surveyor that there was another per diem RN who does MDS. She further stated that there was no facility policy with regard to MDS and that the facility follows the RAI Manual in doing MDS. The MDSC/RN informed the surveyor that MDS was used for the resident's assessment that will generate CAAs (process and guides how to focus on key issues identified

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during a comprehensive MDS assessment. The triggered MDS items target care areas for additional assessment and review, as warranted by MDS item responses) triggers, and that was why the MDS should be accurate. She further stated that the MDS information was gathered from "my" personal assessments, nursing assessments, therapy notes, and assessment, CNA's information for the ADL, nutrition team notes, and diagnosis from the resident's medical chart.

On that same date and time, the surveyor asked the MDSC/RN how she code Section G for NJ Exec O use. The MDSC/RN stated that it was being coded as NJ Exe because all residents were pediatrics and they do not use the toilet like elder residents. The surveyor then asked the MDSC/RN to provide a copy where she got the information in the RAI manual that the Section G for NJ Exec O use should be coded as NJ Exe, and the MDSC/RN stated that she will get back to the surveyor.

On 6/22/23 at 12:08 PM, the survey team met with AVPAMRA, DON#1 and #2, Manager of Regulatory Affairs & Accreditation (MRAA), and the DoT, and they were made aware of the above findings.

On 6/26/23 at 11:18 AM, the surveyor interviewed CNA#2 who informed the surveyor that she was the assigned aide of the resident, and Resident #14 was NJ Exec Order 26.4b1 due to a medical condition. CNA#2 stated that the resident required total assistance with activities of daily living (ADL) including NJ Exec Order 26 and NJ Exec Order 26 which the nurse does for NJ Ex, and that the resident was NJ Exec O. She further stated that the resident was

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provided with NJ Exec Order 26.4b1 frequently to make sure that the resident was NJ Exec Order 26.4b1 [redacted]

On 6/26/23 at 11:35 AM, the surveyor interviewed RN#2 and LPN #2. The RN stated that the resident required total assistance with ADL, including NJ Exec Order 26 by CNA and NJ Exec for the nurse because the resident also was NJ Exec Orde. The RN further stated that the resident was NJ Exec Order 26.4b1 and care was provided as often as needed to make sure that the resident was NJ Exec Order 26.4b1 [redacted]

9. On 6/15/2023 at 9:37 AM, the surveyor observed Resident #27 seated in a recliner stroller inside their room with a NJ Exec Order 26.4b1 attached to a NJ Exec Order 26.4b1. The resident was NJ Exec O [redacted] to the surveyor's questions.

The surveyor reviewed the medical records of Resident #27.

The resident's RF reflected that the resident was admitted to the facility and had a diagnosis of NJ Exec Order 26.4b [redacted]

The resident's PN dated NJ Exec Order 26 by the MD with a date of service of NJ Exec Order 26 included past medical history diagnoses that were not limited to NJ Exec Order 26.4b1 [redacted]

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The resident's most recent CMDS with an ARD of [redacted] reflected that the CSDDM indicated that the resident's NJ Exec Order 26.4b1 Section G of the CMDS revealed that the [redacted] use was coded as [redacted]

On 6/19/23 at 11:22 AM, the surveyor interviewed CNA #4. The CNA informed the surveyor that Resident #27 was NJ Exec Order 26.4b1 and required total assistance with ADL, and on [redacted]. She further stated that the resident was [redacted] of both [redacted] and NJ Exec Order 26.4b1 and on NJ Exec Order 26.4b1 [redacted] care was provided as needed and NJ Exec Order 26.4b1 [redacted]. She indicated that the resident was [redacted] and on a [redacted] for [redacted].

10. On 6/20/2023 at 9:23 AM, the surveyor observed Resident #28 seated in a [redacted] wheelchair inside their room with a [redacted] attached to a [redacted] The resident was [redacted] to the surveyor's questions.

The surveyor reviewed the medical records of Resident #28.

The resident's RF reflected that the resident was admitted to the facility and had a diagnosis of NJ Exec Order 26.4b1 [redacted] and NJ Exec Order 26.4b1 [redacted].

The resident's PN dated [redacted] by the MD with a date of service of [redacted] included past

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medical history diagnoses that were not limited to,NJ Exec Order 26.4b1 [redacted]

The resident's most recent CMDS with an ARD of NJ Exec Order 26.4b1 reflected that the CSDDM indicated that the resident's NJ Exec Order 26.4b1 . Section G of the CMDS revealed that the [redacted] use was coded as [redacted].

Section H of the CMDS revealed that the NJ Exec Order 26.4b1 was coded as none of the above.

A review of resident #28's personalized care plan revealed NJ Exec Order 26.4b1 assessment to be done by nursing was initiated on [redacted] with start date of [redacted].

On 06/26/23 at 11:11 AM, the surveyor interviewed CNA#2. The CNA informed the surveyor that Resident #28 was [redacted] and required total assistance with ADL, and on [redacted]. She further stated that the resident was [redacted] of both [redacted] and [redacted]. [redacted] care was provided as needed and that nursing was doing [redacted] on the resident every six hours.

11. On 06/15/2023 at 10:29 AM, the surveyor observed Resident #33 seated in a [redacted] wheelchair inside their room with a [redacted] attached to a [redacted]. The resident was [redacted] to the surveyor's questions.

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The surveyor reviewed the medical records of Resident #33.

The resident's RF reflected that the resident was admitted to the facility and had a diagnosis of NJ Exec Order 26.4b1 [redacted].

The resident's PN dated NJ Exec Order 26.4b1 by the MD with a date of service of NJ Exec Order 26 included past medical history diagnoses that were not limited to, NJ Exec Order 26.4b1 [redacted].

The resident's most recent CMDS with an ARD of NJ Exec Order 26.4b1 reflected that the CSDDM indicated that the resident's NJ Exec Order 26.4b1 [redacted]. Section G of the CMDS revealed that the NJ Exec Orde and NJ Exec O use were coded as NJ Exe.

A review of Residents #33's nutrition note dated NJ Exec Order 26.4b1 revealed the resident is NJ Exec Orc and is NJ Exec Order 26.4b1.

On 6/20/23 at 09:43 AM, the surveyor interviewed RN #3. The RN informed the surveyor that Resident #33 was NJ Exec Order 26.4b1 and required total assistance with ADL. The RN further stated that the resident is on a NJ Exe and wears a NJ Exec Order because of NJ Exec Order 26.4b1 of both NJ Exec Orde and NJ Exec Order 26.4b1.

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12. On 6/20/2023 at 10:29 AM, the surveyor reviewed the closed record for Resident #48 for hospitalization.

The resident's RF reflected that the resident was admitted to the facility and had a diagnosis of NJ Exec Order 26.4b1.

The resident's PN dated NJ Exec Order 26.4b1 by the MD with a date of service of NJ Exec Order 26.4b1 included past medical history diagnoses that were not limited to, NJ Exec Order 26.4b1

The resident's most recent CMDS with an ARD of NJ Exec Order 26.4b1 reflected that the CSDDM indicated that the resident's NJ Exec Order 26.4b1. Section G of the CMDS revealed that the NJ Exec Orde and NJ Exec O use were coded as NJ Exe.

A review of Residents #48's nutrition note dated NJ Exec Order 26.4b1 revealed the resident is NJ Exec Ord and is NJ Exec Order 26.4b1.

On 6/26/23 at 12:00 PM, the surveyor in the presence of another surveyor interviewed the MDSC/RN. The MDSC/RN informed the surveyors that Section G in the MDS was the responsibility of the PT and OT. The MDSC/RN stated that the PT was responsible for Section G from A to F (where H is for NJ Exec Orde) and the OT was responsible from G to J (where I is for NJ Exec O use) of Section G. She further stated that she did not have formal training in doing MDS and that her education was from a previous outside contractor who no longer affiliated with the facility. The MDSC/RN stated that it was the previous

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contractor also who taught her to code [NJ Exe] for [NJ Exec Order 26.4b1].

On that same date and time, the MDSC/RN informed the surveyors that after reviewing the RAI manual, after the surveyor's inquiry, "I get it, it should be coded [NJ Exec Order 26.4b1]," and that she understood now based on the RAI manual. The MDSC/RN stated that "moving forward, we will correct it." She further stated that there was a "rationale around it, and we are working on a correction plan."

On 6/26/23 at 12:36 PM, the survey team met with the PT who informed the surveyors that she was working at the facility and had been doing the MDS for some Sections of G and O [NJ Exec. Order 26:4.b.1]. The PT stated that "I do the top portion and the OT the other half" of Section G, and at times when the OT was not present, she takes care of the whole of Section G.

On that same date and time, the PT informed the surveyors that "I do not have proper training" in doing MDS, and did not have a formal class for MDS training. The PT stated that she answers the portions in Section G of MDS according to her training as a physical therapist. She further stated that after the surveyor's inquiry and the MDSC/RN reached out to her, "I am now aware," that the [NJ Exec Order 26.4b1] use should have been coded as [NJ Exec Order 26.4b1].

On 6/26/23 at 01:34 PM, the survey team met with the LNHA, MDSC/RN, DON#1 and #2, and the DoT. The surveyor asked the facility management if there will be an additional information regarding the above findings regarding MDS accuracy of assessment for

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F 641	Continued From page 24 Sections C, H, I, and O. The MDSC/RN stated that "I provided you an explanation, there were discrepancies, and there was nothing else to add." On 6/27/23 at 12:33 PM, in the presence of the survey team, LNHA, DON #1, MRAA and AVPAMRA, DON #2 stated that [in response to the residents that were coded incorrectly for NJ Exec Order 26.4b1] their perception of coding [Section G NJ Exec Order 26.4b1] was not the same as the survey team. DON#2 confirmed that they were coded NJ Exec and that they misunderstood it. On 6/27/23 at 01:11 PM, the survey team met with the LNHA, DON#1 and #2, AVPAMRA, MRAA, DoT, and there was no additional information provided by the facility management. NJAC 8:39-11.1, 33.2(d)	F 641		
F 658 SS=D	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, and review of facility provided documents, it was determined that the facility failed to ensure a) proper disposal of a controlled substance (narcotic; medications, that due to their high potential for abuse, are tracked with detail) medications, b) medication was crushed, c) proper disposal of non-controlled substance and	F 658	1. Three residents were identified to have been affected by the deficient practice outlined in the CMS 2567. For resident #40, the medication did not reach the resident. LPN #1 and RN #1 were re-educated on proper disposal of a controlled substance and the corresponding documentation.	8/8/23

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F 658	Continued From page 25 was identified during the medication administration observation for two of three nurses in accordance to standards of clinical practice and facility policy. This deficient practice was evidenced by the following: 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 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." A review of the manufacturer's specification for [brand name redacted] oral/enteral syringe with [brand redacted] connector for pharmacy use, included:	F 658	For Resident #25, the resident received the crushed medication. LPN #2 was re-educated on the proper way to crush medication and prepare medication for administration. For Resident #1, the medication did not reach the resident. LPN #2 was re-educated on the proper disposal of a non-controlled medication. 2. All residents have potential to be affected by the deficient practice outlined in the CMS 2567. 3. The Director of Nursing, Assistant Nurse Managers, Nurse Educator or their designee will provide all Registered Nurses (RN) and Licensed Practical Nurses (LPN) will receive education by the completion date, or before their next shift, on the following; a. The crushing of medications will only be completed with a Children□s Specialized Hospital approved pill crushing pouch. b. The proper disposal of non-controlled substances. Non-controlled substance pills will be crushed and disposed into a Children□s Specialized Hospital approved designated drug disposal container and non-controlled substance liquid will be poured in a Children□s Specialized Hospital approved designated drug disposal container. c. The proper disposal of controlled substances. Controlled substance pills will be crushed and disposed into a Children□s Specialized Hospital approved designated drug disposal container and	

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F 658	Continued From page 26 Indication for use, the device is indicated for use as a dispenser, a measuring device, and a fluid transfer device. It is used to deliver fluids into the body orally and enterally (administration by mouth or esophagus or artificial opening to the intestine). It is intended to be used in clinical or home care settings by users ranging from clinicians to layperson (under the supervision of a clinician) in all ages. Contraindications included: This device is intended for oral /enteral applications only ...5) Do not modify this device as this may lead to leakage, inadequate nutrition delivery or patient harm. 1. On 6/02/23, at 9:35 AM, the surveyor began the Medication Observation Pass for Resident #40. The surveyor observed Licensed Practical Nurse #1 (LPN#1) and Registered Nurse #1 (RN #1) obtain a NJ Exec Order 26.4b1 that contained NJ Exec Order 26.4b1 from the electronic back-up machine. At that time, LPN #1 stated that the pharmacy made NJ Exec Order 26.4b1 and that she had to waste NJ Exec Orde because Resident's order was for NJ Exec Order At that time, the surveyor observed LPN#1 began to run the water from the faucet and wasted NJ Exe of the NJ Exec Order 26.4b1 into the sink. The surveyor observed RN#1 and LPN#1 document the disposal into the electronic backup machine and LPN #1 relabeled the NJ Exec Order 2 for administration. The surveyor reviewed the medical record for Resident #40.	F 658	controlled substance liquids will be poured in a Children□s Specialized Hospital approved designated drug disposal container. This disposal must be witnessed and documented by two licensed nurses. 4. a. Compliance for adhering to the use of Children□s Specialized Hospital approved pill crushing pouch will be monitored by the Nursing Supervisor, or designee, in the form of direct observation and completion of the audit tool. There will be five (5) observations per week until 100% compliance has been maintained for four (4) consecutive weeks. Then five (5) observations per month until 100% compliance has been maintained for three (3) consecutive months. Audit reports will be submitted to the QAPI committee quarterly by the Director of Nursing or designee. b. Compliance for adhering to the proper disposal of both non-controlled substances and controlled substances will be monitored by the Nursing Supervisor, or designee, in the form of direct observation and completion of the audit tool. There will be five (5) observations per week until 100% compliance has been maintained for four (4) consecutive weeks. Then five (5) observations per month until 100% compliance has been maintained for three (3) consecutive months. Audit reports will be submitted to the QAPI committee quarterly by the Director of Nursing or designee.	

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F 658	Continued From page 27 The Registration Form (RF; or facesheet; an admission summary) reflected the resident was admitted to the facility with a diagnosis of [redacted]. The electronic Medication Administration Report (eMAR) included an order for: [redacted] [twice a day] 10:00 and 22:00 (8 PM), with a start date of [redacted]. A review of the manufacturer specifications revealed [redacted] was classified as a [redacted]. On 6/22/23 at 12:36 PM, during an interview with the surveyor, LPN #1 stated [redacted] medications must be wasted within the medication room in a trash can and a second nurse must sign that we are wasting/disposing of the [redacted]. We then have to let the pharmacy know that we wasted the medication. LPN#1 also stated [redacted] medications, are disposed in the garbage with the second nurse present. We have additional doses that we can retrieve from the cassettes [in the medication cart]. 2. On 6/22/23 at 11:19 AM, the surveyor observed LPN #2 prepare medications for Resident #25 in the resident's room. The eMAR included an order for [redacted]	F 658		

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NJ Exec Order 26.4b1 schedule for 12:00 PM.

At that time, the surveyor observed LPN #2 use an Alcohol based hand rub (ABHR) and donned gloves.

At that time, the surveyor observed LPN #2 retrieve the NJ Exec Order 26.4b1 tablet from the Resident #25's designated cassette from the medication cart, opened the unit dose of NJ Exec Orde, leaving the pill within its package and placed it on the medication cart.

At that time, LPN #2 retrieved an open system [brand redacted] NJ Exec Order 2 from the medication cart drawer, pulled the NJ Exec Order 26.4b1 and placed the NJ Exec Orde tablet into the NJ Exec Order 2. LPN #2 placed the NJ Exec Order 26.4b1 and crushed the tablets that emitted dust particles from the open end of the NJ Exec Order 2. The nurse drew water and capped the NJ Exec Order 2 with her gloved finger and shook the NJ Exec Order 2 to dissolve its contents.

At 11:20 AM, the surveyor observed a [brand redacted] pill crusher on the medication cart and asked the nurse if that was the facility policy to crush the pill in the NJ Exec Order 2. LPN #2 stated "I was not told I can not crush into a NJ Exec Order 2."

The surveyor reviewed the medical record for Resident #25.

The RF reflected that the resident was admitted to facility with a diagnosis of NJ Exec Order 26.4b1

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A review of the eMAR reflected an order that included:

NJ Exec Order 26.4b1 scheduled for 6:00 AM, 12:00 PM and 18:00 (6 PM), with a start date of NJ Exec Order 26

3. On 6/22/23 at 11:24 AM, the surveyor observed LPN #2 prepare medications for Resident #1 in the resident's room.

The eMAR reflected an order that included NJ Exec Order 26.4b1

At that time, the surveyor observed LPN #2 use an ABHR and donned gloves.

At 11:29, the surveyor observed LPN #2 crush the NJ Exec Order 26.4b1 using the pill crusher, as she was transferring the crushed medication into the NJ Exec Order 2, LPN #2 spilled some crushed medication onto the medication cart, and some were in the open system NJ Exec Order 2.

At that time, the surveyor observed LPN #2 throw the NJ Exec Order 2 that contained some of the crushed NJ Exec Order 26.4b1 into the trash bin that was attached to the medication cart. LPN #2 wiped the spilled medication and threw the paper towel into the trash bin.

At that time, the surveyor asked LPN #2 what the facility policy for disposal of a NJ Exec Order 26.4b1 medication. LPN #2 stated "I don't know where else to throw it". LPN #2 could not recall receiving an in-service (education) for medication disposal.

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The surveyor reviewed the medical record for Resident #1.

The RF reflected Resident #1 was admitted with a diagnosis of NJ Exec Order 26.4b1 [redacted].

On 6/26/23 at 9:31 AM, during an interview with the surveyors the Pharmacy Director (PD) confirmed that NJ Exec Order 26.4b1 was a NJ Exec Order 26.4b1 [redacted] medication. The PD stated that the Joint Commission recommended that it can be flushed down the sink. The PD stated liquids were flushed down the sink and that tablets were brought back to the pharmacy; "We have proper bins to dispose of those." The PD informed the surveyors that the facility did not have a drug disposal solution (bottle of solution used to disintegrate pills and tablets). The PD was unable to respond when asked where should spilled crushed medications be disposed. The PD stated the policy was appropriate.

At that time, during an interview with the surveyors the PD stated medications should not be crushed within a NJ Exec Order 2 because she can not ensure the medication could be completely crushed but can be dissolved within the NJ Exec Order 2. The PD stated that crushing a medication through an open system NJ Exec Order 2 can result to medication being lost through the opening and did not guarantee 100% delivery of the medication.

At that time, the PD confirmed the facility policy should be followed.

At that time, the PD also stated that placing a finger over the open system NJ Exec Order 26 was not a clean process and that was an infection control

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issue.

On 6/26/23 at 9:55 AM, during an interview with the survey team, the Consultant Pharmacist (CP) stated she was in the facility once a month and conducted medication pass observations. The CP stated she had observed the nurses crush a medication in a [redacted] and that it was okay to do. The CP informed the surveyors that she did not report any competency issue with crushing a medication in a [redacted]. The CP stated she would provide information regarding crushing medications using a [redacted]. No further information was provided.

At that time, the CP stated that all medications including crushed medication should be returned to the in-house pharmacy in the building.

At that time, the CP stated she would provide an in-service/education to the individual nurse but has not provided the education yet. The CP stated she has not provided in-service on the topic of medication administration and drug disposal.

On 6/26/23 at 01:34 PM, the survey team met with the Minimum Data Set Coordinator, the Director of Nursing (DON #1) and DON #2, the Director of Therapy (DoT), and were made aware of the above findings.

On 6/27/23 at 12:09 PM, the survey team met with the AVP (Assistant Vice President) of Access Management & Regulatory Affairs (AVPAMRA), Manager of Regulatory Affairs & Accreditation (MRAA), DON#1, DON#2, and the Licensed Nursing Home Administrator (LNHA). The LNHA stated that there was no further information that

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F 658	Continued From page 32 the facility can share. At that time, DON #2 stated the facility had a [brand name redacted] pill crusher and we would like to streamline the process. At that time, DON #2 stated she would not recommend the use of a hand in dissolving the medication in the [redacted] because of infection control. A review of the facility policy provided, Destruction of Medication with an effective date of 01/01/23, included following: It is the policy of the [facility name redacted] that the pharmacy department shall be responsible for the destruction of outdated, discontinued, contaminated or otherwise unusable medication. Under section, II. Destruction Procedure subsection A. Non-controlled Substance: 1. Individual, small quantities of liquids that are non-poisonous, non- corrosive, non-hazardous or nonflammable will be kept in their container and deposited in the red medical waste receptacle. 2. Small quantities of tablets and capsules that cannot be returned for credit through an authorized drug disposal company will be kept in the container and deposited in the red medical waste receptacle, 3. Hazardous medications will be discarded in the black hazardous medication bin. B) Controlled Substances: 1. Unused or expired controlled substances will be locked in a designated cabinet in the pharmacy department the prior to planned disposition. A review of the facility policy provided, Medication	F 658		

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F 658	Continued From page 33 Management with an effective date of 02/10/23, included following: Purpose: This policy establishes the process for [facility name redacted] for safe medication prescribing, dispensing and administration. Departments Affected: Pharmacy, Nursing, Respiratory, Medical Outpatient Services. Under section D. Administration, subsection 5. Verifies the medication is stable based on visual examination for particulates or discoloration and that the medication has not expired.	F 658		
F 686 SS=D	NJAC 8:39- 19.4(a), 29.7 (c), 29.4(g), 27.1(a), Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility provided documents, it was determined that the facility failed to ensure a) that a physician's [NJ Exec Order 2] care order was followed	F 686	1. One resident (resident #3) was found to have been affected by the deficient practice outlined in the CMS 2567. Upon disclosure of this concern by surveyor, RN	8/1/23

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F 686	Continued From page 34 and clarified, b) provide [NJ Exec Order] care in accordance with the facility's policy and professional standards of clinical practice for 1 (one) of 2 (two) residents (Resident #3) reviewed for [NJ Exec Order 26.4b1]. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey state: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well being, and executing a medical regimen 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 state: "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." On 6/20/23 at 10:59 AM, the surveyors observed [NJ Exec Order] care performed by Registered Nurse #1 (RN#1) assigned to Resident #3 and assisted by	F 686	#1 was educated on proper hand hygiene during [NJ Exec Order] care, how to clarify provider orders and disinfection of scissors. 2. All residents have the potential to be affected by the deficient practice outlined in the CMS 2567. 3. The Director of Nursing, Assistant Nurse Managers, Nurse Educator or their designee will provide all Registered Nurses (RN) and Licensed Practical Nurses (LPN) with education by the completion date, or before their next shift, on the following policy and procedure, “Pressure Injury Prevention and Management”, Lippincott procedures of wound care and proper disinfection of scissors. “Pressure Injury Prevention and Management” and Lippincott procedures of wound care include: how to follow provider orders, how to clarify provider orders, proper hand hygiene during wound care, and disinfection of scissors. 4. Compliance for adhering to policy “Pressure Injury Prevention and Management”, Lippincott procedures of wound care and proper disinfection of scissors will be monitored by the Assistant Nurse Manager, or designee, in the form of direct observation and completion of an audit tool. Assistant Nurse Manager, or designee, will complete five (5) observations per week until 100% compliance has been maintained for four (4) consecutive weeks. Then five (5) observations per month until 100% compliance has been maintained for three	

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F 686	Continued From page 35 RN#2. RN#1 removed her scissor from her pocket and cut the NJ Exec Order 26.4b1 into four pieces, cut the NJ Exec Order 26.4b1 and poured NJ Exec Order 26.4b1. RN#1 placed a rolled pillow behind the resident and removed the NJ Exec Order 26.4b and the old NJ Exec Order 26.4b1. RN#1 did not performed hand hygiene after removing the old NJ Exec Order 26.4b1. At 11:12 AM, RN #1 stated that the NJ Exec Order 26 on the NJ Exec. Order 26:4.b.1 was intact and will not be removed at that time. RN #1 kept the NJ Exec Order 26.4b1 and wiped the skin with NJ Exec Order 26.4b1. At that time, the surveyors observed RN #1 continued to wipe on the NJ Exec. Order 26:4.b.1, removed the old NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1, and immediately replaced it with the new NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. RN #1 did not perform hand hygiene after cleansing the NJ Exec. Order 26:4.b.1 and immediately replaced with NJ Exec Order 26.4b1. RN #1 took a NJ Exec Orde RN#1 did not perform hand hygiene before going to another site after cleansing the NJ Exec. Order 26:4.b.1. At 11:15 AM, the surveyors observed RN#1 dry the NJ Exec Order 2 applied the new NJ Exec Order 26.4b1 threw all the used supplies, removed her gloves, threw it away, and placed the scissors in her pocket. At that time, the surveyor asked the nurse if she was going to disinfect her scissors. The surveyors observed RN #1 remove the scissors from her	F 686	(3) consecutive months. Audit reports will be submitted to the QAPI committee quarterly by the Director of Nursing or designee.	

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pocket, used an alcohol-based hand rub cleanser to clean the scissors, and placed it back into the same pocket.

The surveyor reviewed Resident #3's medical record.

The resident's RF reflected that the resident was admitted to the facility on [NJ Exec Order 26] and had a diagnosis of NJ Exec Order 26.4b1 [redacted]

The resident's most recent CMDS with an ARD of [NJ Exec Order 26], revealed a Cognitive Skills for Daily Decision-Making assessment which indicated the resident's NJ Exec Order 26.4b1

Further review of the CMDS section M, indicated the resident had 1 (one) NJ Exec Order 26.4b1.

A review of the facility provided Interdisciplinary Plan of Care, with a status of active, at that time, revealed a problem of NJ Exec Order 26.4b1. A goal to exhibit NJ Exec Order 26.4b1 [redacted]. Interventions, instruction was NJ Exec Order 26.4b1 assessment; See physician orders for [NJ Exec Order] care.

The Physician's Order Sheet contained an order, dated [NJ Exec Order 26.4], "Instructions: wash the [NJ Exec Order] with [NJ Exec Ord] and pat it dry. Apply NJ Exec Order 26.4b1 to [NJ Exec Order 26.4b1] and place in the [NJ Exec Order 26.4b1] [NJ Exec Ord] [redacted]. Repeat every 48 hours or when [NJ Exec Order] For the NJ Exec. Order 26:4.b.1: Apply the NJ Exec Order 26.4b1. Change [NJ Exec Order 26.4b] twice daily. "

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On 6/22/23 at 01:04 PM, during a telephone interview with the surveyor, RN#1 stated the scissors were her personal scissors which she did not disinfect prior to using during the NJ Exec Order care treatment that was observed on NJ Exec Order 2[redacted].

On that same date and time, RN#1 stated she noticed that the NJ Exec Order 26.4b1 on the NJ Exec. Order 26:4.[redacted] was clean and dry. The NJ Exec. Order 26:4.b.1[redacted] did not have a NJ Exec Order 2[redacted] and it was a protection barrier for an NJ Exec Order 26.4b1.

At that time, the RN further stated that after removing the NJ Exec Order 26.4b1 with the NJ Exec Order 26.4[redacted] from the NJ Exec. Order 26:4.b.1[redacted], "I should have" performed hand hygiene, changed gloves then applied the new NJ Exec Order 26.4b1 with the NJ Exec Order 26.4[redacted], followed by cleaning the NJ Exec Order[redacted].

Furthermore, RN #1 stated, "I am removing something soiled and touching something clean," and that if she did not perform hand hygiene, and donned new gloves, "I could have re-contaminated resident's NJ Exec Order[redacted] and possibly exposed resident to NJ Exec Order 26.4b1[redacted] through his/her NJ Exec Orde[redacted] which is also an NJ Exec Order 26.4[redacted]."

On 6/26/23 at 01:34 PM, the survey team met with the Minimum Data Set Coordinator, Director of Nursing #1 (DON #1), DON #2, and the Director of Therapy (DoT), and were made aware of the above findings.

On 6/27/23 at 9:06 AM, the surveyor received a subsequent physician order that included an order, dated NJ Exec Order 2[redacted], to wash the NJ Exec Order[redacted] on the NJ Exec. Order 26:4.b.1[redacted] with NJ Exec Order[redacted] and pat dry. Apply NJ Exec Order 26.4b1[redacted] and place in the NJ Exec Order 26.4b1[redacted]. Cover with NJ Exec Order 26.4b1[redacted] and then

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the [redacted]. Repeat every 48 hours or when soiled. For the [redacted]: Apply [redacted]. Change [redacted] twice daily.

On 6/27/23 at 12:09 PM, the survey team met with the Manager of Regulatory Affairs & Accreditation, the AVP of Access Management & Regulatory Affairs and Compliance, DON #1 and #2, and the Licensed Nursing Home Administrator (LNHA). DON #1 confirmed that hand hygiene should have occurred. DON #1 further stated that it is a standard of practice before going to the next area, the gloves should have been removed, and hand hygiene should have occurred.

A review of the facility provided policy Cleaning of equipment Utensils and Toys, dated 02/13/23 included: The purpose of this policy is to prevent the transmission of infectious organisms from patient to patient and patient to healthcare workers during contact with equipment, toys, and utensils.

A review of the facility provided Wound Care, pediatric procedure for the practice of [facility name redacted], revised 02/20/23 included the following :
Implementation ...
Clean versus Sterile Technique for Dressing Changes ... Children who are immunocompromised or who have multiple organ dysfunction syndrome, severe nutritional deficits, or impaired ventilation and circulation are better served with sterile technique because of the threats of cross-contamination and new contamination, which could overwhelm the system... Inspect the dressing... discard the old dressing in an appropriate receptacle, observe

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F 686	Continued From page 39 the condition of the wound, remove and discard your gloves, perform hand hygiene, put on new gloves, clean the wound... inspect the wound bed..measure the wound dimensions...apply a primary dressing to the wound surface... A review of the undated, facility provided Wound care, pediatric checklist included the following: Objectives, to perform wound care for a child according to the standard of care Checklist step ...Remove the old dressing ...inspect the dressing, discard the old dressing, observe the wound, remove and discard gloves. Perform hand hygiene. Put on new gloves ...Apply a primary dressing to the wound ... A review of the facility provided policy, Pressure Injury and Management, dated 01/01/2023, that included: Purpose, to promote the prevention of pressure injuries and provide evidence-based care to patients at risk of or who have existing pressure injury. Under Pressure Injury Dressings, section 1. Change dressing according to the manufacturer's recommendation, as ordered. at least every seven (7) days, and as needed for excess drainage and soiling. NJAC 8:39-11.2(b), 19.4(a), 27.1(a), 29.2(d)	F 686		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 756		8/8/23

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F 756	Continued From page 40 §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on the interview, record review, and review of the facility provided documents, it was determined that the facility failed to identify medication irregularity during the monthly MRR (Medication Record Review) of the CP	F 756	1. Three residents were found to have been affected by the deficient practice outlined in the CMS 2567.Corrective action was taken to add stop dates to NJ Exec Order 26.4b1 orders for residents # 14,	

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F 756	Continued From page 41 (Consultant Pharmacist) for three (3) of five (5) residents reviewed for unnecessary medications, Residents#14, #24, and #28. This deficient practice was evidenced by the following: According to Lexi-Drugs (or Lexicomp an evidenced-based drug referential content; that provides evidence and recommendations to help clinicians as they treat and advise patients with complex conditions) included that review of the Erythromycin with pharmacologic category of antibiotic; Gastroparesis (off-label use; gastoparesis is a condition that affects the normal spontaneous movement of the muscles in stomach). There is a Patients refractory/intolerant to other prokinetic agents (eg, metoclopramide, domperidone; type of drug which enhances gastrointestinal motility) to limit the duration of therapy, tachyphylaxis (the appearance of progressive decrease in response to a given dose after repetitive administration of a pharmacologically or physiologically active substance and tachyphylaxis occurs when medications suddenly become less effective) may occur after four (4) weeks. According to The Use of Long-Term, Low Dose Erythromycin in Treating Persistent Gastric Stasis, volume 29; issue 5, P430-433, May 2005 included that Erythromycin also has been used in other conditions that have gastroparesis as a problem. Most studies have had follow-up periods of less than four weeks, but a recent study followed some patients for up to 18 months and suggested that tolerance may develop over time. A major concern that has been raised about using erythromycin in this way is that resistance of	F 756	24, and 28. 2. All residents have the potential to be affected by the deficient practice. 3. The Director Pharmacy will provide the Consultant Pharmacist with education that erythromycin for gastrointestinal motility must be reviewed monthly for risk versus benefit of tachyphylaxis and resistance. Consultant Pharmacist, Manager of Pharmacy Services, Director of Pharmacy Services and Medical Director will review the use of erythromycin for gastrointestinal motility monthly, and prescriber will document risk versus benefit of tachyphylaxis and resistance in routine progress note. 4. The Consultant Pharmacist and the Consultant Pharmacist report will be monitored by the Director of Pharmacy. Monitoring will be audited by the Director of Pharmacy and irregularities will be reported during their monthly Medication Record Review (MRR). Auditing will continue until 100% compliance is achieved and has been maintained for three (3) consecutive months. The Director of Pharmacy will report any irregularities to the QAPI committee on a quarterly basis.	

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pathogens, such as S. pneumoniae (Streptococcus pneumoniae is a gram-positive bacterium and a cause of community-acquired pneumonia), may increase. Although the doses of erythromycin used are smaller doses than those typically used in treating bacterial infections, they may provide almost ideal conditions for the induction of bacterial mutation, and selection and resistance to erythromycin is well recognized.

1. On 6/19/2023 at 11:43 AM, the surveyor observed Resident #14 seated in a NJ Exec Order 26 wheelchair inside their room with a padded headboard, lap tray, and leg rest. The resident was NJ Exec Order 26.4b1 to the surveyor's questions.

The surveyor reviewed Resident #14's medical record.

The resident's Registration Form (RF; or facesheet; an admission summary) reflected that the resident was admitted to the facility and had a diagnosis of NJ Exec Order 26.4b1.

The resident's Progress Note (PN) dated NJ Exec Order 26 by the Medical Doctor (MD) with a date of service of NJ Exec Order 26 included past medical history diagnoses that were not limited to NJ Exec Order 26.4b1

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The resident's most recent Comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of [redacted] reflected that the [redacted] indicated that the resident's [redacted].

The [redacted] electronic Medication Administration Record (eMAR) revealed a physician order (PO) dated [redacted] for [redacted] every 6 (six) hours (Q6HR) with a clinical indication for [redacted]

According to the [redacted] CP's Monthly Report for Resident#14, the CP did not identify irregularity with the continued use of [redacted] medication.

A review of the provided documents of the CP via email showed that the CP included the article about [redacted] as a reference. The article provided by the CP did include the whole report that showed the article above regarding a major concern that has been raised about using [redacted] in this way is that resistance of [redacted], may increase and although the doses of [redacted] used are smaller doses than those typically used in treating [redacted], they may provide almost ideal conditions for the induction of [redacted] is well recognized.

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On 6/26/23 at 9:55 AM, the survey team met with the CP. The CP stated that she was responsible for monthly MRR where she reviews residents' medications, identify irregularities, and notify the nursing and the physicians of the recommendations. The surveyor asked the CP if she was familiar with and use Lexicomp for medication reviews, and the NJ Exec Order 26.4b1 concern with continued use of [redacted], and the CP stated "Yes." The CP stated that NJ Exec Order 26.4b1 "does not mean" that the medication was not working, "but" the efficacy was reduced, "meaning" that there is still a clinical benefit even though the efficacy was reduced over time.

On that same date and time, the surveyor asked the CP if she was aware of the NJ Exec Order 26.4b1 effect of continued use of [redacted] to Resident #14, why she did not include it in her monthly MRR on [redacted], and if she notify the physician about it. The CP stated that "I did not" inform the doctor about it. The CP further stated that "I do not have it," documented, that she discussed the medication with the doctor, "but I know" the doctor knows about the medication.

2. On 6/19/23 at 11:02 AM, during the initial tour, the surveyor observed Resident #24 from the hallway in a wheelchair wit NJ Exec Order 26.4b1 [redacted]

The surveyor reviewed the medical record for Resident #24.

The resident's RF reflected that the resident was admitted to the facility and had a diagnosis of NJ Exec Order 26.4b1 [redacted]

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The quarterly MDS (qMDS) with an ARD of [NJ Exec Order 2], reflected that the resident was NJ Exec Order 26.4b1

A review of the Advanced Practical Nurse's (APN) Progress Note signed [NJ Exec Order 26], reflected diagnoses which included, NJ Exec Order 26.4b1 [redacted]

Further review of the APN progress note, under current medications, reflected an order for NJ Exec Order 26.4b1 [redacted] with a start date of [NJ Exec Order 26] and was indicated for [NJ Exec Order 26.4b1] [redacted]

The eMAR dated [NJ Exec Order 26.4b] confirmed Resident #24 received the [NJ Exec Order 26.4b1] Q8HRS since [NJ Exec Order 2].

A review of the CP's Recommendations report from [NJ Exec Order 26.4b] through [NJ Exec Order 2] did not reflect a recommendation to identify the duration of therapy and inform the prescriber of the studies that reflect a rapidly diminishing response to the use of [NJ Exec Or] that may occur after four (4) weeks of use.

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3. On 6/20/2023 at 9:23 AM, the surveyor observed Resident #28 seated in a NJ Exec Order 26 wheelchair inside their room with a NJ Exec Order 26.4b1 attached to a NJ Exec Order 26.4b1. The resident was NJ Exec Or [redacted] to the surveyor's questions.

The surveyor reviewed Resident #28's medical record.

The resident's RF reflected that the resident was admitted to the facility and had a diagnosis of NJ Exec Order 26.4b1 [redacted] and NJ Exec Order 26.4b1 [redacted]

The resident's PN dated NJ Exec Order 26.4b1 by the MD with a date of service of NJ Exec Order 26 included past medical history diagnoses that were not limited to, NJ Exec Order 26.4b1 [redacted]

The resident's most recent CMDS with an ARD of NJ Exec Order 26 reflected that the NJ Exec Order 26.4b1 [redacted] indicated that the resident's NJ Exec Order 26.4b1 [redacted].

The NJ Exec Order 26.4b1 eMAR revealed a PO dated NJ Exec Order 26 for NJ Exec Order 26.4b1 Q8HR with a clinical indication for NJ Exec Order 26.4b1.

According to the NJ Exec Order 26 CP's Monthly Report for Resident #28, the CP did not identify irregularity with the continued use of NJ Exec Or medication.

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On 6/26/23 at 10:32 AM, the MD (also the Medical Director of the facility) and the Licensed Nursing Home Administrator (LNHA) met with the survey team. The MD presented herself to be interviewed and stated that there was a concern with [NJ Exec O] and that the doctor wanted to talk about it. The LNHA then left.

On that same date and time, the surveyor in the presence of the survey team notified the MD of the above findings and concerns regarding [NJ Exec Ord] medication that the CP did not identify and notify the MD and the facility of irregularities even though the CP admitted that she knew about the [NJ Exec Order 26.4b1] issue with continued use of medication for more than 4 (four) weeks. The MD did not disagree with what the CP informed the surveyors that the CP did not notify the MD of the [NJ Exec Order 26.4b1] irregularity with continued use of [NJ Exec O] and that there was no report about it on [NJ Exec Order 2] MRR. Furthermore, the MD stated that she can not disagree more with the surveyor about the ABT (antibiotic) stewardship regulation and pharmacy review regulation that the facility should follow concerning the review of unnecessary medications should have been followed and that the irregularity should have been reported to the physician during the monthly MRR.

At that same time, the MD stated that "moving forward" she should document the justification for continued use of [NJ Exec O] according to the requirement of the regulation.

On 6/27/23 at 12:09 PM, the survey team met with the AVP (Assistant Vice President) of Access Management & Regulatory Affairs (AVPAMRA),

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Manager of Regulatory Affairs & Accreditation (MRAA), Director Of Nursing#1 (DON#1), DON#2, and the LNHA. The LNHA stated that there was no further information that the facility can share about the EES medication.

A review of the facility's Pharmacy-Pharmacist Consultation LTC Policy that was provided by DON#2 with an effective date of 01/01/23 included that the consulting pharmacist shall review each patient's drug regimen at least monthly. The monthly review of the patient's drug regimen shall include, but not be limited to, laboratory tests, dietary requirements, physician's and nurse's clinical notes, physician's orders, and progress notes. Potential adverse reactions, allergies, drug interactions, contraindications, rationally of therapy, drug therapy evaluation, and laboratory test modifications shall also be monitored.

On 6/27/23 at 01:11 PM, the survey team met with the LNHA, DON#1 and #2, Director of Therapy, AVPAMRA, and MRAA. There was no additional information provided by the facility management.

NJAC 8:39- 29.1(a), 29.3 (a)(1)

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	22249L	A. BUILDING: _____ B. WING _____	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDRENS SPECIALIZED HOSPITAL MOUNTAINSID	150 NEW PROVIDENCE ROAD MOUNTAINSIDE, NJ 07092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments THE FACILITY WAS IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES.	S 000		

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

Electronically Signed | 07/10/23

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
315239 Y1	A. Building B. Wing Y2	8/9/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDRENS SPECIALIZED HOSPITAL MOUNTAINSIDE	150 NEW PROVIDENCE ROAD MOUNTAINSIDE, NJ 07092

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 F0641	Correction	ID Prefix F0658	Correction	ID Prefix F0686	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed
LSC	07/31/2023	LSC	08/08/2023	LSC	08/01/2023
ID Prefix F0756	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/08/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
6/27/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315239	A. BUILDING **01** B. WING _____	**06/27/2023**

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CHILDRENS SPECIALIZED HOSPITAL MOUNTAINSIDE	**150 NEW PROVIDENCE ROAD** **MOUNTAINSIDE, NJ 07092**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 06/20/2023 and Childrens Specialized Hospital of Mountainside and 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 Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Childrens Specialized Hospital of Mountainside is a seven (7) story facility. The Existing Health Care Occupany section of the facility is two (2) levels (#B and #1 levels) Type II Protected building. The building has two smoke compartments on #1 level.	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available	K 222		7/11/23

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

Electronically Signed | 07/10/2023

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CHILDRENS SPECIALIZED HOSPITAL MOUNTAINSIDE	**150 NEW PROVIDENCE ROAD** **MOUNTAINSIDE, NJ 07092**

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K 222	Continued From page 1 to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout	K 222		

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K 222	Continued From page 2 by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 6/20/2023, it was determined that the facility failed to provide 2 (two) of 10 (ten) designated exit discharge doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. Findings include: On 6/20/2023 during the survey entrance at approximately 8:50 AM, a request was made to the AVP of Access Management and Regulatory Affairs and Director of Facilities (DOF) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility has two levels (#B level and #1 level) in the facility with 10 (ten) designated exit discharge doors (illuminated exit signs above doors) that Resident, Staff and Visitors would use in the event of an emergency to exit the building. Starting at approximately 9:17 AM, in the presence of the facility's DOF a tour of the facility was conducted.	K 222	1. No residents were found to have been affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practice. 3. A device will be installed by the Facilities Management Team to prevent the thumb lock/latch from engaging. 4. The Director of Facilities Management or their designee will report to the QAPI Committee at the next quarterly meeting the status of these locks.	

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K 222	Continued From page 3 During the building tour the of the facility, the surveyor inspected 10 (ten) designated exit discharge doors with the following results, 1) At approximately 10:10 AM, the surveyor observed on the #B level next to the Facilities Management office, one set of double automatic sliding exit discharge doors revealed a thumb turn lock on the egress side of the sets of doors. The thumb turn lock and fastening device on the door could restrict emergency use of the exit. The doors had a sign that read, Push here in the event of an emergency. Thumb turn locks and fastening device on the door could restrict emergency use of the exit. 2) At approximately 10:37 AM, the surveyor observed on the #1 level the Main Entrance two (2) sets of automatic sliding exit discharge doors (internal set of doors and external set of doors) revealed thumb turn locks on the egress side of both sets of doors. The thumb turn lock and fastening device on the door could restrict emergency use of the exit. The doors had a sign that read, Push here in the event of an emergency. Thumb turn locks and fastening device on the door could restrict emergency use of the exit. The DOF confirmed the findings at the time of observations. The surveyor informed the AVP of Access Management and Regulatory Affairs of the deficiency at the Life Safety Code exit conference on 06/21/2023 at approximately 9:33 AM.	K 222		

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K 222	Continued From page 4 NJAC 8:39 -31.2 (e) NFPA 101 2012 - 7.2.1.6.1 (4).	K 222		
K 341 SS=D	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility provided documentation on 6/20/2023, in the presence of the facility management, it was determined that the facility failed to provide fire alarm notification by audible and visible signals for one (1) of one (1) outside enclosed courtyards in accordance with NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9 The deficient practice was evidenced by the following:	K 341	1. No residents were found to have been affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practice. 3. A certified fire alarm company has been contracted by Children's Specialized Hospital to install an audible and visual fire alarm device in the affected area. 4. Upon completion of the installation and verification the Director of Facilities Management or their designee will report to the QAPI Committee at the next quarterly meeting	7/31/23

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K 341	Continued From page 5 On 6/20/2023 during the survey entrance at approximately 8:50 AM, a request was made to the AVP of Access Management and Regulatory Affairs and Director of Facilities (DOF) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility has two levels (level #B and level #1) with one (1) outside enclosed (surrounded by the building) center courtyard. Starting at approximately 9:17 AM, in the presence of the facility's DOF a tour of the facility was conducted. 1) At tour at approximately 10:43 AM, the surveyor observed in the enclosed outside courtyard, that the facility failed the have an audio and visual alarm to notify Resident, Staff and Visitors of an activation of the buildings fire alarm system. At this time the surveyor asked the DOF, "Do you have an audio and visual alarm tied into the buildings fire alarm system." The DOF looked around and said to the surveyor, "no." The DOF confirmed the findings at the time of observation. The surveyor informed the AVP of Access Management and Regulatory Affairs of the deficiency at the Life Safety Code exit conference on 6/21/2023 at approximately 9:33 AM. NJAC 8:39-31.2(a)	K 341		

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K 341	Continued From page 6 NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9	K 341		
K 351 SS=E	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 review of facility provided documentation on 6/20/2023, in the presence of facility management it was determined that: 1) The Facility failed to properly install sprinklers, as required by CMS regulation §483.90 (a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition, and as required by the New Jersey Uniform	K 351	1. No residents were found to have been affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practice. 3. A certified sprinkler company has been contracted by Children's Specialized Hospital to install a sprinkler head in the affected area. 4. Upon completion of the installation and verification the Director of Facilities Management or their designee will report	7/31/23

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K 351	Continued From page 7 Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. The deficient practice is evidenced by the following, On 6/20/2023 during the survey entrance at approximately 8:50 AM, a request was made to the AVP of Access Management and Regulatory Affairs and Director of Facilities (DOF) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility has two levels (level #B and level #1) with one stairwell that connects the two floors. Starting at approximately 9:17 AM, in the presence of the facility's DOF a tour of the facility was conducted. At approximately 10:30 AM, the surveyor observed no evidence of a fire sprinkler inside the B- level 6'- 9" by 11'- 6" lower stairwell landing. The DOF confirmed the finding at the time of observation. The surveyor informed the AVP of Access Management and Regulatory Affairs of the deficiency at the Life Safety Code exit conference on 06/21/2023 at approximately 9:33 AM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351	to the QAPI Committee at the next quarterly meeting	
K 511 SS=D	Utilities - Gas and Electric	K 511		7/11/23

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K 511	Continued From page 8 CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation on 6/20/2023, in the presence of facility management, it was determined that the facility failed to ensure that one (1) of four (4) electrical outlets located next to a water source (with-in 6 feet) was equipped with safe and secured Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: On 6/20/2023 during the survey entrance at approximately 8:50 AM, a request was made to the AVP of Access Management and Regulatory Affairs and Director of Facilities (DOF) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility has two levels (level #B and level #1) in the facility.	K 511	1. No residents were found to have been affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practice. 3. The affected outlet will be removed by a licensed electrician. 4. Upon completion of the installation and verification the Director of Facilities Management or their designee will report to the QAPI Committee at the next quarterly meeting	

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K 511	Continued From page 9 Starting at approximately 9:17 AM, in the presence of the facility's DOF a tour of the facility was conducted. Along the building tour the surveyor observed and tested four (4) electrical outlets (with-in 6 feet of a sink) in wet locations with a GFCI tester to de-energize the outlets. The surveyor observed the following, 1) At approximately 11:40 AM, the surveyor observed inside the level one Environmental Services porters closet, one Duplex electrical outlet located 47 inches to the left of the slop sink in the room. When the surveyor tested the Duplex electrical outlet with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. The DOF confirmed the findings at the time of observations. The surveyor informed the AVP of Access Management and Regulatory Affairs of the deficiency at the Life Safety Code exit conference on 6/21/2023 at approximately 9:33 AM. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 511		
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	K 521		6/29/23

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CHILDRENS SPECIALIZED HOSPITAL MOUNTAINSIDE	**150 NEW PROVIDENCE ROAD** **MOUNTAINSIDE, NJ 07092**

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K 521	Continued From page 10 specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations on 6/20/2023 in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for three (3) of four (4) Resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: On 6/20/2023 during the survey entrance at approximately 8:50 AM, a request was made to the AVP of Access Management and Regulatory Affairs and Director of Facilities (DOF) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility has 18 Resident sleeping rooms and various commons areas. Starting at approximately 9:17 AM, in the presence of the facility's DOF a tour of the facility was conducted. Along the tour the surveyor inspected and tested four (4) Resident sleeping rooms bathroom exhaust systems.	K 521	1. No residents were found to have been affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practice. 3. On 6/29/23 the energy recovery unit system was placed back in service. 4. Compliance of facility's ventilation systems for bathroom exhaust systems will be monitored by the Director of Facilities Management, or designee, in the form of direct observation and completion of the audit tool. There will be ten (10) observations per week until 100% compliance has been maintained for four (4) consecutive weeks. Then ten (10) observations per month until 100% compliance has been maintained for three (3) consecutive months. Audit reports will be submitted to the QAPI committee quarterly by the Director of Facilities Management or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315239	A. BUILDING **01** B. WING _____	**06/27/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDRENS SPECIALIZED HOSPITAL MOUNTAINSIDE	**150 NEW PROVIDENCE ROAD** **MOUNTAINSIDE, NJ 07092**

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K 521	Continued From page 11 This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in three (3) of four (4) resident bathrooms in the following locations: 1. At approximately 10:46 AM, inside Resident room #101 bathroom, when tested the exhaust system did not function properly. At this time, the surveyor informed the DOF that the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 2. At approximately 10:51 AM, inside Resident room #109 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 3. At approximately 11:01 AM, inside Resident room #107 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. The DOF confirmed the findings at the time of observations. The surveyor informed the AVP of Access Management and Regulatory Affairs of the	K 521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315239	A. BUILDING **01** B. WING _____	**06/27/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDRENS SPECIALIZED HOSPITAL MOUNTAINSIDE	**150 NEW PROVIDENCE ROAD** **MOUNTAINSIDE, NJ 07092**

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K 521	Continued From page 12 deficiency at the Life Safety Code exit conference on 6/21/2023 at approximately 9:33 AM. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		

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
315239 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	8/9/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDRENS SPECIALIZED HOSPITAL MOUNTAINSIDE	150 NEW PROVIDENCE ROAD MOUNTAINSIDE, NJ 07092

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 K0222	07/11/2023	LSC K0341	07/31/2023	LSC K0351	07/31/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0511	07/11/2023	LSC K0521	06/29/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
6/27/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO