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	315037	A. BUILDING _____ B. WING _____	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS Survey Date: 12/16/21 Census: 88 Sample: 21 + 3 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) complete a thorough investigation for a fall	F 610	How the corrective action will be accomplished for those residents found to be affected by the deficient practice?	1/30/22

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

Electronically Signed | 01/06/2022

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F 610	Continued From page 1 incident that was identified and documented on the Nurse's Notes (NN) from 9/24/21 through 9/25/21 for Resident#39 and b.) ensure that the physician and responsible party (RP) were notified and documented on 11/20/21 fall investigation for Resident#60. The deficient practice was evidenced for 2 of 3 residents reviewed for incident/accident. This deficient practice was evidenced by the following: 1. On 12/2/21 at 9:15 AM, during the tour, the surveyor observed Resident #39 sitting in a chair next to the South unit nursing station. A review of the Admission Record for Resident #39 revealed that the resident was admitted to the facility with diagnoses that included, but were not limited to: NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 A review of the Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate care management dated 9/16/21, indicated a Brief Interview for Mental Status (BIMS) scored at , which indicated that the resident had A review of Resident #39's NN revealed the following: NN dated 9/24/21 at 10:30 PM, reflected that the nurse was notified by a Certified Nursing Assistant (CNA) that Resident #39 was observed sitting on the floor by the entrance of the Television Room. The NN revealed that the resident denied falling and that the CNA observed	F 610	Investigate/Prevent/Correct Alleged Violation F610 CFR(s): 483.12(c)(2)-(4) F610-D Based on observation, interview, and record review, it was determined that the facility failed to a.) Complete a thorough investigation for a fall incident that was identified and documented on the Nurse's Notes (NN) from 9/24/21 through 9/25/21 for Resident#39 and b.) Ensure that the physician and responsible party (RP) were notified and documented on 11/20/21 fall investigation for Resident#60. The deficient practice was evidenced for 2 of 3 residents reviewed for incident/accident. Facility failed to complete a thorough investigation for a fall incident for residents #39 and resident's # 60 to ensure the responsible party were notified. Interdisciplinary Team will discussed and review all incident report from the previous day for completion of notification/documentation for both family and primary Physician. Incident report from September 2021 to current were reviewed and no other residents were affected with this deficient practice. How will the facility identify other residents having the potential to be affected by the deficient practice? All incident reports will be reviewed daily for notification and documentation.	

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F 610	Continued From page 2 urine on the floor and the notes further reflected that the floor was cleaned and that upon assessment of the resident, they found NJ Exe . NN dated 9/24/21 at 11:15 PM, revealed that the nurse observed the resident getting out of their wheelchair and started ambulating. The nurse observed Resident #39 limping and leaning to the right side. The NN further revealed that the physician was notified, and the nurse received an order to NJ Exec. Order 26:4.b.1 NN dated 9/25/21 at midnight revealed that Resident #39 was NJ Exec. Order 26:4.b.1 workers. NN dated 9/25/21 at 6:45 AM, revealed that Resident #39 returned from the ER with an NJ Exec. Order which indicated NJ Exec. Order 26:4.b.1 . Resident #39 was diagnosed with a NJ Exec. Order 26:4.b.1 On 12/6/21 at 12:30 PM, the surveyor reviewed Resident #39's Incident Report (IR) dated 9/24/21 at 10:30 PM. The IR did not contain information that was documented in the NN on 9/24/21 and 9/25/21. The Incident Report had no information regarding Resident #39 limping and leaning to the right side. There was no documentation that the resident was NJ Exec. Order 26:4.b.1 , or returned with a diagnosis of a NJ Exec. Order 26:4.b.1 On 12/07/21 at 1:25 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The LNHA acknowledged that Resident #39's Incident	F 610	All residents in the facility have the potential to be affected by this deficient practice. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? • All Licensed Nurses were reeducated regarding completion of investigation of fall Incident Reports. • Licensed Nurses were reeducated regarding accurate documentation and notification of resident's responsible party. • Interdisciplinary Team will review all Incident Reports in morning clinical meeting for completion and proper documentation and notification of responsible party and attending physician. • Unit Manager or primary nurse will review incident reports for documentation and notification, A follow up call will be made to notify family or responsible party How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and not recur? Director of Nursing or Unit Manager will review incident reports weekly for 3 months and monthly thereafter, for accuracy of documentation and notification. Results will be discussed in Monthly QAPI and will be a part of Facility Quarterly Quality Assurance Program.	

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F 610	Continued From page 3	F 610		

Report was incomplete and should have included all the information that was in the NN which included the nurse's observation of the resident limping and leaning to the right side, then [redacted], the [redacted] results and the resident's diagnosis of a [redacted].

2. On 12/6/21 at 9:23 AM, the surveyor reviewed the last four months' Incident/Accident Committee Meeting and Incident Report's that were provided by the LNHA and revealed that 2 out of 4 IR's were not completed appropriately. On the 11/20/21 IR the physician and the responsible party (RP) were not notified of the fall incident. On the 10/30/21 IR the RP was notified but not the physician of the fall incident.

On 12/6/21 at 9:26 AM, the surveyors interviewed the Regional MDS Nurse (RMDSN) and the MDS Nurse (MDSN). The MDSN informed the surveyors that as a facility practice, the assigned nurse would document and fill out the IR, the DON then will check and make sure that the form was filled out completely. The MDSN stated that the notification of physician and RP should have been documented in the IR. The surveyor informed the RMDSN and the MDSN of concerns regarding the IR's dated 10/30/21 and 11/20/21.

On 12/6/21 at 9:46 AM, the surveyor informed the Registered Nurse/Unit Manager (RN/UM) about the 10/30/21 and 11/20/21 IR concerns. Both the surveyor and the RN/UM were not able to locate documentation about the 11/20/21 notification of RP and the physician in the Nurses Notes (NN). On 10/31/21 NN reflected that the POA (Power of Attorney) was notified of the fall incident and that the physician was called. The RN/UM informed the surveyor that it was the responsibility of the

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F 610	Continued From page 4 DON to check the completeness of the IR. On 12/6/21 at 9:51 AM, the surveyor asked the DON in the presence of the RN/UM about the 11/20/21 IR concerns. The DON informed the surveyor that it was her responsibility to check the completeness of the IR and "it was an oversight on my part." She further stated that the nurses always notify the RP and the physician about "any incident, and I don't know why it was not documented." On 12/6/21 at 11:36 AM, the surveyor called and spoke to the POA on the phone. The POA informed the surveyor that the facility staff had called regarding the 11/20/21 fall incident and that "the facility was diligent when calling for any changes with the resident." On 12/6/21 at 11:38 AM, the surveyors met with Regional RN (RRN) #1, RRN#2, COO (Corporate Operation Officer), DON, and LNHA and were made aware of the above concerns. RRN#1 and the DON both stated that the physician was notified but not documented for the IR on 11/20/21, it should have been documented, and the IR should have been completed. A review of the facility's policy for Accidents and Incidents- Investigating and Reporting that was undated and was provided by the Regional Nurse indicated that "The disposition of the injured (i.e., transferred to hospital, put to bed, sent home, returned to work, etc.)." NJAC 8:39-4.1 (a) (5)	F 610		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		12/17/21

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F 658	Continued From page 5 §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, interviews, record review, and review of other facility documents it was determined that the facility failed to a.) ensure residents identified as elopement risks were wearing a physician's ordered wander guard (a device that allows residents to have freedom within their facility while providing security by "alarming" to prevent the resident from exiting the building unattended) and b.) ensure that Elopement Assessment's and care plan's were done according to facility policy and procedure and standards of clinical practice. This was identified for 3 of 11 residents (Resident #51, #56, and #47). 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."	F 658	How the corrective action will be accomplished for those residents found to be affected by the deficient practice? Services Provided Meet Professional Standards F658 CFR(s): 483.21(b)(3)(i) 483.21(b)(3) Comprehensive Care Plans F658—D Based on observation, interviews, record review, and review of other facility documents it was determined that the facility failed to a.) Ensure residents identified as elopement risks were wearing a physician's ordered wander guard (a device that allows residents to have freedom within their facility while providing security by "alarming" to prevent the resident from exiting the building unattended) and b.) Ensure that Elopement Assessment's and care plans were done according to facility policy and procedure and standards of clinical practice. This was identified for 3 of 11 residents (Resident #51, #56, and #47) Residents #51, #55 and #47 were assessed for the appropriate use of	

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F 658	Continued From page 6 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." 1. On 12/1/21 at 10:40 AM, the surveyor observed Resident #51 self-propelling a wheelchair on the South nursing unit. On 12/2/21 at 12:15 PM, the surveyor was conducting a record review on the South nursing station and overheard a Licensed Practical Nurse (LPN) #1 ask a Certified Nursing Assistant (CNA) #1 where the wander guard was for Resident #51's. On 12/2/21 at 12:20 PM, the surveyor observed Resident #51 in the Center unit dining room waiting for lunch to be served. The surveyor observed no wander guard on the resident's chair or the resident's ankle. The Director of Nursing (DON) was unable to find the wander guard and she told the surveyor that she will find out what happened to the resident's wander guard. On 12/2/21 at 12:30 PM, the surveyor interviewed LPN #1 who stated that Resident #51 was not wearing a wander guard and they were unable to find the resident's wander guard.	F 658	wander guard as evidenced by using the Elopement Risk Assessment. These 3 residents remains NJ Exec. Order 26 4.b.1 and requiring the use of wander guard. Physician Orders, and Care plan were updated and Wander Guard was placed to 3 residents. Facility Wander guard system was checked and verified for function. Supervisor or primary nurse will verify wander guard function every shift to ensure it is properly working, All new admission will be assessed for wandering/elopement, quarterly, Annually and if significant changes occurs. No other residents were affected with this deficient practice. How will the facility identify other residents having the potential to be affected by the deficient practice? All residents in the Facility have the potential to be affected by the deficient practice. Therefore, this applies to all residents (current and future). What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? All Licensed Nurses were reeducated regarding resident safety on the wander guard used.	

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F 658	Continued From page 7 On 12/2/21 at 12:40 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) regarding Resident #51 not having a wander guard and that LPN #1 was unable to locate the resident's wander guard. The LNHA stated that he sent a new wander guard to the unit and had it placed on the resident. On 12/2/21 at 12:45 PM, the surveyor observed Resident #51 eating lunch and the surveyor observed no wander guard on the resident. On 12/2/21 at 12:50 PM, the surveyor team went back to the Center unit dining room with the LNHA and observed Resident #51 with no wander guard. At that time, the LNHA had a facility nurse bring up a new wander guard and had it placed on Resident #51's ankle. A review of the resident's Face sheet (an admission summary) revealed that the resident was admitted to the facility with diagnoses that included NJ Exec. Order 26:4.b.1 and NJ Exec. O A review of the Quarterly Minimum Data Set (QMDS) dated 8/13/21, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec, which indicated that the resident had NJ Exec. Order 26:4.b.1 . In addition, it reflected that the resident used a "wander/elopement alarm" daily. A review of the resident's December 2021 Physician's Order Form (POF) revealed an order dated 10/25/18 for NJ Exec. Order 26:4.b.1 every shift with a Diagnosis NJ Exec. Order 26:4.b.1	F 658	All residents will be assessed for wandering/elopement on admission, quarterly, annually and if significant changes occurs All residents with wander guard will be reviewed quarterly or as needed. Residents using a wander guard will be checked for placement and function every shift using a “wander guard wand” All residents with wander guard will have and order and Care plan. A list of residents with wander guards will be posted in the Nurses station and in the receptionist area. Unit manager or Primary Nurse will check residents with wander guard weekly for documentation, function and care plan. Missing wander guard will be reported immediately for replacements. Facility will have at least 3 spare wander guard reserved in house. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and not recur? DON or Nurse will check wander guards for orders, placement, function and documentation weekly for 90 days and thereafter. Results will be discussed in morning clinical meeting for immediate resolution and this will be a part of	

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F 658	Continued From page 8 A review of the Treatment Record for December 2021 reflected the above physician's orders. The surveyor reviewed Resident #51's interdisciplinary care plan (IDCP) dated 11/5/20, under the Problem area which revealed that the resident was at risk for NJ Exec. Order 26:4.b.1 due to a history of NJ Exec. Order 26:4.b.1. The last Resident #51's evaluation revealed that the resident had NJ Exec. Order 26:4.b.1 and to proceed with the care plan. 2. On 12/2/21 at 1:11 PM, in the presence of another surveyor, the surveyor requested a list of residents who required wander guards from the DON. Thereafter, three surveyors accompanied the DON to verify that those resident's wander guards were in place. In the presence of the DON, two surveyors observed Resident #56 seated in a wheelchair at a table in the Center unit dining room. The DON checked the resident for wander guard placement and acknowledged to the surveyors that Resident #56 did not have a wander guard in place. The DON further stated that there had been no incidents of elopement reported for the facility. A review of the resident's Face Sheet (an admission summary) reflected that Resident #56 was admitted with diagnoses that included but were not limited to: NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1. A review of a QMDS dated 8/11/21, reflected that the resident had a BIMS score of NJE, which indicated that the resident had NJ Exec. Order 26:4.b.1 In addition, it reflected that the resident used a "wander/elopement alarm" daily.	F 658	monthly QAPI and quarterly Quality Assurance.	

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A review of the POF for December 2021 reflected an order for NJ Exec. Order 26:4.b.1 weekly on Fridays on (7-3) shift; check NJ Exec. Order 26:4.b.1 every shift", dated 11/12/20.

A review of the Treatment Record for December 2021 reflected the above physician's orders.

A review of the residents individualized Care Plan reflected a plan of care for NJ Exec. Order 26:4.b.1 updated 2/18/21 which reflected that the resident should NJ Exec. Order 26:4.b.1 ."

During review of the medical record, the surveyor could not find an "Elopement Risk Assessment."

3. In the presence of the DON, two surveyors observed Resident #47 in the Center unit dining room able to ambulate independently. The DON checked the resident for wander guard placement and acknowledged to the surveyors that Resident #47 did not have a wander guard in place. The DON further stated that there had been no incidents of elopement reported for the facility.

A review of the resident's Face Sheet (an admission summary) reflected that Resident #47 was admitted with diagnoses that included but were not limited to NJ Exec. Order 26:4.b.1 and, NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1

A review of the Comprehensive MDS dated 9/16/21 reflected that the resident had a BIMS score of NJ Exe which indicated that the resident had NJ Exec. Order 26:4.b.1 . In addition, it

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F 658	Continued From page 10	F 658		

reflected that used a NJ Exec. Order 26:4.b.1" daily.

A review of the POF for December 2021 reflected an order dated 9/4/21 for a NJ Exec. Order 26:4.b.1 to NJ Exec. Or for NJ Exec. Order 26:4.b.1 and to NJ Exec. Order 26:4.b.1 every shift.

A review of the Treatment Record for December 2021 reflected the above physician's orders.

A review of Resident #47's Interdisciplinary Care Plan (IDCP) dated 9/4/21, under the Problem area which revealed that the resident was NJ Exec. Order 2 due to NJ Exec. Order 26: and NJ Exec. Order 26 4.b.1. Under Evaluations, dated 9/4/21 revealed that Resident #47 had NJ Exec. Order 26:4.b.1 and can make his/her needs known. The resident was a NJ Exec. Order 26:4.b for NJ Exec. Order 26 4.b.1 and has a NJ Exec. Order 26:4.b.1 on the NJ Exec. Order 26:4.b.1. The resident's behaviors will be monitored.

During a review of the medical record, the surveyor could not find an "Elopement Risk Assessment."

On 12/2/21 at 2:29 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), the DON, and the Regional Nurse. At that time the LNHA, the DON and the Regional Nurse acknowledged that these residents did not have Elopement Risk Assessments. The Regional Nurse stated that the elopement assessment should be done upon admission to the facility for residents who were a high risk for elopement and then quarterly or in the event of a change. The DON was not aware of the Elopement Risk Assessment and was unaware of the assessment requirements.

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F 658	Continued From page 11 On 12/3/21 at 12:31 PM, the survey team met with the LNHA, the DON and two Regional Nurses. The administrative team again acknowledged that the three residents did not have Elopement Risk Assessments in their medical record. A review of the facility policy "Resident Alarms? Used of Wander guard" that was provided by the LNHA, with a review date of 11/21, reflected that "each resident should be assessed for elopement risk upon admission and periodically thereafter as part of the comprehensive assessment process. It also reflected that supervision should be provided to the resident in accordance with the residents' plan of care. When alarms are used additional monitoring should be provided such as verifying alarms are working properly." NJAC 8:39-11.2 (b)	F 658		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility	F 688		1/22/22

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F 688	Continued From page 12 receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and other facility documents it was determined that the facility failed to follow through with the resident's Restorative Nursing Program (RNP) for 2 of 2 residents (Resident #19 and 24), according to the facility's policy and procedure and standards of clinical practice. This deficient practice was evidenced by the following: 1. On 12/1/21 at 10:56 AM, the surveyor observed Resident #19 lying on the bed eyes closed, with a NJ Exec. Order 26:4.b.1 with NJ Exec in use. A review of the Physician's Oder Form (POF) for December 2021 with a list of residents' diagnoses included NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26 4.b.1 Further review of the November and December 2021 POF showed that there was no order for a NJ Exec. Order 26:4.b.1 or NJ Exec. Orde. A review of the 8/19/21, Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care, indicated a Brief Interview for Mental Status (BIMS) score of NJ Exec which reflected that the resident's cognition was NJ Exec. Order 26:4.b.1. The QMDS indicated	F 688	How the corrective action will be accomplished for those residents found to be affected by the deficient practice? Increase/Prevent Decrease in ROM/Mobility F688 CFR(s): 483.25(c)(1)-(3) F688-D 483.25(c) Mobility. 483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; Based on observation, interview, record review and other facility documents it was determined that the facility failed to follow through with the resident's Restorative Nursing Program (RNP) for 2 of 2 residents (Resident #1 and 24), according to the facility's policy and procedure and standards of clinical practice. Both resident #19 and resident #24 were re –evaluated by Occupational Therapy to	

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F 688	Continued From page 13 that the resident had NJ Exec. Order 26:4.b.1 in range of motion and NJ Exec. Order 26:4.b.1 . A review of the Screen/Referral Form (S/RF) dated 11/19/21, for a Quarterly review showed a recommendation to continue the use of a NJ Exec. Order 26:4.b.1 as NJ Exec. Order 26:4.b.1 for NJ Exec. Order 26:4.b.1 A review of the Interdisciplinary Team Care Plan Conference (ITCPC) for annual review dated 8/26/21, revealed that the resident remained NJ Exec. Ord with NJ Exec. Order 26:4.b.1 and there were no NJ Exec. Order 26:4.b.1 . A review of the personalized care plan showed that there was a care plan problem identified on 11/17/20 for a NJ Exec. Order 26:4.b.1 with an intervention that included NJ Exec. Order 26 4.b.1 discharge on 11/23/20. Patient to NJ Exec. Order 26:4.b.1 ." A review of the Certified Nursing Aide (CNA) Accountability Form for November and December 2021 did not include accountability for a NJ Exec. Order 26:4.b.1 to be applied to the resident. On 12/7/21 at 10:19 AM, the surveyor observed the resident seated in a regular chair in the dining area with other residents with a cane beside the resident. The resident had NJ Exec. Order 26 4.b.1 or NJ Exec. Orde in use. On 12/7/21 at 10:41 AM, the surveyor interviewed the Registered Nurse/Supervisor (RN/S) in the presence of the Staffing Coordinator. The RN/S informed the surveyor that as a facility practice when the resident was discharged (d/c) from rehab, the rehab staff will recommend if the	F 688	ascertain appropriateness of current interventions. Resident # 19 and resident #24 were picked up for NJ Exec. Order 26:4.b.1 . All residents was assessed and reevaluated for mobility and function and no other residents were affected with this deficient practice. How will the facility identify other residents having the potential to be affected by the deficient practice? All residents in the facility have the potential to be affected by the deficient practice. Therefore, this applies to all residents (current and future). What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? Rehabilitation staff will use a communication form to be given to Licensed Nurses when a residents is on a rehab program. Facility Procedure was reviewed with staff on how to communicate to Nursing Department following the discontinuation of the skilled services. Rehabilitation staff will demonstrate the proper use of any devices to residents. Nursing staff will signed the education	

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F 688	Continued From page 14 resident was appropriate for splinting, ambulation, and ROM (range of motion) to be included in the restorative program. The RN/S stated that the nurse will then notify the physician with the recommendation, "which the doctor will 100% agree with the therapist's recommendations, the order will be placed, transcribed to the TAR (Treatment Administration Record), to the CNAs accountability, and should be in the care plan as well." On that same date and time, the surveyor and the RN/S reviewed the 11/19/21 S/RF for recommendation to continue the use of the NJ Exec. Order 26:4.b.1 as tolerated for NJ Exec. Order 26:4.b.1 . The RN/S stated "I don't know" what happened why there was no order for a NJ Exec. Order 26:4.b.1 . She further stated that "It should have been in the CNAs accountability and TAR for nurses to sign." On 12/7/21 at 11:08 AM, the Licensed Practical Nurse (LPN) informed the surveyor that CNA#1 assigned to the resident was not available for an interview. The LPN stated that there should be an order from the doctor concerning the NJ Exec. Order 26 4.b.1 of the resident, transcribed to the TAR, and "it was missed." The LPN acknowledged that the resident had no NJ Exec. Order 26:4.b.1 when the surveyor observed the resident on 12/1/21 and 12/7/21. On 12/7/21 at 1:08 PM, the surveyors interviewed the Physical Therapist/Rehab Director (PT/RD). The PT/RD informed the surveyors that the facility had a functional maintenance program (FMP). The PT/RD stated that once the resident was d/c from therapy and remained in Long Term Care, the resident would be on FMP and an Alert Form would be given to nursing on the floor, and	F 688	form. . A licensed nurses will verify orders with the attending physician and will transcribed appropriately in the TAR or in the CNA accountability book for signatures. Care Plan will be personalized to include appropriate intervention, and devices used for residents to maintain the maximum practicable independence. Range of motion to be included in the restorative program. Unit manager or Rehab Director will review resident's clinical records for proper documentation and to ensure residents is using proper devices recommended by rehabilitation staff. This will be done weekly x 90 days and thereafter, Results will be discussed in daily clinical meeting. Unit manager and primary nurse will check appropriate devices during clinical rounds 2x a week and results will be discussed with interdisciplinary team for immediate resolution. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and not recur? Interdisciplinary Team will review weekly all residents on skilled Services during Utilization Review.	

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F 688	Continued From page 15 the Unit Manager would be given a copy that would be part of the resident's medical record. The PT/RD further stated that it was the responsibility of the nurse to call the doctor for recommendations and to obtain an order for a splint, ambulation, and ROM. The PT/RD indicated that "there was no situation that the doctor did not agree upon our recommendations." 2.On 12/1/21 at 11:00 AM, the surveyor observed Resident#24 laying on a bed with a NJ Exec. Order 26:4.b.1 and told the surveyor NJ Exec. Order 26:4.b.1 " that was why the resident indicated that they can not NJ Exec. Order 26:4.b.1 . The resident denied refusing a NJ Exec. Order On 12/3/21 at 11:18 AM, the surveyor observed the resident laying on a bed with no NJ Exec. Orde in use to their NJ Exec. Order 26:4.b . CNA#2 came out of the resident's room and informed the surveyor that Resident#24 was NJ Exec. Order 26:4.b.1 with some NJ Exec. Order 26:4.b.1 required extensive assistance with activities of daily living (ADLs), set up with meals due to the NJ Exec. Order 26:4.b.1 . CNA#2 stated that the resident had no NJ Exec. Orde to the NJ Exec. She further stated that the NJ Exec. Order 26:4.b. was not something new to the resident and "the resident came with it." A review of the resident's Face sheet (an admission summary) disclosed that the resident had diagnoses that included NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 A review of the Comprehensive Minimum Data Set (CMDS), dated 8/24/21, indicated a BIMS score of NJ Exec , indicating that the resident's	F 688	Rehabilitation Director and Director of Nursing will review all residents in the skill services and those that are in the maintenance program weekly for 90 days and thereafter. Findings will be discussed in monthly QAPI and will be a part of Facility quarterly Quality Assurance Program.	

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F 688	Continued From page 16 cognition was NJ Exec. Order. The CMDS further indicated that the resident had NJ Exec. Order 26:4.b.1 A review of the December 2021 POF showed that there was no order for a NJ Exec. Order 26:4.b.1. A review of the Initial ITCPC dated 8/27/21 showed that the resident was NJ Exec. Order 26:4.b.1 with a history of NJ Exec. Ord, the Rehab/Therapy Resident's Rehabilitative status includes NJ Exec. Order 26:4.b to NJ Exec. Order 26:4.b.1. A review of the 9/16/21 OT Discharge Summary included "pt (patient) will tolerate NJ Exec. Order 26 4.b.1 NJ Exec. Order 26:4.b.1. Baseline 8/16/21 NJ Exec. Order 26 4.b.1, previous 9/16/21 NJ E, Discharge 9/16/21 NJ Exec. Order 26:4.b.1 hrs (hours)." A review of the personalized care plan did not include interventions for NJ Exec. Order 26:4.b.1. A review of the CNA Accountability Form for November and December 2021 did not include accountability for a NJ Exec. Order 26:4.b.1 to be applied to the resident. On 12/7/21 at 10:41 AM, the surveyor interviewed the RN/S while both reviewing the resident's medical record. The RN/S stated "I don't know" why the OT Discharge Summary dated 9/16/21 for a NJ Exec. Order 26:4.b.1 for NJ Exec. Orde was not ordered, not in the care plan, and was not ordered to reflect on the November and December 2021 TAR. She further stated that the NJ Exec. Order 26:4.b.1 should have been documented in the CNAs Accountability Form.	F 688		

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F 688	Continued From page 17	F 688		

On 12/7/21 at 11:08 AM, the LPN informed the surveyor that there should have been an order from the doctor about the resident's NJ Exec. Order 26:4.b. transcribed to the TAR, and "it was missed." The LPN acknowledged that the resident had no NJ Exec. Order 26:4.b.1 when the surveyor observed the resident on 12/1/21, 12/3/21, and 12/7/21.

On 12/7/21 at 1:08 PM, the PT/RD informed the surveyor that the resident had no behavior of refusing a NJ Exec. Order The PT/RD further stated that the resident was admitted to the facility with a NJ Exec. Order 26:4.b.1, was not something new to the resident, and had NJ Exec. Order 26:4.b.1

On 12/8/21 at 10:36 AM, the surveyors met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Regional Registered Nurse#1 and 2 (RRN#1 and 2), and Corporate Operation Officer (COO) and were made aware of the above concerns. The COO stated "we spoke to rehab director and the rehab staff failed to notify the nursing department about the Rehab Alert," and the recommendation from the S/RF on 11/19/21 for Resident#19 and #24 on OT Discharge Summary on 9/16/21. The COO informed the surveyors that there was a communication problem, and that the therapist should have communicated the recommendations with nursing "not just putting the paper in the chart," so that the nurse could have called the physician for an order. The COO further stated that there was no NJ Exec. Order 26: and NJ Exec. Orde to Resident #19 and 24.

A review of the facility Restorative Nursing Programs with an effective date of 10/2018, that

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F 688	Continued From page 18 was provided by the LNHA included "It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. Policy Explanation and Compliance Guidelines: ...5. Residents, as identified during the comprehensive assessment process, will receive services from restorative aides when they are assessed to have a need for such services. These services may include: a. Passive or active range of motion. b. Splint or brace assistance ....6. Residents may receive Level II restorative nursing services upon admission when not a candidate for specialized rehabilitation services, when restorative needs arise during the course of a longer-term stay, in conjunction with specialized rehabilitation therapy, or upon discharge from therapy ...8. The discharging therapist, Restorative Coordinator, or designated licensed nurse will communicate to the appropriate restorative aide, the provisions of the resident's restorative nursing plan, providing any necessary training to carry out the plan ...." On 12/8/21 at 1:14 PM, the LNHA informed the surveyors that there was no additional information.	F 688		
F 761 SS=D	NJAC 8:39-27.1 (a), 27.2 (m) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		12/30/21

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F 761	Continued From page 19 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to properly label, store and dispose of medications in 1 of 3 medication carts and in 2 of 3 medication refrigerators inspected. This deficient practice was evidenced by the following: On 12/07/21 at 11:55 AM, the surveyor inspected the North unit medication refrigerator in the presence of a Licensed Practical Nurse (LPN) #1 which was in the North unit nursing station unlocked. The North unit medication refrigerator contained insulin, Purified Protein Derivative (PPD) and a narcotic lockbox (it was locked and affixed to the refrigerator) that contained Ativan topical gel and Ativan intramuscular vials. The	F 761	How the corrective action will be accomplished for those residents found to be affected by the deficient practice? Label/Store Drugs and Biologicals F761 CFR(s): 483.45(g)(h)(1)(2) 483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 483.45(h) Storage of Drugs and Biologicals 483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	

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F 761	Continued From page 20 surveyor interviewed LPN #1 who stated that the medication refrigerator should have been locked. On 12/07/21 at 12:15 PM, the surveyor inspected the South unit medication refrigerator in the presence of a Registered Nurse (RN) #1. The surveyor observed the South unit medication refrigerator thermometer at 26 degrees Farhenheit (F). The surveyor reviewed the South unit temperature log which had a temperature for 12/7/21 at 34 degrees F. The temperature log also revealed that the refrigerator temperature should be between 36 degrees and 46 degrees F. The surveyor interviewed RN #1 who stated that the temperature inside the South unit medication refrigerator was too cold and that the proper refrigerator temperature for medication should be between 36 to 46 degrees F. RN#1 also stated that she would call maintenance to check the refrigerator. A review of the November 2021 Consultant Pharmacist's Nursing Station Inspection Checklist revealed that the South unit medication refrigerator temperature was not between 36 to 46 degrees F. On 12/7/21 at 1:00 PM, the surveyor inspected the Center unit medication cart in the presence of LPN #2. The surveyor observed an opened Levemir insulin vial that was not dated. The surveyor interviewed LPN #2 who stated that an opened Levemir Insulin should have been dated. On 12/8/21 at 9:15 AM, the surveyor inspected the South unit medication refrigerator in the presence of RN #2. The surveyor observed the medication refrigerator thermometer with a temperature around 26 to 27 degrees F. The	F 761	biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. Based on observation, interview, and record review, it was determined that the facility failed to properly label, store and dispose of medications in 1 of 3 medication carts and in 2 of 3 medication refrigerators inspected. All medication refrigerators were checked for safety storage of biologicals. Must have a double locked and medication refrigerators temperature must be between 36 degrees and 46 degrees F. The unlocked fridge identified was checked by the maintenance director and was identified that the refrigerator was not working properly and this was immediately replaced with the new refrigerator. Staff on duty was counselled for not following the proper procedure of locking the refrigerator when unattended. Unlocked refrigerator was replaced and was locked. All refrigerators were checked to ensure they are properly locked. The undated Levemir vial identified in this deficient practice was properly disposed by two Registered Nurses. Pharmacy and MD were notified for replacement of Lavemir. All 3 medication carts were reviewed for proper storage and labelling of medications.	

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F 761	Continued From page 21 surveyor interviewed RN #2 who stated that the medication refrigerator was not working properly and that all the South unit refrigerated medications were moved to the North unit medication refrigerator. A review of the Manufacturer's Specifications for the following medications revealed the following: 1. Levemir Insulin vial once opened had an expiration date of 42-days. On 12/08/21 at 10:30 PM, the surveyor met with the Licensed Nursing Home Administrator and the Director of Nursing (DON) and no further information was provided by the facility. A review of the facility's policy for Storing Medications that was undated and was provided by the DON indicated the following: "Medications are to be stored at proper temperature. Medications requiring storage at room temperature are to be stored at a temperature of not less than 15 degrees Celsius (59 degrees Fahrenheit) or more that 30 degrees Celsius (86 degrees Fahrenheit). Medications requiring refrigeration are to be stored at a temperature not less than 2 degrees Celsius (36 degrees Fahrenheit) or more than 8 degrees Celsius (46 degrees Fahrenheit). A medication requiring storage in a cool place may be stored in the refrigerator unless otherwise specified on the label. A thermometer is kept in the refrigerator containing medications to measure proper temperatures." "Medications are stored in an orderly manner in cabinets, drawers, or carts of sufficient size to	F 761	All Facility non-controlled medications were checked and it was stored in a locked cabinet or in a room in accessible to residents and visitors. All Facility Controlled Dangerous Substances are stored separately from Non – Controlled under double lock. Facility, label. Storage of biologicals were reviewed and no other residents were affected of this deficient practice. How will the facility identify other residents having the potential to be affected by the deficient practice? All residents in the facility have the potential to be affected by this deficient practice. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? Licensed Nurses will be re-educated regarding the policy and procedure of the storage of biologicals. The Unit manager and the 11-7 supervisor will check medication refrigerators daily for the accuracy of temperature readings and to ensure it is properly locked and that all medications were properly labelled. Maintenance will be notified for immediate repair or replacement when needed.	

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F 761	Continued From page 22 prevent crowding. All medications and other drugs, including treatment items are stored in a locked cabinet or room inaccessible to the residents and visitors." A review of the facility's policy for Controlled Substances that was undated and was provided by the DON indicated the following: Storage of Controlled Substances indicated the following: "All substances in schedules II, III, IV and V of the Controlled Dangerous Substances Act shall be stored separate from non-controlled under double lock." NJAC: 8:39-29.4 (a) (h) (d)	F 761	The Pharmacy Consultant will check all medication carts and refrigerators monthly for proper labelling and storage. The Pharmacy Consultant will also ensure refrigerator temperatures are in an acceptable temperature range. The Regional nurses will conduct weekly audits of medication carts and refrigerators for proper labeling of medications, storage and refrigerator temperatures. The findings will be discussed in morning meeting for immediate resolution. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and not recur? The Director of Nursing or Unit Manager will conduct daily rounding for 1 month then weekly x 90 days and thereafter. Therefore, the Inspection for the Storage of Biologicals will be discussed in monthly QAPI and will be a part of the facility quarterly Quality Assurance program.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		1/30/22

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F 812	Continued From page 23 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of documentation provided by the facility, it was determined that the facility failed to a.) properly date, store and dispose of potentially hazardous and dry foods in a manner to prevent food borne illness and b.) maintain the kitchen environment and equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development a food borne illness. This deficient practice was observed and evidenced by the following: On 12/01/21 at 10:42 AM, during the initial tour of the kitchen in the presence of the Food Service Director (FSD), the surveyor observed the following: 1. Five broken floor tiles and a missing tile in the dish machine area. 2. A white epoxy covered chipped and rust colored wall mounted wire rack. The rack was directly over the three compartment sinks for	F 812	How the corrective action will be accomplished for those residents found to be affected by the deficient practice? F812 Procurement, Store/Prepare/Serve- F812 Sanitary CFR(s): Based on observation, interview, and review of documentation provided by the facility, it was determined that the facility failed to a.) Properly date, store and dispend dry foods in a manner to prevent food borne illness and b.) Maintain the kitchen environment and equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development a food borne illness. Surveyor□s initial tour of the kitchen in the presence of the Food Service Director (FSD),	

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F 812	Continued From page 24 rinsing and sanitizing. The FSD acknowledged that there was a potential for cross contamination. 3. Two pieces of clear plastic used to tie the sanitizer solution tubing to the sink faucet. One of the plastic pieces had a heavy buildup of a black substance which was hanging directly over the sanitizing sink. The FSD acknowledged that there was a potential for cross contamination. 4. An air-drying rack which had sticky black debris on four shelves which the FSD was able to remove with a clean paper towel. The FSD acknowledged that the shelves "wasn't clean but should be." In addition, there were three inverted muffin pans which had an unidentified white substance that the FSD was able to remove with his hand. There was also a 1/3 sized restaurant pan lid which had a sticky buildup on the underside . The FSD stated that it was "not clean and should not have been on the rack." At 11:04 AM, in the presence of the FSD, the surveyor observed the following: 5. A Cook washed and rinsed a blender canister in the wash sink of the three-compartment sink; instead of washing, rinsing and properly sanitizing in three separate dedicated sinks. The FSD had previously stated that the three-compartment sink had been used to wash pots earlier that morning but was currently not set up for use. In the presence of the FSD, the surveyor interviewed the Cook who stated that he did not sanitize the blender canister and that the sanitizer should have been "70 parts per billion" and "I did not use a test strip." The Cook further stated that he had been employed for four weeks and was not educated on how to properly use the	F 812	the surveyor observed the following: 1. Five broken floor tiles and a missing tile in the dish machine area. Missing tiles was replaced by facility Maintenance Director. Dietary staff will inform their supervisor for any broken tiles and this will be noted in the maintenance log for immediate repair. Dietary supervisor will check the maintenance log book daily to follow up any job order. 2. A white epoxy covered chipped and rust colored wall mounted wire rack. The rack was directly over the three compartment sinks for rinsing and sanitizing. The FSD acknowledged that there was a potential for cross contamination. These rusty, chipped colored wall was removed and replaced. 3. Two pieces of clear plastic used to tie the sanitizer solution tubing to the sink faucet. One of the plastic pieces had a heavy buildup of a black substance which was hanging directly over the sanitizing sink. The FSD acknowledged that there was a potential for cross contamination. This piece of clear plastic was replaced by the chemical supplier company the next day after inspection. 4. An air-drying rack which had sticky black debris on four shelves. Air drying rack was cleaned immediately and Dietary staff were reeducated regarding proper cleaning after each used.	

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F 812	Continued From page 25 three-compartment sink. At 11:12 AM, in the presence of the FSD, the surveyor observed the following in the walk-in refrigerator: 6. An opened five-gallon bottle of BBQ sauce with no opened date and an opened five-gallon bottle of French dressing with a "best if used by date" of 2/5/21. 7. Seven opened packages of cheese with no opened date (one five-pound package of sliced Cheddar cheese, one five-pound package of shredded Cheddar cheese, four five-pound packages of sliced yellow American cheese and one five-pound package of sliced white American cheese). The FSD acknowledged there should have been opened dates on the packages to know if the cheeses could still be consumed. 8. Two fan covers with a heavy build up of a black fuzzy substance. The FSD acknowledged that the substance could dislodge from "air blowing and go onto the food." 9. Ice buildup on the condenser. 10. Sticky white and black debris (which could be wiped off with a paper towel) on all of the wire racks in the refrigerator (four racks with five shelves each and one rack with four shelves). On continuation of the tour in the presence of the FSD, the surveyor observed the following: 11. A five well portable steam table used to serve resident meals which was not in use. There was a heavy buildup of food splatter and debris on the	F 812	5. A Cook washed and rinsed a blender canister in the wash sink of the three-compartment sink; instead of washing, rinsing and properly sanitizing in three separate dedicated sinks. Cook was educated on how to use the 3 sink compartment using the right PPM of the 3rd compartment sink. A guide on how to test the chemicals using the test strip was posted on the wall. The blender was washed and properly sanitized in a three □compartment sink. 6. An opened five-gallon bottle of BBQ sauce with no opened date and an opened five-gallon bottle of French dressing with a "best if used by date" of 2/5/21. 5 Gallon of bottle BBG sauce was discarded. 7, Seven opened packages of cheese with no opened date (one five-pound package of sliced Cheddar cheese, one five-pound package of shredded Cheddar cheese, four five-pound packages of sliced yellow American cheese and one five-pound package of sliced white American cheese). All expired cheese were discarded and replaced with new items labelled with common names and dates of delivery and date opened. 8. Two fan covers with a heavy buildup of black fuzzy substance, Maintenance Detector cleaned the fan cover.	

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F 812	Continued From page 26 underside of the metal shelf which was directly over the food wells. 12. An opened bag of ziti pasta with no opened date and an opened bottle of "gravy aide" with no opened date on the spice rack. 13. A wall mounted knife rack which had a buildup of debris. 14. The hood over the cooking equipment which had seven baffles (a device used to restrain the flow of a fluid, gas, or loose material) that had a heavy sticky build up of what the FSD described as "grease" and "dust". The substance was able to be wiped off with a paper towel. 15. In the dry storage area, there were five opened bags of pasta with no opened dates (one ziti, two elbow, one bowtie, and one fine noodles). A review of the facility policy "Cleaning and Sanitizing", with a revised date of 4/30/20, reflected that all food contact surfaces need to be cleaned and sanitized to reduce the number of pathogens to a safe level. It also reflected that to clean and sanitize equipment, food should be scraped or removed from the equipment surfaces, washed and rinsed with clean water and then sanitized. It reflected that when storing clean and sanitized tableware and equipment they must be on a clean and sanitized shelf or rack. It further reflected that nonfood-contact surfaces should be cleaned regularly to prevent dust, dirt, food residue and other debris from building up. A review of the facility policy "Three Compartment Sink", with a revised date of 7/1/20, reflected that	F 812	9. Ice buildup on the condenser. The ice buildup was cleaned right away by the maintenance director. 10. Sticky white and black debris (which could be wiped off with a paper towel) on all of the wire racks in the refrigerator (four racks with five shelves each and one rack with four shelves). The rack was cleaned and sanitized , 11. A five well portable steam table used to serve resident meals which was not in use. There was a heavy buildup of food splatter and debris on the underside of the metal shelf which was directly over the food wells. This was immediately cleaned by dietary staff. 12. An opened bag of ziti pasta with no opened date and an opened bottle of "gravy aide" with no opened date on the spice rack. All items with no dates were discarded and replaced. 13. A wall mounted knife rack which had a buildup of debris. Knife rack was cleaned. 14. The hood over the cooking equipment which had seven baffles (a device used to restrain the flow of a fluid, gas, or loose material) that had a heavy sticky buildup of what the FSD described as "grease" and "dust". The substance was able to be wiped off with a paper towel.	

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F 812	Continued From page 27 the process is five step to clean and sanitize all kitchen wares which include washing, rinsing and sanitizing separately. In addition, it reflected that the sanitizer should be a Quaternary Ammonium solution with a measurement of 200-400 parts per million. A review of an undated facility "Cleaning Schedule" reflected that a "6:00-2:00" shift employee should "date and label everything inside the walk-in refrigerator." NJAC 8:39-17.2 (g)	F 812	The hood over the cooking equipment□s was cleaned. 15. In the dry storage area, there were five opened bags of pasta with no opened dates (one ziti, two elbow, one bowtie, and one fine noodles Items that are opened were discarded and replaced All food items that were undated, opened were discarded. Equipment, hoods, portable steam table, fan cover, table with heavy buildup of sticky grease, and dust were cleaned and sanitized. Kitchen was thoroughly cleaned by house keeper and dietary staff. No other residents were affected of this deficient practice. How will the facility identify other residents having the potential to be affected by the deficient practice? All residents in the Facility have the potential to be affected by the deficient practice. Therefore, this applies to all residents (current and future). What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? All dietary staff were reeducated on proper dating for food items, store, and	

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F 812	Continued From page 28	F 812	proper disposal of potentially hazardous and dry foods to prevent food borne illness and to maintain kitchen environment and equipment in a sanitary manner to prevent contamination from foreign substances and potential for development of food borne illness. Dietary staff were reeducated regarding the use of 3 sink compartment. Dietary staff will be able to demonstrate the right PPM (Parts Per Million) of sanitizing chemicals in the 3rd compartment and staff was able to follow the correct procedure on how to test the sanitizer with a test trip. (litmus paper) A cleaning schedule was developed for kitchen staff to follow every day. Maintenance Director will rounds weekly to check the tiles, flooring, and other equipment that are not working or defective. This will be reported to the administrator for immediate resolution. Maintenance Director and Food Service Director will rounds weekly to check all supplies to ensure it is dated accordingly. Regional Registered Dietician will observed staff assigned in the 3 sink compartment weekly x90 days and thereafter on a proper procedure of	

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F 812	Continued From page 29	F 812	checking the PPM of the sanitizer Regional Director or dietary supervisor will in-service and demonstrate to new employee for proper procedure of checking the PPM of the sanitizer. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and not recur? Administrator and food Services Director will conduct a weekly rounds x90days and thereafter, to check overall sanitation, Infection Control, and proper dating of food items. Findings will be discussed in Facility QAPI and will be a part of Facility Quarterly Quality Assurance program.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 842		1/30/22

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F 842	Continued From page 30 (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services	F 842		

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F 842	Continued From page 31 provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain complete, accurate, and readily accessible medical records. This deficient practice was identified for 2 of 24 residents reviewed, Resident#12 and 63 and was evidenced by the following: 1. On 12/2/21 at 9:50 AM, the Director of Nursing (DON) in the presence of the Regional Registered Nurse (RRN) #1) informed the surveyor that Resident#12 was "probably" walking around that was why the resident was not in their room. The DON further stated that the resident had a diagnosis of NJ Exec. Order 26:4.b.1 On that same date at 9:52 AM, the Certified Nursing Aide (CNA) informed the surveyor that the resident had NJ Exec. Order 26 4.b.1, was able to walk independently without an assistive device and was on supervised smoking. On 12/2/21 at 9:56 AM, the Registered Nurse/Unit Manager (RN/UM) informed the surveyors that Smoking Assessment was "probably in the care plan," and it was the Minimum Data Set Nurse (MDSN) responsibility to do the Smoking Assessment.	F 842	How the corrective action will be accomplished for those residents found to be affected by the deficient practice? Resident Records - Identifiable Information F842 CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) 483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in Resident Records - Identifiable Information F842 Based on observation, interview, and record review, it was determined that the facility failed to maintain complete, accurate, and readily accessible medical records. This deficient practice was identified for 2 of 24 residents reviewed, Resident#12 and 63 and was evidenced by the following: Resident #12 was found with missing smoking and elopement assessment as per facility policy. This was corrected	

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F 842	Continued From page 32 A review of the resident's Face sheet (an admission summary) disclosed that the resident had diagnoses that included NJ Exec. Order 26:4.b.1 [redacted], and NJ Exec. Order 26:4 [redacted]. A review of the Comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate care management dated 5/7/21, indicated a Brief Interview for Mental Status (BIMS) score of [redacted], indicating that the resident's cognition was NJ Exec. Order 26:4.b.1 [redacted]. The CMDS further indicated that the resident was a smoker and with a wander guard. There was a smoking care plan that included an intervention for supervised smoking. A review of the medical records showed that the Resident Smoking Assessment was incomplete, the last assessment was done on 2/7/21, which was previously being done quarterly. Also, there was no Resident Smoking Assessment after 2/7/21 and there was no Elopement Risk Assessment. On 12/2/21 at 10:00 AM, the MDSN showed to the surveyors the Smoking Assessment from the resident's chart and the last assessment was completed on 2/7/21. The MDSN informed the surveyors that it was her responsibility to do a quarterly Smoking Assessment and it "should be in the resident's chart." The MDSN stated, "it's probably in my office because there were documents that are still in my office for filing." At that same time, the surveyors and the MDSN went to her office and she informed the surveyors that before the transition of the facility to a new company, she was also the acting Assistant	F 842	during survey. Resident #12 was re assessed for smoking and elopement. Assessment was filed in resident's clinical record. Resident #63 NJ Exec. Order 26:4 [redacted] communication book was incomplete as evidenced by no documentation NJ Exec. Order 26 4.b.1 [redacted]. All residents' charts were reviewed for smoking and elopement assessment. These was completed and was placed in resident's clinical record, ready and accessible for review. All residents that goes to NJ Exec. Order 26:4 [redacted] their communication book was reviewed for completeness and accuracy. Active Charts were reviewed for readiness and accessibility. No other residents were affected of this deficient practice. How will the facility identify other residents having the potential to be affected by the deficient practice? All residents in the Facility have the potential to be affected by the deficient practice. Therefore, this applies to all residents (current and future). What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? Licensed Nurses were reeducated	

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F 842	Continued From page 33 Director of Nursing (ADON) when the previous ADON left. The MDSN showed to the surveyors a folder with documents for filing, which included a paper for Resident#12's Resident Smoking Assessment dated 5/13/21 and 8/19/21. There was no Resident Smoking Assessment for November 2021 and the MDSN stated: "it was missed." On 12/2/21 at 1:11 PM, the DON in the presence of RRN#2 provided the surveyors a list of residents with a wander guard that included Resident#12. On 12/2/21 at 2:29 PM, the surveyors met with RRN#1, DON, and the Licensed Nursing Administration (LNHA) and were made aware of the above concerns. Both the LNHA, DON, and RRN#1 acknowledged that there was no Elopement Assessment. RRN#1 informed the surveyors that the elopement assessment should be done upon admission on residents high risk for elopement when there is a change, "or quarterly by law during quarterly and annual MDS." RRN#1 further stated that since the new company acquired the facility, they were in the process of checking the requirements with the assessment to comply with the regulations. RRN#1 indicated that the wander guard should be in the care plan. On 12/3/21 at 12:31 PM, the surveyors met with the LNHA, RRN#1 and 2, DON, and Regional Food Service Director (RFSD). Both the LNHA and RRN#1 acknowledged that yesterday on 12/2/21, there was no Elopement Assessment in the medical records of the resident. On 12/6/21 at 9:26 AM, the surveyors interviewed	F 842	regarding the completion of assessment (Smoking and elopement) in a timely manner. The Unit manager and Primary Nurse will review resident assessments during admission, quarterly, annually and when significant changes occurs to ensure resident clinical records are complete, accurate and readily accessible and systematically organized. Licensed Nurses were re in serviced regarding the completion of the HD Communication sheet pre- and post-dialysis. Unit manager will review the communication sheets daily to ensure it is accurate and recommendations were being followed up as indicated. The Primary nurses will review and complete the post dialysis form upon return from NJ Exec. Order 254 treatment. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and not recur? The Director of Nursing or the Regional Nurses will review residents smoking, elopement and dialysis form for completion and accuracy weekly for 90 days and thereafter. The Findings will be discussed in Monthly QAPI and this will be a part of Facility Quarterly Quality Assurance.	

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F 842	Continued From page 34	F 842		

the Regional MDS Nurse (RMDSN) and the MDSN. The MDSN informed the surveyors that "normally" it was the Unit Manager (UM), "me," and all department heads will initiate the care plan within 24-48 hours, then quarterly when there's a change according to the facility policy. The MDSN stated that the care plan for wander guard or elopement was in the "chart of the resident," and the smoking assessment was in the care plan book. She further stated "I'm not sure" why it was not there at the time the DON and the surveyors checked it.

Furthermore, the MDSN further stated that upon inspection of the medical records, which was five days after, the assessments were found in a different area of the "chart." Both the MDSN and the RMDSN acknowledged that the medical records must be organized, readily available, complete, and accurate.

2. On 12/06/21 at 10:30 AM, the surveyor interviewed Resident #63 who was in their room in a wheelchair. The resident denied any issues with going to [redacted] and denied any transportation issues.

A review of the paper chart showed that Resident #63 was admitted to the facility with medical diagnoses that included [redacted] and [redacted]

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F 842	Continued From page 35 A review of the Quarterly Minimum Data Set (QMDS), a quarterly assessment completed 10/2021, reflected that Resident #63 had a BIMS score of [NJ Exec. Order 26:4.b.1], which indictaed that the resident was [NJ Exec. Order 26:4.b.1]. Section O, of the MDS, titled special procedures and treatments included [NJ Exec. Order 26:4.b.1] On 12/06/21 at 10:50 AM, the surveyor asked the residents nurse for the dialysis communication book. The Licensed Practical Nurse (LPN) gave the surveyor a binder with [NJ Exec. Order 26:4.b.1] communication logs for Resident #63. The surveyor reviewed the logs for the month of November 2021 in the resident's communication book. During the month of November, the Resident #63 had gone to [NJ Exec. Order 26:4.b.1]. Review of the communication book revealed that 9 of the 13 communication forms were not completed by the facility staff when the resident returned from [NJ Exec. Order 26:4.b.1]. The section included changes in resident condition, vital signs, [NJ Exec. Order 26:4.b.1] access site assessment and the signature of the receiving nurse. On 12/06/21 at 10:58 AM, the surveyor asked the LPN to explain how they are filled out and the nurse said, "we fill out the top of the form before the resident leaves and include vital signs." The LPN then pointed to the middle of the form and said, "the dialysis center fills out this section, and on the bottom gets filled out by us when the resident returns from dialysis". The surveyor asked why there were so many blank post dialysis sections and the LPN could not answer. A review of facility the policy titled, "Care of the Resident Receiving Dialysis", the policy had a reviewed date of 11/2021. Under the section	F 842		

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F 842	Continued From page 36 titled Policy Explanation and Procedures, it indicated the following: Dialysis communication form will be sent with the resident on each visit, upon return from dialysis the nurse will complete the post dialysis information located on the bottom of the dialysis communication record. NJAC 8:39-35.2 (d) (5)	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		4/14/22

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F 880	Continued From page 37 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 880	How the corrective action will be	

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F 880	Continued From page 38 review, it was determined that the facility failed to perform hand hygiene appropriately for 2 of 7 Staff observed after wound treatment and garbage disposal in accordance with the Centers for Disease Control and Prevention guidelines for infection control. This deficient practice was evidenced by the following: According to the U.S. CDC guidelines Hand Hygiene Recommendations, Guidance for Healthcare Providers for Hand Hygiene and COVID-19, page last reviewed 1/8/2021 included, "Hand Hygiene means cleaning your hands by using either handwashing (washing hands with soap and water), antiseptic handwash, antiseptic hand rub (i.e. alcohol-based hand sanitizer including foam or gel), or surgical hand antisepsis ..... Multiple opportunities for hand hygiene may occur during a single care episode. Following are the clinical indications for hand hygiene: Use an Alcohol-Based Hand Sanitizer: Immediately before touching a patient, ... Before moving from work on a soiled body site to a clean body site on the same patient, After touching a patient or the patient's immediate environment, After contact with blood, body fluids or contaminated surfaces, Immediately after glove removal. Wash with Soap and Water: When hands are visibly soiled ... Glove Use: Wear gloves, according to Standard Precautions, when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur. Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, before	F 880	accomplished for those residents found to be affected by the deficient practice? Infection Prevention & Control F880 CFR(s): 483.80(a)(1)(2)(4)(e)(f) 483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of Communicable Diseases and infections Based on observation, interview, and record review, it was determined that the facility failed to perform hand hygiene appropriately for 2 of 7 Staff observed after wound treatment and garbage disposal in accordance with the Centers for Disease Control and Prevention guidelines for infection control. LPN#1failed to perform hand hygiene after performing treatment stated that "I should have removed my gloves inside the resident's room and performed hand hygiene inside the room of the resident. The Root Cause Analysis was implemented and the findings were that the nurse forgot to remove the glove. LPN#1 was reeducated on proper hand hygiene after performing treatment either used of soap and water or antiseptic hand wash. LPN#1 was able to perform or demonstrate proper handwashing technique.	

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F 880	Continued From page 39 touching the patient or the patient environment. Perform hand hygiene immediately after removing gloves." 1. On 12/1/21 at 12:58 PM, the surveyor observed the Licensed Practical Nurse (LPN) #1 come out of Resident#42's room with a left-hand glove without performing hand hygiene. When LPN#1 was in the hallway, in front of Resident#42's room, LPN#1 removed her glove and disposed of it in the garbage bin that was in the medicine (med) cart which was parked outside the resident's room. Later on, LPN#1 walked toward the treatment cart that was parked across the resident's room and returned a box of dressing and a cleanser spray inside the treatment cart. Afterward, LPN#1 walked back to the med cart and performed hand hygiene with the use of the alcohol-based hand rub (ABHR). At that time, the surveyor interviewed LPN#1 regarding the above observation. LPN#1 informed the surveyor that "I did the [redacted] of the resident." LPN#1 stated that "I should have removed my gloves inside the resident's room and performed hand hygiene inside the room of the resident. I realized that I still have the glove on when I'm outside the room already. I was rushing." 2. On 12/1/21 at 1:04 PM, the surveyor observed the Housekeeper (HK) donn (applied) gloves and doff (removed) gloves when she picked up the garbage from the Center Unit medicine cart without performing hand hygiene. The surveyor observed the HK walk down in the hallway toward the clean utility room and dispose of the garbage that was picked up from the Center unit medicine cart.	F 880	Surveyor observed Housekeeper (HK) donn (applied) gloves and doff (removed) gloves when she picked up the garbage from the Center Unit medicine cart without performing hand hygiene. Affected Housekeeping employee was reeducated on proper hygiene after removing gloves. HK was able to perform or demonstrate proper handwashing technique. All staff were reeducated on proper hand hygiene technique. Either used of soap and water or antiseptic hand wash. No other residents were affected with this deficient practice. How will the facility identify other residents having the potential to be affected by the deficient practice? All residents in the facility have the potential to be affected by this deficient practice, therefor this applies to all residents current and future. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? All staff were reeducated regarding Infection Control and proper Hand Hygiene technique after touching a patient or the patient's immediate environment, After contact with blood, body fluids or contaminated surfaces, Immediately after doffing or glove removal. Staff was able to	

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F 880	Continued From page 40 At that time, the surveyors interviewed the HK after the HK disposed of the garbage in the clean utility room about the above concerns with hand hygiene. The HK acknowledged that she did not perform hand hygiene before or after using gloves when she picked up the garbage from the medicine cart and stated "I know, I should have used my ABHR from my pocket." She further stated that she was educated about hand hygiene by the Director of Nursing (DON). On 12/3/21 at 12:31 PM, the surveyors met with the Licensed Nursing Home Administration (LNHA), DON, Regional Registered Nurse (RRN) #1, RRN#2, all of which were made aware of the above concerns regarding hand hygiene of LPN#1. The DON informed the surveyors that "LPN#1 is a new nurse and also an agency nurse." On 12/6/21 at 11:38 AM, the surveyors met with the LNHA, DON, RRN#1 and 2, Corporate Operation Officer (COO) and were made aware of the surveyors concern with the HK's hand hygiene. RRN#2 stated that "it should be the wall hand sanitizer, not their hand sanitizer in the pocket to be used when performing hand hygiene." Both the LNHA, DON, COO, and Regional nurses acknowledged that HK should have performed hand hygiene before and after glove removal. On 12/8/21 at 1:14 PM, the LNHA informed the surveyors that there was no additional information. NJAC 8:39-19.4 (a) (1) (n)	F 880	demonstrate proper hand washing technique. All Housekeeping staff will be reeducated and will perform return demonstration on how to properly perform hand hygiene LPN#1 failed to performed proper hand hygiene after removing gloves. LPN acknowledge that she received prior education regarding hand hygiene. LPN #1 was re inserviced on proper hand hygiene technique. Education materials was given to the nurse to review and she was observed on hand washing. Infection Preventionist and Facility educator will re- educated staff quarterly on proper handwashing technique. Infection Preventionist will check 5 employee weekly for handwashing technique x 90 days and thereafter. Re-education provided to both employee LPN#1 and housekeeping that were identified regarding proper handwashing by Infection Preventionist and Facility Educator with successful return demonstration. . Handwashing competencies were completed for nursing personnel by the Infection Preventionist, Regional Nurse and Direct DON, and ADON Infection Preventionist placed and verified	

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F 880	Continued From page 41	F 880	signage regarding proper handwashing at sinks or of Nursing to ensure compliance. Facility provided in service training to appropriate staff, with staff competency. Module 1- Infection Prevention and Control Program was viewed by Topline Staff and Infection Preventionist CDC COVID -19 Keep COVID-19 □ Out! Viewed by Frontline Staff CDC COVID -19 Clean Hands Viewed by Frontline Staff CDC COVID-19 Closely Monitored Residents Viewed By Frontline Staff Module 11B Environmental Cleaning and Disinfection. Viewed By All Staff including Topline and Infection Preventionist Module 4- Infection Surveillance. Viewed By Topline staff and Infection Preventionist Module 7- Hand Hygiene Viewed By All Staff including Topline and Infection Preventionist Module 6A □ Principles of Standard Precaution Viewed By All Staff including Topline and Infection Preventionist	

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F 880	Continued From page 42	F 880	Module 6B- Principles of Transmission Based Precaution Viewed By All Staff including Topline and Infection Preventionists Education on DOH required training initiated an online modules and you tube videos. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and not recur? Results of handwashing observation and check will be discussed in monthly QAPI and will be a part of facility quarterly Quality Assurance. This corrective plan of action will be monitored by the administrator or Infection Preventionist weekly. Findings will be discussed in daily morning meeting for immediate resolution. This will be a part of monthly QAPI and will be discussed in facility quarterly QA program.	
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility-provided documents, it was determined that the facility failed to provide a safe, sanitary, and comfortable environment for residents and	F 921	How the corrective action will be accomplished for those residents found to be affected by the deficient practice?	12/30/21

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F 921	Continued From page 43 staff in the laundry area according to facility policy and procedure. This deficient practice was evidenced by the following: On 12/8/21 at 9:24 AM, the surveyor toured the laundry area with the Director of Environmental Services (DES) who informed the surveyor that he's in charge of the laundry and the housekeeping department. There were 4 out of 6 hanging rack carts parked in the hallway near the laundry room with clean clothes which also had soiled bottom racks and used gloves. The DES informed the surveyor that "probably it was the nurse from the unit who left the used gloves there." He further stated that it was the responsibility of the housekeeping department to check and make sure that the hanging rack carts were clean. At the same time, the surveyor observed another hanging cart with clothes that were not covered on the other side of the hallway. The DES stated, "there were clean clothes without names and there should have a cover." The DES further stated, "I don't know, probably a nurse came down here and removed the cover." Afterward, the surveyor and the DES entered the laundry room and observed used gloves on the floor next to the covered garbage bin. There was an assortment of debris including plastic, paper, a heavily soiled mop head, and heavy build-up of a black substance at the back of the two washing machines. Also, there was a white build-up accumulation on the surfaces of the two washing machines that extended to the concrete base and floor, on and underneath of the washing machine.	F 921	F921 Safe/Functional/Sanitary/Comfortable Environ F921 CFR(s): 483.90(i) 483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and facilityprovided documents, it was determined that the facility failed to provide a safe, sanitary, and comfortable environment for residents and staff in the laundry area according to facility policy and procedure. There were 4 out of 6 hanging rack carts parked in the hallway near the laundry room with clean clothes which also had soiled bottom racks and used gloves. Gloves were taken and discarded. Clean clothes was laundered and was separated with the soiled clothes Laundry room and observed used gloves on the floor next to the covered garbage bin. There was an assortment of debris including plastic, paper, a heavily soiled mop head, and heavy build-up of a black substance at the back of the two washing machines. Used gloves were discarded. A soiled map, papers and plastic were discarded and the washing machines were cleaned including the floor were the buildup of dirt	

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F 921	Continued From page 44 In addition, there was a build-up of lint and dust around the laundry area floor and walls. There were two heel boots and a gown on the floor, and a ladder that were both covered with dust and lint. At that time, there was an exhaust fan that was not in use was covered with dry leaves. The DES had no answer why there was a build-up of dust and lint in the surrounding laundry room. Furthermore, the Laundry Staff (LS) informed the surveyor that she checks the laundry dryer for lint and logs it every two hours. The LS had no answer why there were dust, dirt, and lint in the laundry room. There was a log for checking the lint every two hours. There was no log for routine cleaning of the laundry area. Later on that same date and time, the surveyor and the LS went to the next room and observed the chute (a sloping channel or slide for conveying things to a lower level) for dirty clothes. The LS explained to the surveyor that the chute was connected to the second-floor nursing unit and that staff drop the soiled linens, gowns, towels, and blankets to the first-floor soiled laundry room. The soiled laundry room had multiple used gowns, towels, blankets, and linens that were observed directly on the floor. On 12/8/21 at 9:45 AM, the surveyors went to the laundry room, met with the Maintenance Director (MD) and Maintenance Staff (MS), and discussed the concern with dust, dirt, and lint surrounding the laundry room and the electric wiring. The MS informed the surveyors that "there is no live electric current with that old telephone wirings." The MS stated that the laundry room should have been cleaned and there was no reason that the	F 921	was accumulated. . There was no log for routine cleaning of the laundry area. This was developed Administrator contacted an outside Cleaning agency to clean the Laundry. All dirt, debris were removed in the entire Laundry Department. No other residents were affected with this deficient practice. How will the facility identify other residents having the potential to be affected by the deficient practice? All residents in the facility have the potential to be affected by the deficient practice. Therefore, this applies to all residents (current and future). What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? All Laundry Department staff were reeducated regarding Infection Control and Sanitation. A cleaning log was developed for Laundry staff to follow everyday Laundry Department Supervisor will checked the Laundry Department daily for cleanliness and organization, Laundry Staff was reeducated on how to file clean clothes to the rack with cover. Infection Preventionist will check Laundry	

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	315037	A. BUILDING _____ B. WING _____	12/16/2021

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F 921	Continued From page 45 laundry room was not dusted off. The MD further stated that the exhaust fan was not being used at this time because it was wintertime and that the dried leaves should have been removed. On 12/8/21 at 10:00 AM, the LNHA informed the surveyors that the facility had identified the problem with the laundry area regarding the above concerns. The LNHA stated that the DES "was not snap about it, that is why I'm putting the MD eventually to be in charge of the housekeeping and laundry department." On that same date and time, the COO stated to the surveyors that "the bottom line, it is beyond their capabilities to clean." She further stated that I will have an outside vendor to do the general cleaning of the laundry." A review of the facility Departmental (Environmental Services)-Laundry and Linen Policy with a revised date of October 2010 that was provided by the LNHA included "The purpose of this procedure is to provide a process for the safe and aseptic handling, washing, and storage of linen. .....In the Laundry ....4. Keep soiled and clean linen, and their respective hampers and laundry carts, separate at all times. 6. Reprocess any linen that is not visibly clean upon completion of the cycle or any linen that falls onto the floor." A review of the facility Cleaning and Disinfection of Environment Surfaces Policy with a revised date of October 2009 that was provided by the LNHA included "Policy Statement: Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OSHA Bloodborne Pathogens Standard. Policy	F 921	Department weekly for sanitation and Infection Control. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and not recur? Administrator and Laundry Supervisor will rounds daily x30days then weekly for 90 days and thereafter, Results will be discussed to monthly QAPI and this will be a part of quarterly QA.	

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F 921	Continued From page 46 Interpretation and Implementation: .....9. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. 10. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled. 11. Walls, blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled." On 12/8/21 at 1:14 PM, the LNHA informed the surveyors that there was no additional information. NJAC 8:39-31.4 (a) (d) (f)	F 921		

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S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey for the weeks of 11/14/21 to 11/20/21 and 11/21/21 to 11/27/21. The facility was deficient in Certified Nursing Assistant (CNA) staffing for residents on 14 of 14 day shifts, deficient in total staffing for residents on 2 of 14 evening shifts, and deficient in total staffing for residents on 12 of 14 overnight shifts as follows: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform	S 560	How the corrective action will be accomplished for those residents found to be affected by the deficient practice? S560 8:39-5.1(a) Mandatory Access to Care S560 (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey for the weeks of 11/14/21 to 11/20/21 and 11/21/21 to 11/27/21. The facility was deficient in Certified Nursing Assistant (CNA) staffing for residents on 14 of 14 day shifts, deficient in total staffing for residents on 2 of 14 evening shifts, and deficient in total staffing for residents on 12 of 14 overnight shifts as follows: The Administrator and Director of Nursing immediately reviewed staffing schedules and modified accordingly to capture all nurses that worked in the Certified Nursing Assistant (CNA) role.	1/30/22

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S 560	Continued From page 1 nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. - 11/14/21 had 7 CNAs for 87 residents on the day shift, required 11 CNAs. - 11/14/21 had 5 total staff for 87 residents on the overnight shift, required 7 total staff. - 11/15/21 had 9 CNAs for 85 residents on the day shift, required 11 CNAs. - 11/15/21 had 5 total staff for 85 residents on the overnight shift, required 7 total staff. - 11/16/21 had 10 CNAs for 85 residents on the day shift, required 11 CNAs. - 11/17/21 had 7 CNAs for 85 residents on the day shift, required 11 CNAs. - 11/17/21 had 6 total staff for 85 residents on the overnight shift, required 7 total staff. - 11/18/21 had 9 CNAs for 85 residents on the day shift, required 11 CNAs. - 11/18/21 had 3 total staff for 85 residents on the overnight shift, required 7 total staff. - 11/19/21 had 8 CNAs for 85 residents on the day shift, required 11 CNAs. - 11/19/21 had 5 total staff for 85 residents on the overnight shift, required 7 total staff. - 11/20/21 had 10 CNAs for 89 residents on the day shift, required 12 CNAs. - 11/20/21 had 8 total staff for 89 residents on the evening shift, required 9 total staff. - 11/20/21 had 5 total staff for 89 residents on the overnight shift, required 7 total staff. - 11/21/21 had 8 CNAs for 89 residents on the day shift, required 12 CNAs. - 11/21/21 had 8 total staff for 89 residents on the evening shift, required 9 total staff. - 11/21/21 had 4 total staff for 89 residents on	S 560	How will the facility identify other residents having the potential to be affected by the deficient practice? All residents in the Facility have the potential to be affected by the deficient practice. Therefore, this applies to all residents (current and future). What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? The Administrator and Director of Nursing shall continue to review the daily Certified Nursing Assistant (CNA) staffing schedules to ensure compliance with the state□s minimum CNA staffing requirement. Furthermore, the facility will review CNAs current rates, the facility shall continue its recruitment program and hiring efforts to attract and hire CNAs, as evidenced by placing advertisements, contacting recruitment agencies, and offering referral bonuses to current staff for securing additional staff. The center shall offer overtime, incentive pay, and bonuses to current staff when a staffing shortage is identified or occurs throughout the day and/or week. Facility staffing coordinator will work with sister facilities staffing coordinator for CNAs/License Nurses for daily backup when call outs occurs. CNAs will received free meals and incentives on top of their regular pay.	

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S 560	Continued From page 2 the overnight shift, required 7 total staff. - 11/22/21 had 8 CNAs for 89 residents on the day shift, required 12 CNAs. - 11/23/21 had 9 CNAs for 89 residents on the day shift, required 12 CNAs. - 11/23/21 had 6 total staff for 89 residents on the overnight shift, required 7 total staff. - 11/24/21 had 9 CNAs for 89 residents on the day shift, required 12 CNAs. - 11/24/21 had 5 total staff for 89 residents on the overnight shift, required 7 total staff. - 11/25/21 had 10 CNAs for 88 residents on the day shift, required 11 CNAs. - 11/25/21 had 5 total staff for 88 residents on the overnight shift, required 7 total staff. - 11/26/21 had 10 CNAs for 88 residents on the day shift, required 11 CNAs. - 11/26/21 had 5 total staff for 88 residents on the overnight shift, required 7 total staff. - 11/27/21 had 7 CNAs for 88 residents on the day shift, required 11 CNAs. - 11/27/21 had 5 total staff for 88 residents on the overnight shift, required 7 total staff. On 12/8/21 at 10:55 AM, the surveyors interviewed the Staffing Coordinator (SC) regarding staffing and ratios. The surveyor asked if the SC was aware of the New Jersey ratios and she stated that she was aware. The SC was asked if the facility was meeting the staffing requirements and she stated that, "some days we do, not every day and weekends are a struggle, most time on the weekends we have call outs." The SC was asked what process was followed once she was aware there was a staffing shortage. The SC stated that she notified administration and they were using two agencies for both nurses and CNAs. The surveyor asked what other ways beside utilizing agencies was the facility working on to meet staffing requirements	S 560	Facility will offer overtime, bonuses or incentives to Licensed Nurses to work as Nursing Assistant when warranted. The facility also maintain an agreement with nursing staffing agencies in the event of any staffing shortage. Flyers posted in the breakroom regarding referral bonuses, overtime pay for staffing call outs and staffing needs. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and not recur? The Administrator and Director of Nursing or designee shall review/audit the Certified Nursing Assistant (CNA) staffing schedule daily for 4 weeks, then monthly x 3 months and then quarterly to determine compliance with the state□s minimum CNA staffing requirement. The Administrator shall continue to monitor the facility□s recruitment and retention practices to identify potential areas of improvement. The results of these audits will be submitted to the Quality Assurance and Performance Improvement (QAPI) committee monthly for review and determination of further action.	

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S 560	Continued From page 3 and the SC stated that "we ask staff to work with us, offer incentives, but I am unaware of the amount of the incentives."	S 560		

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/16/2021 and Teaneck Nursing Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Teaneck Nursing Center is a two (2) story, Type II Un-Protected building that was built in July 1968. The facility is divided into 6 smoke zones.	K 000		
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.	K 341		1/30/22

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K 341	Continued From page 1 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 and interview on 12/16/2021, in the presence of facility management, it was determined that the facility failed to provide fire alarm notification by audible and visible signals for one (1) enclosed courtyard 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: During the building tour in the presence of the facility Maintenance and Environmental Services Director (MEVSD) at 11:21 AM an inspection of the outside enclosed Resident smoking courtyard was performed. The surveyor observed no evidence of a fire alarm notification (horn/ strobe) in the enclosed courtyard area. At this time the surveyor asked the MEVSD if there was a horn/strobe for the fire alarm system. The MEVSD said, no. The findings were verified and confirmed by the MEVSD during the observations. The Administrator was notified of the finding at the Life Safety Code exit conference on 12/16/2021 at 1:55 PM. NJAC 8:39-31.2(a)	K 341	How the corrective action will be accomplished for those residents found to be affected by the deficient practice? K341 Fire Alarm System - Installation K341 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 The deficient practice was evidenced by the following: During the building tour in the presence of the facility Maintenance	

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K 341	Continued From page 2	K 341	and Environmental Services Director (MEVSD) at 11:21 AM an inspection of the outside enclosed Resident smoking courtyard was performed. The surveyor observed no evidence of a fire alarm notification (horn/ strobe) in the enclosed courtyard area. At this time the surveyor asked the MEVSD if there was a horn/strobe for the fire alarm system. The MEVSD said, no. Fire alarm notification (horn/ strobe) in the enclosed courtyard area will be replaced. Horn/Strobe in the resident smoking courtyard will be installed. No other residents were affected with this deficient practice. How will the facility identify other residents having the potential to be affected by the deficient practice? All residents in the facility have the potential to be affected by this deficient practice, Fire Alarm System Installation, therefore, this POC applies to all residents, current and future. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? Maintenance Director will check weekly and monitor the fire alarm system for function and the transmission path to ensure it is effective when in an event there is a fire in the building. Maintenance Director will check resident	

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K 341	Continued From page 3	K 341	Smoking Courtyard daily for functions. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and not recur? Administrator and Maintenance Director will conduct facility rounds weekly x 90 days and thereafter, Results will be discussed in monthly QAPI and this will be a part of Quarterly QA.	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations, interview and review of facility documentation on 12/16/2021, in the presence of facility management, it was determined the facility failed to perform and document on the tag attached to the fire extinguisher a monthly visual examination for 3 of 17 fire extinguishers, as required by code and National Fire Protection Association (NFPA) 10 and N.J.A.C. 5:70. requirements. This deficient practice was evidenced by the following: Reference: NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 7.3 Maintenance.	K 355	How the corrective action will be accomplished for those residents found to be affected by the deficient practice? K355 Portable Fire Extinguishers K355 CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observations, interview and	1/10/22

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TEANECK NURSING CENTER	**1104 TEANECK ROAD** **TEANECK, NJ 07666**

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K 355	Continued From page 4 - 7.3.1.1 All Fire Extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. According to NFPA 10- 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguisher. During the building tour starting at 10:16 AM in the presence of the facility's Maintenance and Environmental Services Director (MEVSD), the surveyor observed 17 fire extinguishers in various locations throughout the first and second floors. The surveyor observed that the fire extinguishers were last annually inspected March 2021 which was documented on the tags attached to the fire extinguishers. The surveyor observed three (3) fire extinguishers that had no evidence of a monthly visual examinations being performed and documented on the tags attached to three (3) fire extinguishers in the following locations, 1) At 11:45 AM, inside the Boiler room one (1) BC type fire extinguisher (facility identification #25) had no evidence of a monthly examination for November 2021 being performed and documented on the tag attached to the extinguisher. 2) At 11:51 AM, on the first floor one (1) ABC type fire extinguisher (facility identification #11) had no evidence of a monthly examination for	K 355	review of facility documentation on 12/16/2021, in the presence of facility management, it was determined the facility failed to perform and document on the tag attached to the fire extinguisher a monthly visual examination for 3 of 17 fire extinguishers, as required by code and National Fire Protection Association (NFPA) 10 and N.J.A.C. 5:70. Requirements. This deficient practice was evidenced by the following: Reference: NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 7.3 Maintenance. - 7.3.1.1 All Fire Extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. According to NFPA 10- 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguisher. 3 Fire Extinguisher was immediately inspected by facility Maintenance Director, dated and was documented to the tag attached to the fire extinguisher. Fire Extinguisher in the boiler room was inspected by Maintenance Director, date of inspection was documented to the tag attached to the fire extinguisher.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315037	A. BUILDING **01** B. WING _____	**12/16/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEANECK NURSING CENTER	**1104 TEANECK ROAD** **TEANECK, NJ 07666**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 355	Continued From page 5 October and November 2021 being performed and documented on the tag attached to the extinguisher. 3) At 12:12 PM, inside the main Kitchen one (1) class K Wet Chemical fire extinguisher had no evidence of a monthly examination for November 2021 being performed and documented on the tag attached to the extinguisher. The MEVSD confirmed the finding at the time of the observation. The surveyor informed the Administrator of the finding at the Life Safety Code exit conference on 12/16/2021 at 1:55 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 10.	K 355	First floor one (1) ABC type fire extinguisher. Inside the main Kitchen one (1) class K Wet Chemical fire extinguisher was inspected by Facility Maintenance Director and date was documented to the tag attached to the Fire Extinguisher Portable Fire Extinguishers K355 CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers and subject to yearly maintenance. All Portable Fire Extinguisher will be inspected by Facility Maintenance Director according to NFPA 10.4-3.4. No other residents were affected of this deficient practice. How will the facility identify other residents having the potential to be affected by the deficient practice? All residents in the facility have the potential to be affected by this deficient practice. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? Maintenance Director will develop a maintenance log. All portable Fire Extinguisher will be listed and will be visually inspected monthly. This will be documented to the tag attached to the	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315037	A. BUILDING **01** B. WING _____	**12/16/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEANECK NURSING CENTER	**1104 TEANECK ROAD** **TEANECK, NJ 07666**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 355	Continued From page 6	K 355	portable extinguisher. Maintenance Director will do visual inspection monthly, and will document to the tag attached to the portable fire extinguisher. Maintenance Director was reeducated of the importance of visual inspection of portable fire extinguisher and yearly maintenance check. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and not recur? Administrator and Maintenance Director will conduct monthly rounds X 90 days and thereafter, Findings will be discussed in monthly QAPI and this will be a part of quarterly Quality Assurance Program	
K 912 SS=D	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 912		1/10/22

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315037	A. BUILDING **01** B. WING _____	**12/16/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEANECK NURSING CENTER	**1104 TEANECK ROAD** **TEANECK, NJ 07666**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 912	Continued From page 7 Based on observations and interview on 12/16/2021 in the presence of facility management, it was determined that the facility failed to ensure that 1 of 3 electrical outlets located next to a water source were equipped with proper working Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: During the building tour in the presence of the facility Maintenance and Environmental Services Director (MEVSD), at 10:31 AM an inspection inside the Beauty Salon was performed. The surveyor observed a GFCI electrical outlet located 47 inches to the left of the hair washing sink. When the surveyor used a GFCI tester to de-energize the GFCI outlet, the one GFCI electrical outlet had not de-energize, as required by code. The MEVSD confirmed the finding at the time of the observation. The surveyor informed the Administrator of the finding at the Life Safety Code exit conference on 12/16/2021 at 1:55 PM. NJAC 8:39 -31.2 (e) NFPA 99	K 912	How the corrective action will be accomplished for those residents found to be affected by the deficient practice? K912 Electrical Systems - Receptacles K912 CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) Based on observations and interview on 12/16/2021 in the presence of facility management, it was determined that the facility failed to ensure that 1 of 3 electrical outlets located next to a water source were equipped with proper working Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidence During the building tour in the presence of the facility Maintenance and Environmental Services Director (MEVSD), at 10:31 AM an inspection	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315037	A. BUILDING **01** B. WING _____	**12/16/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEANECK NURSING CENTER	**1104 TEANECK ROAD** **TEANECK, NJ 07666**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 912	Continued From page 8	K 912	inside the Beauty Salon was performed. The surveyor observed a GFCI electrical outlet located 47 inches to the left of the hair washing sink. When the surveyor used a GFCI tester to de-energize the GFCI outlet, the one GFCI electrical outlet had not de-energize, as required by coded by the following: Beauty Salon electrical outlet was corrected a Ground-Fault Circuit Interrupter (GFCI) protection was installed. All electrical outlet was inspected and to ensure that the Ground □Fault Circuit Interrupter (GFCI) was installed as needed. No residents were affected with this deficient practice. How will the facility identify other residents having the potential to be affected by the deficient practice? All residents in the Facility have the potential to be affected by the deficient practice. Therefore, this applies to all residents (current and future). What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? Maintenance Director was reeducated regarding the importance of grounding pole that capable of maintaining low contact resistance with its mating plug.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315037	A. BUILDING **01** B. WING _____	**12/16/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEANECK NURSING CENTER	**1104 TEANECK ROAD** **TEANECK, NJ 07666**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 912	Continued From page 9	K 912	A Log was developed to monitor all electrical outlets to ensure were equipped of proper working Ground-Fault Circuit Interrupter (GFCI) protection. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and not recur? Administrator and Maintenance Director will conduct monthly rounds x 90days and thereafter, results will be discuss in monthly QAPI and will be a part of quarterly QA.	

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
315037 Y1	A. Building B. Wing Y2	4/18/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TEANECK NURSING CENTER	1104 TEANECK ROAD TEANECK, NJ 07666

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 F0610	Correction	ID Prefix F0658	Correction	ID Prefix F0688	Correction
Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(c)(1)-(3)	Completed
LSC	01/30/2022	LSC	12/17/2021	LSC	01/22/2022
ID Prefix F0761	Correction	ID Prefix F0812	Correction	ID Prefix F0842	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed
LSC	12/30/2021	LSC	01/30/2022	LSC	01/30/2022
ID Prefix F0880	Correction	ID Prefix F0921	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.90(i)	Completed	Reg. #	Completed
LSC	04/14/2022	LSC	12/30/2021	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/16/2021	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060217	A. Building B. Wing	4/18/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TEANECK NURSING CENTER	1104 TEANECK ROAD TEANECK, NJ 07666

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 01/30/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 12/16/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ YES ☐ NO

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
315037 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	4/18/2022 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TEANECK NURSING CENTER	1104 TEANECK ROAD TEANECK, NJ 07666

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0341	Correction Completed 01/30/2022	ID Prefix Reg. # NFPA 101 LSC K0355	Correction Completed 01/10/2022	ID Prefix Reg. # NFPA 101 LSC K0912	Correction Completed 01/10/2022
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
12/16/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO