STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT NEW MILFORD	**800 RIVER ROAD NEW MILFORD, NJ 07646**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Survey Date: 01/18/23 Census: 177 Sample: 35 + 2 closed records+11 =48 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 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care.	F 553		2/28/23

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

Electronically Signed | 02/10/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 553	Continued From page 1 (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on the interview and review of the facility provided documents, it was determined that the facility failed to ensure that the care planning (care conference meeting) was scheduled and that the resident's representative (RR) was provided sufficient notice in advance of the meeting according to the facility practice and policy for one of three quarters care conference reviewed for Resident#83. This deficient practice was evidenced by the following: On 01/11/23 at 8:58 AM, the RR informed the survey team that he/she visits Resident #83 almost every day. The RR had a concern that care planning meetings stopped since August 2022 and no invitation was provided to the RR. On 01/11/23 at 11:04 AM, the surveyor observed Resident #83 seated in a wheelchair, clean and	F 553	F-553 Element #1 Resident # 83 Care Conference was scheduled with the Resident's Representative on 01-17-2023. No negative adverse effect noted to the resident. Element #2 All residents with scheduled Quarterly Meetings have the potential to be affected by this deficient practice. For those Residents with Quarterly Scheduled MDS, Residents identified sustained no negative outcomes by this deficient practice. Element #3 DON provided education to the MDS staff and Social Workers regarding Care planning Conferences meeting schedule	

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F 553	Continued From page 2 well-dressed. The surveyor reviewed the medical record of Resident #83. The resident's [redacted] reflected that the resident was admitted to the facility with diagnoses that included [redacted]. The Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care with an Assessment Reference Date (ARD) [redacted] showed that the resident's cognitive skills for daily decision-making were [redacted]. The Care Conference Note (CCN) dated 9/07/22 which included that the meeting was held in person for a Quarterly meeting and the department and individuals present were the Social Services, Nursing, Nutrition, and Recreation. The CCN on 9/07/22 did not include that the resident and RR were invited. Further review of the CCN revealed that there was no further documentation that the CCN was done after the 9/7/22 meeting. There were CCN on dates 3/11/22, 6/08/22, and 9/07/22 which corresponded to the resident's [redacted]. There was no CCN for MDS that was done on [redacted]	F 553	process 01-17-2023. Case managers will send out a list of the Care Conference Schedules of the previous month and the upcoming month for the Social Worker to review and ensure care conferences are scheduled. DON or designee will review residents Quarterly schedules during morning meeting weekly. Element #4 Case Managers will audit Social Workers to ensure that they invite resident/Family to the care plan meeting weekly X2 weeks then monthly X 2, the Quarterly X3. Review of the findings will be presented to the Monthly QAPI for further review and recommendations.	

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F 553	Continued From page 3 On 01/17/23 at 9:41 AM, the surveyor interviewed the Director of Social Services (DSS). The surveyor asked the DSS about the facility protocol and practice with regard to the care planning meeting. The DSS stated that the social workers are responsible for scheduling the care planning meeting. She further stated that the social worker documents the care planning meeting in the electronic medical records in the CCN. She indicated that the social worker will also document in the CCN the department and individuals who attended the care planning meeting which included the documentation that the resident and RR were invited and attended the meeting. On that same date and time, the surveyor notified the DSS of the above findings. The DSS stated that currently, the facility had two full-time social workers that were assigned to the 1st and 3rd-floor units. The DSS further stated that the Social Worker (SW) assigned to the 2nd floor where Resident #83 resided had left the facility and the DSS was unable to remember when the 2nd-floor social worker left. She indicated that the two remaining social workers now divide the task for the 2nd-floor residents for social services work which includes the care planning meeting. Furthermore, the DSS further stated that it was an expectation that the previous SW called the RR to schedule the care conference meeting. The surveyor then asked the DSS if she knew that the previous SW called and notified the RR of the care conference schedule on 9/07/22 and 11/30/22. The DSS did not respond. At that time, the surveyor asked the DSS what	F 553		

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F 553	Continued From page 4	F 553		

happened there was no further CNN after the 9/07/22 documentation, and the DSS did not respond. The surveyor asked the DSS to provide documentation that the RR was notified of the care planning meeting from 9/07/22 onwards, and she stated that she will get back to the surveyor.

On 01/17/23 at 11:35 AM, the surveyor interviewed the Registered Nurse/MDS Coordinator (RN/MDSC). The RN/MDSC stated that she does not attend the care planning meeting. She further stated that it was the responsibility of the MDS department to inform the other departments which included the Unit Manager (UM), Rehab, Dietitian, Director of Nursing (DON), and DSS for the upcoming schedule of MDS assessment for them to schedule the care planning meeting after the MDS assessment was completed.

On 01/17/23 at 12:44 PM, the DSS informed the surveyor that "it was an oversight from the facility team," and that the care planning meeting was not done after the 9/07/22 care conference. She further stated that there should have a CCN for the 11/30/22 MDS assessment. The DSS was not able to provide documentation that the RR was called or notified of the care planning meeting after the 9/07/22 care conference.

On 01/17/23 at 01:20 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the DON. The surveyor notified the facility management of the above findings.

A review of the facility's provided Resident Participation-Assessment/Care Plan Policy by the DSS with a revised date on December 2016 included that the DSS or designee is responsible

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F 553	Continued From page 5 for notifying the resident and their representative and maintaining records of such notices for a care planning meeting and encouraged to participate in the resident's assessment and the development and implementation of the resident's care plan. A review of the provided payroll cycle of the previous second floor SW that was provided by the DSS showed that the SW last day of work was on [redacted]. On 01/18/23 at 01:56 PM, the survey team met with the LNHA and the DON. The facility management did not provide additional information.	F 553		
F 585 SS=D	NJAC 8:39-13.2(a) Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.	F 585		3/13/23

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F 585	Continued From page 6 §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as	F 585		

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F 585	Continued From page 7 necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent documents, the facility failed to ensure that the method for filing a grievance was	F 585	F585 Element#1	

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F 585	Continued From page 8 consistent with the facility's practice and policy. This deficient practice was identified for three of four grievance incidents of Resident #83. The evidence was as follows: On 01/05/23 at 10:42 AM, during the Entrance Conference of the surveyor with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), the LNHA stated that he started working at the facility three months ago. The DON stated that she started working on [NJ Exec. Order 26:4.b.1], the same time when both the previous DON and Infection Preventionist Nurse left the facility. On 01/11/23 at 8:58 AM, the resident representative (RR) informed the survey team that he/she visits Resident #83 almost every day. The RR stated that he/she complained to the previous administrator about the resident's [Ex Order 26.] and was told that it was taken care of and that the resident had [Ex Order 26. 4B1]. The RR further stated that he/she had an issue with the Certified Nursing Aide (CNA) recently the RR asked the CNA to be removed from the assignment which was immediately resolved. The RR indicated that the CNA will not talk to the RR whenever the RR visited or ask a question and instead will be referred to the nurse or the Unit Manager (UM) that was why the RR asked the CNA to be removed from the resident's assignment. On 01/11/23 at 11:00 AM, the surveyor asked the LNHA for a copy of Resident #83's grievance reports for the last seven months, and the LNHA stated that he will get back to the surveyor.	F 585	Resident # 83 Grievance form was completed by the Administrator and Social Worker for Resident # 83 on 01/18/23 as it relates to Resident Representative (RR) complaint regarding [Ex Order 26. 4B1] on resident #83 [Ex Order 26.] and the follow-up investigation with resident representative. Resident# 83 sustained no adverse effects as a result of this deficient practice. Element #2 All residents or Residents Representatives with complaints have the potential to be negatively affected as a result of this deficient practice. No residents identified were negatively affected by this deficient practice. Social Service Director and Administrator completed a 100% audit of all grievances on 01-17-2023 and 01-18-2023 for the last 4 months to identify any other grievances not thoroughly investigated and no other issues were identified related to grievances. Element#3 The Social Worker provided in-services to the Department heads and staff on the policy & procedure on the grievance process regarding when concerns are brought to their attention on 01-17 & 01-18-2023. The Social Worker Director or designee will place Red folders on each unit titling grievance forms. The Social Worker Director or designee will review the grievance folder for any grievances daily and forward to the appropriate department for follow-up and	

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F 585	Continued From page 9 On 01/11/23 at 11:04 AM, the surveyor observed Resident #83 seated in a *Ex Order 26. 4B1* [redacted] clean and well-dressed. The surveyor reviewed the medical records of Resident #83. The resident's *Ex Order 26. 4B1* [redacted] reflected that the resident was admitted to the facility with diagnoses that included *Ex Order 26. 4B1* [redacted] The Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care with assessment reference date (ARD) [redacted] showed that the resident's cognitive skills for daily decision-making were *Ex Order 26. 4B1* [redacted]. A review of the provided Grievance/Complaint Report (G/CR) showed that on 3/09/22, the RR visited on 3/08/22 at 7:00 PM and complained that the resident's wheelchair was dirty and was immediately cleaned and addressed the issue. On 01/17/23 at 9:41 AM, the surveyor interviewed the Director of Social Services (DSS). The DSS informed the surveyor that "anyone" can initiate a grievance when a resident or RR complained and had a concern, fill out the G/CR form, discuss it in the morning meeting, complete the G/CR form,	F 585	investigations to be closed within 5 working days. The Social Worker or designee will forward completed grievances to the Administrator for final Review. The Social Worker Director or designee will maintain evidence of the completed grievances for no less than 3 years. Education will be completed to all departments heads and managers by Social Service Director or designee by 02-28-2023. Element#4 The Social Service Director or designee will complete an audit of all grievances weekly Monday X 4 weeks then monthly X 2 and findings will be presented to the Quarterly QAPI meeting for review and findings. Element#1 Resident #83 Grievance form was completed by the Social Worker and Administrator on 01-18-23 detailing removal of Certified Nursing Assistance as it relates to Resident representative with follow-up Investigation with resident representative. Element#2 All residents who have complaints have the potential to be affected by this deficient practice. No other residents were identified by this deficient practice. Social Service Director and Administrator completed a 100% audit of all grievances on 01-17-2023 and 01-18-2023 for the last 4 months to identify any other	

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F 585	Continued From page 10 then submit it to the DSS for filing after the interdisciplinary team or the specific department reviewed it, and this is according to the facility practice. On that same date and time, the surveyor notified the DSS of the above problem of the RR regarding the CNA and skin discoloration of the resident. The surveyor asked the DSS why there was no G/CR copy provided to the surveyor when the RR reported the above problem about the CNA and skin discoloration. The surveyor received one grievance report that was provided by the DON dated 3/09/22 regarding the dirty wheelchair of the resident. The DSS stated that she will get back to the surveyor. A review of the provided G/CR after further surveyor's inquiry showed the following: 1. The 01/20/22 G/CR copy was received by the surveyor on 01/17/23 at 12:44 PM after a second follow-up. Then, the attached investigation and statements were received by the surveyor on 01/18/23 at 8:06 AM after the third inquiry of the surveyor. The 01/20/22 G/CR showed that the RR complained that the resident was seen in bed at 7:00 PM and got upset with the aide because the RR wanted the resident to be back in bed at 8:00 PM and noted with a Ex Order 26. 4B1 on the Ex Order 26 [redacted]. The incident was investigated and interventions were put in place. 2. The 8/05/22 G/CR copy was received by the surveyor on 01/17/23 at 12:44 PM after a second follow-up. The 8/05/22 G/CR showed that the RR complained to the nurse that the resident was not seen by the Ex Order 26. 4B1 for the resident's recent NJ Exec. Order 26:4.b.1 [redacted]. The G/CR included	F 585	grievances not thoroughly investigated and no other issues were identified related to grievances. Element#3 The Social Worker provided in-services to the Department heads and staff on the policy & procedure on the grievance process regarding when concerns are brought to their attention on 01-17 & 01-18-2023. The Social Worker Director or designee will place Red folders on each unit titling grievance forms. The Social Worker Director or designee will review the grievance folder for any grievances daily and forward to the appropriate department for follow-up and investigations to be closed within 5 working days. The Social Worker or designee will forward completed grievances to the Administrator for final Review. The Social Worker Director or designee will maintain evidence of the completed grievances for no less than 3 years. Education will be completed to all departments heads and managers by 02-028-2023 by Social Service Director or designee by 02-28-2023. Element#4 The Social Service Director or designee will complete an audit of all grievances weekly Monday X 4 weeks then monthly X 2 and findings will be presented to the Quarterly QAPI meeting for review and findings.	

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F 585	Continued From page 11 that the nurse reminded the RR that the resident's [NJ Exec. Order 26:4.b.1] was not something new and was seen recently by the *Ex Order 26. 4B1* [redacted] on [NJ Exec. Order 26:4.b] In addition, a follow-up group meeting was held on 8/8/22 to discuss the issue. On 01/17/23 at 01:20 PM, the survey team met with the LNHA and the Director of Nursing (DON). The surveyor asked the facility management about the process of handling grievances and the DON stated "I don't know" about the grievance process here. Then, the LNHA stated that once the grievance was reported, it will be followed up, and investigated. The LNHA further stated that he should be aware, and the grievance will be filed for document keeping by the Grievance Officer which is the DSS. At that time, the DON stated that she was the one who found the 01/20/22 and 8/05/22 G/CR from the piled files of the previous DON. The DON and the LNHA both acknowledged that the DSS was not aware of the two grievance reports and should have known about the incidents. On 01/18/23 at 9:00 AM, the surveyor interviewed the Certified Nursing Aide#1 (CNA#1). CNA#1 informed the surveyor that she was the assigned aide of Resident #83, and knew the resident well, and the RR. CNA#1 stated that Resident #83 was *Ex Order 26. 4B1* [redacted] with periods of [NJ Exec. Order 26:4.b.1] [redacted] She further stated that she knew the plan of care for the resident, able to understand the resident because both the resident and the aide speaks the same Spanish language. She indicated that she was educated on how to care for the *Ex Order 26. 4B1* resident.	F 585	Element#1 Certified Nursing Assistant#2 Grievance form was completed by Social Worker and Administrator regarding the complaint made by Resident Representative to Licensed Nursing Home Administrator (LNHA) previous request to change Resident #83 assignment not to assign Certified Nursing Assistant #2 on 01-18-23 with investigation and follow-up with resident representative. Element#2 All residents or Resident Representatives with complaints have the potential to be affected by this deficient practice. No other residents were identified by this deficient practice. Social Service Director and Administrator completed a 100% audit of all grievances on 01-17-2023 and 01-18-2023 for the last 4 months to identify any other grievances not thoroughly investigated and no other issues were identified related to grievances. Element#3 The Social Worker Provided I:I education on the Grievance policy to the Licensed Nursing Home Administrator (LNHA), regarding when complaints are brought to his attention on 01-18-23. The Social Worker provided in-services to the Department heads and staff on the policy & procedure on the grievance process regarding when concerns are brought to	

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F 585	Continued From page 12 On that same date and time, CNA#1 stated that the RR visits the resident in the evening on weekdays and around 2:30 PM on weekends. She further stated that the RR asked questions about the resident and when unable to provide an answer will be referred to the nurse which the RR at times did not like. CNA#1 informed the surveyor that CNA#2 used to take care of the resident and then a few months ago, CNA#1 was unable to remember the date, and the resident was transferred to her assignment. CNA#1 was unable to state the reason why the resident was moved to her assignment. On 01/18/23 at 10:16 AM, the surveyor asked the LNHA why there was no G/CR provided to the surveyor regarding the change in the resident's aide when the RR complained and asked for a change in the aide. The LNHA stated that he forgot to mention the above issue to the surveyor when the surveyor was asking for the grievance report. The LNHA further stated that there was no report from RR about the issue regarding abuse except that the RR "just did not like CNA#2." The surveyor asked the LNHA why there was no documentation about it and he did not write a grievance when the RR came forward to the LNHA about the problem, and the LNHA did not respond. Afterward, the LNHA stated that he cannot remember the exact date when it happened, "it could be the date when I started, the RR came to me and talked about CNA#2," no care issues, the RR just did not like the aide because when the RR comes to visit, the aide will not talk to the RR. He further stated that the problem was immediately resolved because CNA#2 was removed from the assignment.	F 585	their attention on 01-17 & 01-18-2023. The Social Worker Director or designee will place Red folders on each unit titling grievance forms. The Social Worker Director or designee will review the grievance folder for any grievances daily and forward to the appropriate department for follow-up and investigations to be closed within 5 working days. The Social Worker or designee will forward completed grievances to the Administrator for final Review. The Social Worker Director or designee will maintain evidence of the completed grievances for no less than 3 years. Education will be completed to all departments heads and managers by 02-028-2023 by Social Service Director or designee by 02-28-2023. Element#4 The Social Service Director or designee will complete an audit of all grievances weekly Monday X 4 weeks then monthly X 2 and findings will be presented to the Quarterly QAPI meeting for review and findings.	

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F 585	Continued From page 13 A review of the Grievance/Complaints, Filing Policy that was provided by the DSS with a revised date of April 2017 and edited on 4/11/18 included that the Administrator has delegated the responsibility of grievance and/or complaint investigation to the Grievance Officer who is the Social Worker and that upon receipt of a grievance and/or complaint, the Grievance Officer will review and investigate the allegations and submit written report of such findings to the Administrator within five working days of receiving the grievance and/or complaint. On 01/18/23 at 02:16 PM, the survey team met with the LNHA and DON and there was no additional information provided by the facility regarding two grievance reports that DSS was not aware of and one complaint that the RR reported to the LNHA and did not follow the facility's grievance policy and practice of writing and filing the G/CR. NJAC 8:39-13.2(c)	F 585		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		2/28/23

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F 656	Continued From page 14 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of medical records, it was determined that the facility failed to develop a person-centered comprehensive care plan to address the actual	F 656	Element #1 Resident # 15 Care plan was updated to reflect current actual *Ex Order 26. 4B1* on 01/06/2023. Resident # 15 sustained no	

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F 656	Continued From page 15 *Ex Order 26. 4B1* for one of four residents (Resident #15) reviewed for *Ex Order 26. 4B1*. This deficient practice was evidenced by the following: On 01/05/23 at 10:42 AM, during the Entrance Conference of the surveyor with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), the DON stated that she started working on [redacted], the same time when both the previous DON and Infection Preventionist Nurse (IPN) left the facility. The DON further stated that the IPN was also the Wound Nurse (WN). On 01/05/23 at 12:20 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who informed the surveyor that she was not sure if Resident #15 had facility-acquired [redacted]. On 01/05/23 at 12:28 PM, the surveyor observed the resident seated with *Ex Order 26. 4B1*. The surveyor reviewed Resident #15's medical record. The *Ex Order 26. 4B1* [redacted] showed that the resident was admitted to the facility with diagnoses that included *Ex Order 26. 4B1* [redacted].	F 656	adverse effects. Element #2 All residents have the potential to be affected by this deficient practice. No other resident identified was negatively affected by this deficient practice. A audit of all current in house residents were reviewed for an alteration in skin integrity care plan or actual skin impairment care plan was conducted to ensure care plans accurately reflect residents current skin integrity status. Element #3 Facility educator and designee provided education on 01-17-2023 to Nurse Managers, Supervisors, and Nursing staff on the process of ensuring Actual or Alteration in Skin Integrity care plans are initiated within 48 hours of admission or readmission. In addition, education on updating care plans when there is a change in resident's skin integrity to be updated in the care plan within 24 hours. All admission & readmission care plans will be reviewed during morning meeting for an alteration or actual skin integrity care plan with the interdisciplinary team to identify any deficient practice. The Facility Educator or designee will continue in-services to Nursing staff on care plans policy to be completed by February 28, 2023. Element#4 Director of Nursing or designee will audit all admissions & readmissions for an alteration in skin or actual skin integrity	

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F 656	Continued From page 16 The Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of [NJ Exec. Order 26:4.b.1] showed a *Ex Order 26. 4B1* score of [Ex Ord] out of 15 which indicated that the resident's cognitive status was *Ex Order 26. 4B1*. The [Ex Order 26. 4B1] included that the resident had a facility-acquired *Ex Order 26. 4B1* and *Ex Order 26. 4B1*. The Order Summary Report (OSR) showed that there was a *Ex Order 26. 4B1* dated [NJ Exec. Order 26:4.b.1] to apply *Ex Order 26. 4B1* to *Ex Order 26. 4B1* every evening shift daily and PRN (as needed). Another physician's order dated [NJ Exec. Order 26:4.b.1] for *Ex Order 26. 4B1* apply to the *Ex Order 26. 4B1* every day and evening shift and dated [NJ Exec. Order 26:4.b.1] *Ex Order 26. 4B1* apply to the *Ex Order 26. 4B1* two times a day for *Ex Order 26. 4B1*. There was no personalized care plan documented to reflect the *Ex Order 26. 4B1* that the resident had on the *Ex Order 26. 4B1*. On 01/09/23 at 11:50 AM, the surveyor interviewed the RN/UM. The RN/UM informed the surveyor that it was the responsibility of the WN to initiate the care plan for the resident with [Ex Order 26. 4B1]. She further stated that she was unable to remember when the WN left the facility. The surveyor asked the RN/UM if Resident #15 had the care plan for *Ex Order 26. 4B1*, and the RN/UM responded that it should be in the electronic	F 656	care plan weekly X 4 Monthly X 2 and Quarterly x3 and present findings to the Quarterly QAPI for further review and recommendations. If 100% compliance is not achieved an action plan will be developed.	

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F 656	Continued From page 17 medical record. At that time, after the RN/UM checked the electronic medical record, the surveyor asked the RN/UM why the care plan for the Ex Order 26. 4B1 [redacted] was initiated after the surveyor's inquiry. The RN/UM did not respond. On 01/10/23 at 9:12 AM, the surveyor interviewed the DON. The DON stated that the MDS staff, DON, and ADON were responsible for initiating the care plan, and the UM revise or update the care plan. The surveyor asked the DON should the care plan reflect the Ex Order 26. 4B1 on 8/4/22 according to the initial exam of the Ex Order 26. 4B1 [redacted] not on 01/06/23 after the surveyor's inquiry. The DON responded "yes," and stated that she did not know what happened and the care plan was not done. A review of the Care Plans, Comprehensive Person-Centered Policy that was provided by the DON with a revised date of March 2022 included " A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation:...12. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessments (MDS). 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's condition change. 14. The Interdisciplinary Team must review and update the care plan; a. when there has been a significant change in the resident's condition...."	F 656		

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F 656	Continued From page 18 On 01/18/23 at 02:16 PM, the survey team met with the LNHA and DON, and there was no additional information provided by the facility. NJAC 8:39-11.2(e)	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to: a) follow a physician's order with regards to the use of an *Ex Order 26. 4B1* for one of three residents, Resident #5 reviewed for the limited *Ex Order 26. 4B1*; b) utilized the *Ex Order 26. 4B1* [redacted] for two of four residents, Residents #15 and #83 reviewed for *Ex Order 26. 4B1*; c) follow a physician's recommendation and discontinuing a *Ex Order 26. 4B1* treatment for a *Ex Order 26. 4B1* in a timely manner for one of four residents (Resident#136) reviewed for *Ex Order 26. 4B1*. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse	F 658	Element #1 Resident#5 Order for *Ex Order 26.* dated 04/14/2022 *Ex Order 26. 4B1* to *Ex Orde* was updated on the *Ex Order 26. 4B1* on 01-13-2023. Resident#5 sustained no negative adverse outcome as a result of this deficient practice. Resident#5 Physician's orders dated on 04/14/2022 for the *Ex Order 26.* was updated on 01/13/2023 to reflect under the functional Maintenance Program (FMP) for January order summary report. Element #2 All other residents on with assistive devices (splints) have the potential to be negatively affected by this deficient practice. No other residents on program were identified as affected. Element #3	2/28/23

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F 658	Continued From page 19 Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 01/06/23 at 9:02 AM, the surveyor observed Resident #5 seated in a wheelchair inside their room and not wearing an Ex Order 26. 4B1 [redacted] to the Ex Order 26. 4B1 with limitation. The surveyor reviewed the resident's medical record. The resident's Admission Record (AR; or face sheet that included admission summary) showed that the resident was admitted to the facility with diagnoses that included but were not limited to *Ex Order 26. 4B1* [redacted], and	F 658	Facility educator or designee to provide education to nursing staff to ensure residents with assistive devices are applied as recommended by therapy and orders are reflected on the order summary report, all orders for assistive devices are added to the residents assignments and task, & orders on Treatment administration Record for Splints are only signed when Nurse can attests that the splints are applied on 01-18-2023 and ongoing. The Unit Managers and or designee will monitor residents with orders for assistive devices (splints) and that they are applied, removed and signed according to Physicians orders weekly X 4 then Monthly X 4. Element # 4 Director of Nursing or designee will audit 5 resident on Functional Maintenance Program with Splints, Weekly X 2 then monthly X 2 then Quarterly X2 and present findings to Quarterly QAPI meeting for review and recommendations. Tag #F658 Cont'd Element#1 Resident#15: *Ex Order 26. 4B1* [redacted] assessment due 09/13/2022, was completed on 1-18-2023; Resident#15 sustained no adverse outcomes as a result of this deficient practice. Element#2 All residents have the potential to be affected by this deficient practice. For	

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F 658	Continued From page 20 Ex Order 26. 4B1 . The Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care with an Ex Order 26. 4B1 of NJ Exec. Order 26:4.b.1, indicated a Ex Order 26. 4B1 score of Ex out of 15, which reflected that the resident's cognition was Ex Order 26. 4B1. The Ex Order 26. 4B1 revealed that the resident had a Ex Order 26. 4B1 in Ex Order 26. in the Ex Order 26. 4B1 . The Order Summary Report (OSR) for December 2022 revealed an order dated NJ Exec. Order 26:4.b. for a Ex Order 26. 4B1 after morning care and remove after dinner as tolerated, to release during care, Ex Order 26. 4 and Ex Order 26. 4B1, every day and evening shift for Ex Order 26. 4B1 prevention and to document if refused. The Ex Order 26. for January 2023 showed that the NJ Exec. Order 26:4.b. order was updated on NJ Exec. Order 26:4.b. and revealed the same order for the Ex Order 26. 4B1 . On 01/09/23 at 11:38 AM, the surveyor observed the resident seated in a wheelchair inside their room with no Ex Order 26. 4B1. There was no Ex Order 26. at the bedside. On 01/09/23 at 11:39 AM, the surveyor interviewed the Certified Nursing Aide#1 (CNA#1) and informed the surveyor that she was the aide of Resident #5. CNA#1 stated that the resident was Ex Order 26. 4B1, required total assistance with care and Ex Order 26. 4B1, and was able to feed themselves post set up. She further stated that the resident had no Ex Order 26. or other Ex Order 26. 4B1.	F 658	those resident with Quarterly Braden Scale Assessments due, and audit performed identified, no other residents were identified as having a negative outcome. Element#3 The facility educator provided education on 01-18-2023 to the nursing staff. Facility educator or designee will provide ongoing education to the nursing staff. The Minimum Data Set (MDS) Coordinator Director, or designee will trigger the Braden assessment prior to the Quarterly due date, so it will trigger the nurses to complete. The MDS Coordinator Director or designee will generate a list each month for the Unit Managers to post for the Nursing Staff to complete. The Unit Managers will review all due Quarterly Braden Scale assessment during morning meetings. The ADON or designee will review each week for completion of quarterly Braden assessments weekly X4 then monthly X4. Element#4 Director of Nursing or designee will audit 10 Braden assessment per week, then Monthly X2, then Quarterly X 2 and present findings to the Quarterly QAPI meeting for review and recommendations. Element#1 Resident#83 NJ Exec. Order 26:4.b.1 was e-signed on 01/17/23. Resident#83 sustained no negative outcome as a result of this deficient practice.	

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F 658	Continued From page 21 On that same date and time, CNA#1 acknowledged that the resident had a limitation on the Ex Order 26. 4B1 of the body. She further stated that was on functional maintenance program (FMP) active Ex Order 26. in both Ex Order 26. 4B1 and well tolerated. She indicated that there were no significant changes noted with the resident's Ex Order 26. 4, the resident had limitations to Ex Order 26. 4B1 and not something new to the resident. On 01/10/23 at 11:05 AM, the surveyor interviewed Licensed Practical Nurse #1 (LPN#1). LPN#1 stated that Resident #5 was Ex Order 26. 4B1 . At that time, both the surveyor and LPN#1 entered the resident's room and observed the resident seated in a wheelchair not wearing a Ex Order 26. 4B1 . Upon exiting the resident's room, the surveyor asked the nurse if the resident was wearing an Ex Order 26. 4B1 . LPN#1 stated that she did not see the resident wear a Ex Order 26. or any Ex Order 26. 4B1 . Furthermore, the surveyor asked LPN#1 why she signed the January 2023 electronic Treatment Administration Record (eTAR) for having the Ex Order 26. 4B1 when she did not observe and applied a Ex Order 26. to the resident, and LPN#3 did not respond. LPN#1 acknowledged that she worked on January 2023 and she signed the Ex Order 26. 4 that the Ex Order 26. 4B1 was applied even though it was not. LPN#1 indicated that there were no significant changes noted with the resident and that the limitation to the resident's Ex Order 26. 4B1 was not something new to the resident. On 01/11/23 at 12:11 PM, the survey team met	F 658	Element#2 All residents with Quarterly due Braden Scale assessments have the potential to be negatively affected by this deficient practice. For those resident with Quarterly Braden Scale Assessments due, and audit performed identified, no other residents were identified as having a negative outcome. Element#3 The facility educator provided education on 01-18-2023 to the nursing staff on ensuring that they complete due assessments by providing their electronic signature. Facility educator or designee will provide ongoing education to the nursing staff. The Unit Managers will review all due Quarterly Braden assessment during morning meetings to ensure all due assessments are signed and completed. The ADON or designee will review each week for completion the quarterly Braden assessments weekly X4 then monthly X4. Element#4 Director of Nursing or designee will audit 10 Braden Scale assessment for completion per week, then Monthly X2, then Quarterly X 2 and present findings to the Quarterly QAPI meeting for review and recommendations. Element#1 F658 Cont'd	

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F 658	Continued From page 22 with the Licensed Nursing Home Administrator (LNHA) and the DON and were made aware of the above findings. A review of the facility's Physician Orders Policy with a revision date of 9/29/15 that was provided by the DON included that policy directives known as "Physician Orders" will be obtained to manage the medical condition and a plan of care for each resident should be followed. On 01/17/23 at 01:20 PM, the survey team met with the LNHA and the DON. The DON stated that there was no additional information. The DON did not refute that there was an order for a *Ex Order 26. 4B1* for Resident #5. 2. According to the RAI (Resident Assessment Instrument) Manual (helps nursing home staff in gathering definitive information on a resident's strengths and needs which must be addressed in an individualized care plan) revised on October 2019 M-2: Pressure Ulcer/Injury Risk Tools, screening tools that are designed to help identify residents who might develop a pressure ulcer/injury. The common risk assessment tool is the Braden Scale for Predicting Pressure Sore Risk. On 01/05/23 at 12:20 PM, the surveyor interviewed Registered Nurse/Unit Manager#1 (RN/UM#1) who informed the surveyor that she was not sure if Resident #15 had facility-acquired *Ex Order 26. 4B1*. On 01/05/23 at 12:28 PM, the surveyor observed the resident seated with *Ex Order 26. 4B1*. The surveyor reviewed Resident #15's medical	F 658	Element#1 Resident #136 *Ex Order 26. 4B1* recommended by *Ex Order 26. 4B1* physician on 01-05-2023 to discontinue *Ex Order 26. 4B1* to the resolved *Ex Order 26. 4B1* was carried out on 01-11-2023. Resident # 136 sustained no negative outcome as a result of this deficient practice. Element#2 All resident seen by wound care team have the potential to be adversely affected by this deficient practice. A review of all wound care recommendations on 01-05-2023 for Unit 1 were identified and subsequently all treatment order were carried out and transcribed on 01-13-2023. No other residents on any other unit was adversely affected by this deficient practice. Element#3 Facility educator provided education to the Nursing Staff on 01-17-2023 and ongoing. Wound care nurse, Unit Managers or designee will ensure all recommended wound care treatments orders are reviewed and transcribed per physicians orders within 24 hrs. Wound care nurse or designee will audit 5 wound care treatment orders weekly X2 then monthly X 2 then quarterly X 1. Element#4	

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F 658	Continued From page 23 records. The AR showed that the resident was admitted to the facility with diagnoses that included [redacted]. The QMDS with an ARD of [redacted] showed a [redacted] score of [redacted] out of 15 which indicated that the resident's cognitive status was [redacted]. The [redacted] included that the resident had a facility-acquired [redacted]. The electronic medical record showed that the [redacted] was last done on [redacted]. On 01/17/23 at 01:20 PM, the survey team met with the LNHA and the DON and were made aware of the above findings. On 01/17/23 at 02:27 PM, the surveyor met and asked RN/UM#1 regarding the facility practice and protocol with regard to the use of the Braden Scale, how often it should be done, and who was responsible for completing the assessment in the presence of another surveyor and the facility's Director of Social Services (DSS). The RN/UM stated that the facility's protocol was that the Braden Scale assessment was the responsibility of the nurses, "ultimately" the Unit Manager (UM), and should be done every three months (quarterly).	F 658	Director of Nursing or designee will perform and audit of 10 Recommended wound care audit Weekly X2 then Monthly X2 then Quarterly X2 and present finds to Quarterly QAPI for review and findings.	

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F 658	Continued From page 24 On that same date and time, the surveyor asked RN/UM#1 why the resident's *Ex Order 26. 4B1* [redacted] was last done on [redacted]. The RN/UM stated that she was off from November 2022 and came back on January 3rd of 2023. She further stated that the resident was due on September 2022 for a *Ex Order 26. 4B1* [redacted] and it was not done "probably" because she was pulled all over places and at times was assigned to the "cart", and "it was missed." RN/UM#1 further stated "honestly, it was not done," as it was supposed to be done quarterly. On 01/18/23 at 01:56 PM, the DON provided a copy of the *Ex Order 26. 4B1* [redacted] for an effective date of [redacted] and electronically signed (esigned) by RN/UM#1 on [redacted]. The surveyor asked and verified with the DON why the [redacted] *Ex Order 26. 4B1* [redacted] was signed on 01/18/23 after the surveyor's inquiry. The DON acknowledged that the *Ex Order 26. 4B1* [redacted] for the date [redacted] was backdated (to date earlier than the actual date; predate; antedate) and was done and esigned on 01/18/23. The DON did not refute the findings. On 01/18/23 at 02:16 PM, during the exit conference of the survey team with the LNHA and the DON, there was no additional information provided by the facility. 3. On 01/11/23 at 11:04 AM, the surveyor observed Resident #83 seated in a wheelchair with a *Ex Order 26. 4B1* [redacted], clean and well-dressed.	F 658		

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F 658	Continued From page 25 The surveyor reviewed the medical records of Resident #83. The resident's AR reflected that the resident was admitted to the facility with diagnoses that included *Ex Order 26. 4B1* [redacted].	F 658		
	The QMDS with an ARD [redacted] showed that the resident's cognitive skills for daily decision-making were *Ex Order 26. 4B1* and at risk for developing a *Ex Order 26. 4B1*. The [redacted] revealed that there was [redacted] identified during the lookback period. The resident's personalized care plan with a focus that the resident was at risk for alteration in *Ex Order 26. 4B1* related to *Ex Order 26. 4B1* and *Ex Order 26. 4B1* was created on [redacted] with a goal to decrease/minimize *Ex Order 26. 4B1*. The electronic medical record showed that the last *Ex Order 26. 4B1* was on [redacted] with an incomplete assessment. The [redacted] *Ex Order 26. 4B1* was incomplete because it was not esigned. On 01/17/23 at 01:20 PM, the survey team met with the LNHA and the DON and were made aware of the above findings. On 01/18/23 at 9:42 AM, the surveyor interviewed RN/UM#1 in the presence of LPN#1 regarding			

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F 658	Continued From page 26 the resident's Ex Order 26. 4B1 . The surveyor asked the RN/UM why the last Ex Order 26. 4B1 that was done on the resident was on NJ Exec. Order 26:4.B and if the assessment should have been done every quarter every time the Ex Order 26. 4B1 was done. RN/UM#1 stated that the Ex Order 26. 4B1 was not done "probably" because she was pulled all over places and at times was assigned to the "cart", and "it was missed." On 01/18/23 at 12:29 PM, the survey team met with the LNHA and the DON. The DON stated that the Ex Order 26. 4B1 was the assessment tool that the facility utilized for the resident who is at risk for developing a Ex Order 26. 4B1 and should have been done every quarter. On 01/18/23 at 02:16 PM, during the exit conference of the survey team with the LNHA and the DON, there was no additional information provided by the facility. 4. On 01/05/23 at 10:46 AM, the surveyor interviewed RN/UM#2 who stated that Resident #136 had a Ex Order 26. 4B1 on the Ex Order 26. 4B1 that was there upon admission. On 01/05/23 at 11:53 AM, the surveyor observed Resident #136 in bed with eyes closed, lying flat on their back. The resident responded to the surveyor knocking on the door and stated that he/she was watching the television had fallen asleep. The resident stated that he/she had no concerns and had no knowledge of any issues with his/her Ex Order 2.	F 658		

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F 658	Continued From page 27 On 01/10/23 at 11:08 AM, the surveyor interviewed LPN#2 who stated that she was responsible for administering any treatments to Resident #136 but was not the usual nurse and was a floater, meaning that she was not always working on the same floor. The LPN added that she knew she had to administer a [Ex Order 26. 4B1] for Resident #136 but was unsure of the [Ex Order 26. 4B1] and would have to check. LPN#2 added that previously the facility had a *Ex Order 26. 4B1* who was doing treatments. LPN#2 added that she knew the resident currently had [NJ Exec. Order 26:4.b.1]. On 01/10/23 at 12:01 PM, the surveyor interviewed CNA#2 who stated that she performed total care for Resident # 136. The CNA stated that she had seen a [Ex Order 26. 4B1] on the resident's [Ex Order 26. 4B1] area but thought there was [NJ Exec. Order 26:4.b.1]. On 01/10/23 at 12:30 PM, the surveyor reviewed the *Ex Order 26. 4B1* for Resident #136. The resident's [Ex Order 26. 4B1] revealed a diagnosis of *Ex Order 26. 4B1*. The *Ex Order 26. 4B1* with an [Ex Order 26. 4B1] dated [NJ Exec. Order 26:4.b.1], reflected a [Ex Order 26. 4B1] score of [Ex Order 26. 4B1] out of 15, indicating that the resident had a [Ex Order 26. 4B1]. A review of the resident's January 2023 [Ex Order 26. 4B1]) revealed that there was a *Ex Order 26. 4B1* dated [NJ Exec. Order 26:4.b.1] for '*Ex Order 26. 4B1*	F 658		

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Ex Order 26. 4B1 every day and evening shift for care. Apply post care twice a day *Ex Order 26.* ." In addition, the *Ex Order 26. 4* revealed that the *Ex Order* was being signed as administered by the nurses on the day shift and on the evening shift.

The resident's wound physician's consultation dated *NJ Exec. Order 26:4.b.1* revealed that *Ex Order 26. 4B1* located on the *Ex Order 26. 4B1* was resolved. Further review revealed a plan of care: "Plan of care discussed with facility staff-although the *Ex Orde* has been resolved, continue *Ex Order 26. 4B1* ."

On 01/11/23 at 11:19 AM, the surveyor interviewed LPN#2 who stated that she administered the *Ex Order 26. 4B1* to Resident #136's *Ex Order 26. 4B1* according to the *Ex Order 26. 4B1* . The LPN added that she thought the *Ex Order 26. 4B1* was being used *Ex Order 26. 4B1* but could not speak to whether that was appropriate use of *Ex Order 26. 4B1* on a *Ex Order 26. 4B1*. The LPN added that the resident had a prior *Ex Order 26. 4B1* on the *Ex Order 26. 4B1* that was treated with *Ex Order 26. 4B1* and that the *Ex Order 26. 4B1* had healed but was unsure of the date the *Ex Order 26. 4B1* healed. The LPN then stated that a *NJ Exec. Order 26:4* physician came in every week on Thursday mornings.

On 01/12/23 at 10:25 AM, the surveyor interviewed via telephone the *Ex Order 26. 4B1* who stated that she was the scribe who works with the *Ex Order 26. 4B1* assigned to the facility. The *Ex Order 26. 4B* stated that she works for the medical group of *Ex Order 26. 4B1* and had been coming to the facility for years because she was assigned to the

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facility. In addition, the RTSS stated that she works closely with the physician assigned to the facility and would be able to answer any questions regarding the residents at the facility because she had all the records and the physician assigned to the facility had office hours and may not be available. The RTSS stated that she was at the facility that morning with the physician and had not seen Resident #136. The RTSS stated that she completes the recommendations as per the physician's orders and leaves the recommendations with the facility and then uploads them to her computer at the office.

At that time, the RTSS was able to review her notes regarding Resident #136 and stated that the resident was seen by the physician from NJ Exec. Order 26:4.b.1 The RTSS added that 01/05/23 was the last consult because the Ex Order 26. 4B1 was NJ Exec. Order 26:4 and that was indicated on the Ex Order 26. 4B1 consult left at the facility. In addition, the RTSS stated that the Ex Order 26. 4B1 recommendation on 01/05/23 was to apply a Ex Order 26. 4B1 . The Ex Order 26. 4B stated that the Ex Order 26. 4B1 should have been discontinued on 01/05/23 because the Ex Order 26. 4B1 was NJ Exec. Order 26:4. The RTSS stated that Ex Order 26. 4B1 was not a Ex Order 26. 4B1 because it does not work that way. The RTSS stated that she thought the facility would automatically discontinue the Ex Order 26. 4B1 because the Ex Order 26. 4B1 was healed, and the Ex Order 26. 4B1 was used for Ex Order 26. 4B1. The RTSS stated that she had been leaving the recommendations with a Ex Order 26. 4B1 from the facility, but that Ex Order 26. 4B1 had left the facility back in December. The RTSS stated that she currently left the paperwork, which was the recommendations, with the unit manager on each

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floor and does discuss recommendations with them if they were there but sometimes, she was in the facility in the early morning and the unit manager may not be there. The RTSS added that if there was no unit manager for the floor that she left the paperwork in the unit manager's office and if there were any questions, she was readily available.

On 01/12/23 at 12:00 PM, the surveyor further reviewed the medical record for Resident #136.

A review of the resident's electronic ORS revealed that there was a PO with a start date of [redacted] for '[redacted] topically every day and evening shift for care. Apply post care [redacted]." In addition, the [redacted] had a discontinued date of [redacted]

Further review of the [redacted] revealed that the [redacted] for [redacted] dated [redacted] was discontinued on 01/11/23 after surveyor inquiry.

Further review of the January [redacted] revealed that the [redacted] was applied from 01/05/23 until surveyor inquiry on 01/11/23.

On 01/12/23 at 12:37 PM, the surveyor interviewed the DON who stated that the wound physician and RTSS came to the facility every Thursday and left recommendations. The DON added that the unit manager on the floor was responsible for following up with the recommendations for the residents on that floor. The DON stated that there was a disconnect because the RTSS left the consult recommendations with the RN/UM on the first floor and the RN/UM had unexpectedly called out

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F 658	Continued From page 31 and was not returning to the facility because she had previously resigned, and the recommendation was not done. The DON stated that the [redacted] should have been discontinued on [redacted]. The DON added that a [redacted] order was corrected yesterday. On 01/17/23 at 01:20 PM, the survey team met with the LNHA and DON. The DON stated that she was unsure if there was a policy and procedure for the [redacted]. The DON added that the procedure or process was that the recommendations from the [redacted] would go to the [redacted] or unit manager, whoever was designated that day and they would follow up with the recommendations. The DON stated that what happened with Resident #136 was that the RN/UM had not shown up on 01/06/23 and the recommendation was not done. The surveyor was not provided with a policy on the process for the [redacted]. A review of the facility's Pressure Injuries Overview Policy with a revised date of March 2020 that was provided by the LNHA included that the purpose of this procedure is to provide information regarding definitions and clinical features of pressure injuries that can be included but not limited to MDS assessments reference current definitions in the RAI User's Manual. A review of the facility's Pressure Injury Risk Assessment Policy with a revised date of March 2020 that was provided by the DON revealed that the purpose of this procedure is to provide guidelines for the assessment of the structure and identification of residents at risk of developing new pressure injuries or worsening of	F 658		

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F 658	Continued From page 32 existing pressure injuries included the use of only a facility-approved risk assessment tool to obtain risk assessment data.	F 658		
F 689 SS=D	NJAC 8:39- 11.2(b), 27.1(a), 29.2(d) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record, and review of other facility documentation, it was determined that the facility failed to a) initiate a baseline care plan which included at risk for falls within 48 hours of admission and thoroughly and completely investigate a fall to include the addition of interventions to prevent a fall for one of four residents reviewed for [redacted], Resident #321; and b) failed to follow and maintain NJ Exec. Order 26:4.b.1 interventions as written on the resident's plan of care for one of four residents reviewed for [redacted] Resident #132. The deficient practice was evidenced by the following: 1. On 01/05/23 at 12:05 PM, the surveyor observed Resident #321 in a reclined chair in the day room of the [redacted] floor unit. The resident's	F 689	F689 Element#1 Resident#321; admission on Ex Order 26. 4B1 Ex Order 26. 4B1 was not initiated within 48 hours of admissions. Resident was not adversely affected by this deficient practice. Resident#321 Ex Order 26. 4B1 was created on 01/05.23. Resident. Resident#321 Actual Ex Order 26. 4B1 on 12/28/2022; care plan was created on 01/05/2023. Resident#321 sustained no negative adverse outcome as a result of this deficient practice. Element#2	2/28/23

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CAREONE AT NEW MILFORD	**800 RIVER ROAD NEW MILFORD, NJ 07646**

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F 689	Continued From page 33 [redacted] of the [redacted] was [redacted]. On 01/09/23 at 9:45 AM, the surveyor reviewed Resident #321's [redacted]. The [redacted] indicated that the resident had diagnoses which included but were not limited to [redacted]. A review of the electronic medical record included the following Minimum Data Set (MDS), an assessment tool used to facilitate the management of care,: MDS dated [redacted] coded as discharge assessment-return anticipated. MDS dated [redacted]2 coded as discharge assessment-return anticipated. The MDS dated [redacted] indicated the resident was admitted on [redacted]. The resident had a [redacted] score coded as [redacted], which indicated the resident was unable to [redacted]. The resident's Cognitive Skills for Daily Decision Making was coded as [redacted], [redacted]. The electronic Progress Notes included the following: On 12/22/22 Resident #321 was found on the floor and transferred to the [redacted]. The resident was then discharged home to the family on [redacted].	F 689	All other Resident's admitted has the potential to be affected by this deficient practice. After review of current residents admitted with falls no other residents were affected by this deficient practice. All residents with an actual fall has the potential to be affected by this deficient practice. After review of current falls, no other resident was negatively affected by these deficient practice. Element#3 Facility educator or designee provided in-servicing to the Nursing staff on 01-17-2023 and ongoing all shifts to ensure all admissions have an At Risk Fall care plan within 48 hours of admissions. All actual falls are to have a care plans updated with 24 hours of the incident. Facility educator or designee will provide ongoing education to Nursing Staff to ensure all new admissions have an at risk fall care plan initiated within 48 hrs. in addition, all resident with actual falls the nurse will updated the care plan within 24 hours of the incident. Director of Nursing or designee will review all Falls during morning meeting to ensure care plan with interventions are updated. Element#4 Director of Nursing or designee will audit 5 admissions to ensure all newly admitted residents have an risk fall care plans initiated within 48 hrs. of admission, weekly X2, Monthly X2 and Quarterly X 1. The Director of Nursing or designee will	

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F 689	Continued From page 34 On Ex Order 26. 4B1 Resident #321 was readmitted to the facility. On Ex Order 26. 4B1 Resident #321 was found on the floor and transferred to the hospital. On Ex Order 26. 4B1 Resident #321 was readmitted to the facility. The resident's individualized comprehensive care plan included a care plan for at risk for falls due to history of Ex Order 2, Ex Order 26. 4B1 . 12/28/22 Actual Ex Order with NJ Exec. Order 2. Date Initiated: 01/05/2023. created by Ex Order 26. Coordinator. Revision on: 01/10/2023. created by Director of Nursing (DON). The interventions listed included the following: Patient assessed by 2 nurses on floor, vitals taken, Ex Order call placed for immediate hospital transfer to [name redacted]. Date Initiated: NJ Exec. Order 26:4.b.1 Created by: DON Ex Order 26. 4B1 and treatment as ordered Date Initiated: 01/05/2023 Created by: MDS Coordinator Have commonly used articles within easy reach Date Initiated: 01/05/2023 Created by: MDS Coordinator Maintain bed in low position Date Initiated: 01/05/2023 Created by: MDS Coordinator Provide assistance to transfer and ambulate as needed Date Initiated: 01/05/2023 Created by: MDS Coordinator Reinforce the need to call for assistance	F 689	audit 5 Residents with an actual fall incident for updated care plan within 24 hours of incidents. All Incident & Accident will be updated in the care plan within 24 hours of incident occurrences. The Director of Nursing or designee will audit 5 residents with an incident weekly X 2, monthly X 2, then Quarterly X 1. Findings will be reported to the Quarterly QAPI for further review and recommendations. Element#1 Resident#321 Ex Order incident, Interdisciplinary notes and updated care plan with interventions for fall on Ex Order 26. 4B1 when readmitted was initiated on Ex Order 26. 4B1. Resident #321 was not negatively affected by this deficient practice. Element#2 All other fall Risk residents have the potential to be negatively impacted by this deficient practice. All January fall Risk management assessment were audited for review of this deficient practice. All January fall risk management reports were reviewed for Interdisciplinary notes, completed statements, and updated care plans. Element#3 Facility educator or designee provided in-servicing to the Nursing staff on 01-17-2023 and ongoing.	

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F 689	Continued From page 35 Date Initiated: 01/05/2023 Created by: MDS Coordinator Report development of pain, bruises, change in Ex Order 26. 4B1 function, appetite, or Ex Order 26. 4B1 status per facility guidelines. Date Initiated: 01/05/2023 Created by: Ex Order 26.1 Coordinator There was no documented evidence that a care plan for NJ Exec. Order 26:4.b.1 was initiated at the time of Resident #321's admission or within 48 hours of admission or subsequent readmissions after the resident's discharges with return anticipated. On 01/11/23 at 10:35 AM, the DON provided the surveyor two incident/investigations for Resident #321 which the surveyor had requested any incidents or investigations since the resident's admission to the facility. A review of the facility provided incident/investigations included the following: 1. Fall 12/22/2022 09:35. Incident Description: ...resident was observed on the floor lying on the Ex Order 26. 4B1 ...Immediate Action Taken: During assessment, vs was taken ...resident transferred back to bed, able to move Ex Order 26. 4B1. NJ Exec. Order 26:4.b.1 noted. Order received to sent resident to hospital by Ex Order, family made aware. Attached was a Pain Evaluation Form and a Progress Note which included the same information in the incident form. There were no statements from staff members. There was no evidence an interdisciplinary team (IDT) meeting was held. There was no conclusion of the investigation. There was no added intervention to prevent a fall. 2. Ex Order NJ Exec. Order 26:4.b.1 13:00. Incident Description:	F 689	Director of Nursing or designee will review all falls prior to morning meeting. Unit managers & or Supervisor will ensure all statements are reviewed and completed prior to morning meeting. Falls will be reviewed in morning meeting for review of Interdisciplinary notes, & updated care plan with interventions. Director of Nursing or designee will review all Fall risk management for interdisciplinary notes, and updated care plans weekly. Element#4 Director of Nursing or designee will audit the previous months incident reports for completed statements, Interdisciplinary notes, updated Care plan weekly X 2, monthly X2 and Quarterly X 3. Findings will be reported to the Quarterly QAPI for further review and recommendations. Element#1 Resident# 132 NJ Exec. Order 26:4.b.1 were placed at the bedside at the the bedside floor. Resident # 132 was not negatively affected by this deficient practice. Element#2 All residents with orders for Floor mats have the potential to be negatively affected by this deficient practice. No other residents were identified as being negatively impacted by this deficient practice. Element#3 Facility educator and designee provided	

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F 689	Continued From page 36 NJ Exec. Order 26:4.b.1 [redacted] Staff in patients presence while waiting for [redacted]. Observed new [redacted] to patients [redacted] of [redacted]. It is an unwitnessed and unknown injury. Immediate Action Taken: Patient assessed by two nurses on floor, vitals taken, [redacted] call placed for immediate hospital transfer .... Attached was a Fall Risk Evaluation Form, a Pain Evaluation Form and a Progress Note which included the same information in the incident form. There were no statements from staff members. There was no evidence an [redacted] meeting was held. There was no conclusion of the investigation. There was no added intervention to prevent [redacted] On 01/11/23 at 11:15 AM, the surveyor asked the DON if the incident investigations that were provided to the surveyor were the complete and thorough investigation since there were no staff statements and no conclusion. The DON stated that she would look to see where the statements were and added that she just started here on 12/16/22. The surveyor then asked the DON what the process was after a resident fall. The DON stated that the staff would complete an incident report, do a fall assessment, send the resident to the hospital if needed. She then stated that someone would obtain statements from staff, usually team will meet and care plan would be updated with a new intervention to prevent fall. She added that she would have to talk to the UM to see if statements were obtained. On 01/12/23 at 11:34 AM, the surveyor asked the UM what the process was when a resident was admitted in regard to the initial care plan. The UM	F 689	education on 01-17-23 and ongoing to nursing staff regarding application of floor mats while residents is in bed. Nurse manager or designee will make rounds to ensure floor mats are at the bedside on the floor when residents are in bed daily. Nurse managers or designee will add this order to the physician orders under documentation for nurses to confirm and validate floor mats are at bedside as ordered. Element#4 Director of Nursing or designee will audit all resident with orders for floor mats weekly X 2, monthly X2 and Quarterly X 3. Findings will be reported to the Quarterly QAPI for further review and recommendations.	

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stated that the supervisor who initiated the resident's admission would do the care plan which included falls, Activities of daily living, skin integrity, there are eight total and it is done in the electronic medical record. She then added that after the resident was here would do a comprehensive care plan and add medications and diagnoses. The surveyor asked if the resident had an initial care plan. The UM stated that she would not be able to view only the initial baseline care plan. She added that the baseline care plan should be the date of admission.

On 1/12/23 at 11:45 AM, the surveyor interviewed the third floor UM regarding the process when a resident had a fall. The UM stated that the nurse and supervisor would be called and they would assess the resident. That if there was an injury the staff would provide first aid or call 911. The family and physician would be notified. The nurse would then initiate an incident report which included statements from staff. The same day or the following day the IDT would meet which included the DON, the assistant DON, physical therapist, recreation staff and Social Worker to discuss interventions [to put in place to prevent a fall]. She then added that if the fall was not witnessed the staff would investigate how the fall happened and how to prevent another fall.

On that same date and time, the surveyor then asked the UM the reason why Resident #321's care plan did not include an additional intervention to NJ Exec. Order 26:4.b.1. The UM stated that Resident #321 was transferred to the Ex Order 26. 4B1 both times after NJ Exec. Order 26:4.b. That the resident was sent out and did not come back and that the staff would revisit what intervention to put in place when the resident returned. The UM then

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F 689	Continued From page 38 stated that the first [Ex Orde] occurred on [NJ Exec. Order 26:4.b.1] and that the resident went to the [Ex Order 26. 4B1] and the family took the resident home from [Ex Order 26. 4B1]. The resident was then readmitted to the facility here on [Ex Order 26. 4B1]. The UM added that she "was not here" [when the resident returned]. The surveyor then asked the UM the reason why an intervention to [NJ Exec. Order 26:4.b.1] was not implemented on [Ex Order 26. 4B1]. The UM stated that the resident did not return to the facility right away so it [an added intervention] was not revisited. She added that the resident was not our patient anymore so it [an added intervention] was not triggered to be revisited. The UM then stated that the resident was considered a new admission so there was not a trigger for the [Ex Order] team to meet. At that time, the surveyor then asked the UM if there was a IDT team meeting and any additional intervention was added to the care plan to prevent another [NJ Exec. Order 26:4.b.1] the resident returned to the facility. The UM stated that the IDT did not meet, so no additional interventions were added. The UM added that the resident had the interventions that were already in place. The surveyor then asked the UM why the date on care plan for [NJ Exec. Order 26:4] was initiated (started) on [NJ Exec. Order 26:4.b.1] which indicated that the interventions listed were not implemented until [NJ Exec. Order 26:4.b.1]. The UM stated that she did not know why the care plan had the date of [NJ Exec. Order 26:4.b] 3 as when the care plan was initiated. The surveyor then asked the UM if Resident #321 had a care plan for [NJ Exec. Order 26:4] initiated on admission. The UM stated that she could not say if the resident had the care plan for [NJ Exec. Order 26:4] initiated on admission since she was not the person that did it. She added that during that time she had been the nurse on the medication cart so that was the reason why she did not know	F 689		

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F 689	Continued From page 39 about the dates on the care plan. Furthermore, the UM then stated that the second [NJ Exec. Order 26:4.b.1] was on [NJ Exec. Order 26:4.b.1] when the resident was noted to be on the floor in a storage room. The resident was transferred to the [Ex Order 26. 4B1] and returned to the facility on [Ex Order 26. 4B1]. The UM then stated that there was an IDT meeting but there was not an IDT note. She added that the interventions were to have [Ex Order 26. 4B1], given a recliner chair and to be supervised in the dayroom. She stated that the interventions were documented on [NJ Exec. Order 26:4.b.1] in the Progress Notes but that the interventions were not on the care plan. On 01/12/23 at 12:21 PM, the surveyor interviewed the UM again and asked the UM if the expectation was for Resident #321 to have a care plan for risk for [Ex Order 2] prior to [NJ Exec. Order 26:4.b.1] 3. The UM stated that she would expect the resident to have a care plan prior to [NJ Exec. Order 26:4.b.1] but that "things are being done but not always on the care plan." She added that she did not know if the interventions would have been any different [prior to [NJ Exec. Order 26:4.b.1] what was currently on the resident's care plan. The UM then stated that the process was to find out why they were [NJ Exec. Order 26] to stop the next [Ex Orde]. She added that if warranted would put an additional intervention in place after a [Ex Orde]. The UM then stated that she wanted to clarify that the IDT was the one that put interventions into place on the care plan and that the nurses on floor did not. She added that the nurse may implement an immediate intervention but that the nurse does not update the care plan. The surveyor asked the UM is she was part of the IDT. The UM stated that she usually was part of the IDT but that because she had been working on the floor as a staff nurse she was not involved	F 689		

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F 689	Continued From page 40 at the time. On 01/17/23 at 9:10 AM, the surveyor asked the DON where the statements for the investigations for Resident #321 were. The DON stated "the UM didn't give it to you. Will check." On 01/17/23 at 11:30 AM, the surveyor interviewed the UM regarding the process for an incident investigation and if staff statements were obtained as part of the process. The UM stated that part of incident report is staff statements and that she gave the staff statements for Resident #321 to the DON last week. She then stated that the nurse assigned does the incident report and that the conclusion and intervention is done by the IDT. She stated that since the resident was discharged to the [Ex Order 26. 4B1] and then discharged from the [Ex Order 26. 4B1] to their home that a IDT meeting would not have been done. The surveyor then asked if after the second admission if a care plan should have been initiated. The UM stated that she was on a medication cart and did not check to see if the care plan was initiated after admission. She added that the Assistant DON (ADON) and DON are also responsible to look if the care plan is initiated at the time of admission. The UM then stated that when the second [Ex Orde] happened, they talked about [NJ Exec. Order 26:4.b.1] happened. The resident [Ex Orde] due to the obstruction in the storage room. The intervention was to check the storage room lock and send the resident to the [Ex Order 26. 4B1]. On 01/17/23 at 11:42 AM, the surveyor asked the DON the reason why the staff statements were not with the incident reports and were not originally provided to the surveyor. The DON stated she did not have all the paperwork	F 689		

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together because she had recently started at the facility and did not have an ADON or Infection Preventionist (IP) and was working the night shift at the facility. She added that the UM had the statements in her office and that the UM was on the medication cart two to three days a week.

At that same time, the surveyor then asked the DON what the process was after a resident had a fall. The DON stated that at morning meeting the staff would discuss the fall and make physical therapy aware. The team would discuss why the fall happened and what the team could do to mitigate (to lessen the seriousness of) any risk for injury. She added that the nurse does the incident report and the nurse manager would review the incident report. She stated that she had just started. She stated that the IDT meeting should be documented in the electronic medical record and the care plan would typically be updated with any new interventions.

Furthermore, the surveyor asked the DON if Resident #321 should have had a care plan for the risk for [redacted] when the resident was admitted to the facility. The DON stated that the resident should have had a care plan and that the ADON or IP would have initiated the care plan. The DON then stated that the resident went to the [redacted] after both [redacted]. The surveyor then asked the DON if Resident #321 should have had an intervention put in place after each [redacted]. The DON stated that the staff would ask for a [redacted] evaluation and that it would depend on the [redacted]. She added that it may not be a new intervention that is put in place but that it may be a "continuation of fall precaution" and it would depend on the cause of the [redacted] The surveyor then asked the DON if all the documents for an

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incident investigation was kept together. The DON stated that normally everything would be together for incidents and that they usually would be kept in nursing office. She added that she did not get to "put it all together." The DON then stated that she was reprinting the incident reports and would make a copy of staff statements.

On 01/17/23 at 12:34 PM, the DON provided the surveyor with two incident investigations for Resident #321. The surveyor asked the DON if they were the complete and thorough investigations. The DON checked the documents and stated that there was a page missing.

On 01/17/23 at 12:59 PM, the DON provided the surveyor two additional documents which were Progress Notes and included the following:

1. [redacted] 13:00 Care Conference Note. LATE ENTRY. IDT met to discuss Resident #321's [redacted] ...Per IDT will reassess interventions once resident returns from [redacted].

2. [redacted] 19:49 Care Conference Note. LATE ENTRY. ...Team recommends to have resident follow up with [redacted] upon return to facility.

A review of the facility provided incident investigations did not include documented evidence that an intervention was added to Resident #321's care plan after [redacted]

On 01/17/23 at 01:41 PM, the surveyor in the presence of the survey team, informed the Licensed Nursing Home Administrator (LNHA) and DON the concern that Resident #321 did not have a care plan for [redacted] initiated upon

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admission and that there were no added interventions after each [Ex Ord] to prevent another [NJ Exec. O]

On 01/17/23 at 1:44 PM, the surveyor, in the presence of the survey team and the LNHA, asked the DON what the purpose of an investigation of a fall was. The DON stated that the goal was to minimize risk for potential injury. She added that the IDT was to put in a plan and that an intervention would go directly on the care plan to prevent a further fall. She then stated that the nurse manager is responsible to update the care plan.

On 01/18/23 at 12:43 PM, the DON, in the presence of the survey team and the LNHA, stated that Resident #321 [Ex Ord] on [NJ Exec. Order 26:4.b.2] and that the intervention was to send the resident out to the [Ex Order 26. 4B]. She added that the family took the resident home from [Ex Order 26. 4B] and that when the resident came back to the facility that the resident was a new admission. The surveyor asked the DON if the resident was a discharge with a return anticipated (expected to return to the facility). The DON stated that it depended and that there was nothing documented. The DON then stated that the resident came back to the facility and a new assessment was done. She then stated that on [NJ Exec. Order 26:4.b.1] the resident went to the [Ex Order 26. 4B]. The surveyor asked the DON if the expectation after a [Ex Ord] was to add an additional intervention to prevent another [Ex Ord]. The DON stated "not if they left there is no expectation for an added intervention to prevent a [Ex Ord]." The DON then stated that the intervention at that time was to go to the [Ex Order 26. 4B]. The surveyor asked the DON if the expectation was for a resident to have a care plan for risk of [Ex Order 2]. The DON stated that all

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F 689	Continued From page 44 residents should have a care plan upon admission for a [redacted] risk. The surveyor then asked the DON if the expectation was to have a thorough and complete investigation to include an intervention added. The DON stated that it was not expected to have a thorough investigation and an intervention if the resident went to the [redacted]. The surveyor then asked the DON if an investigation should be closed. The DON stated "yes it should have been done." The surveyor then asked if the resident should have had a care plan initiated before 1/5/23. The DON stated that she would have done a care plan based on the resident's assessment when the resident returned to the facility. A review of the facility provided policy titled, "Falls and Fall Risk, Managing" with a revised date of March 2018, included the following: Under Policy Statement Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Under Policy Interpretation and Implementation Resident-Centered Approaches to Managing Falls and Fall Risk 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. 2. if a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e., to try one or a few at a time, rather than many at one). 3. Examples of initial approaches might include	F 689		

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F 689	Continued From page 45 exercise and balance training, a rearrangement of room furniture, improving footwear, changing the lighting, etc ... 5. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. 6. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable .... Under Monitoring Subsequent Falls and Fall Risk 1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling ... 3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. A review of the facility provided policy titled, "Fall Risk Assessment" with a revised date of March 2018, included the following: Under Policy Statement The nursing staff, in conjunction with ...others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information. Under Policy Interpretation and Implementation 1. Upon admission, the nursing staff and the physician will review a resident's record for a history of falls, especially falls in the last 90 days and recurrent or periodic bouts of falling over time ...	F 689		

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F 689	Continued From page 46 9. The staff and attending physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable. A review of the facility provided policy titled, "Assessing Falls and Their Causes" with a revised date of March 2018, included the following: Under Purpose The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. Under General Guidelines ...4. Residents must be assessed upon admission and regularly afterward for potential risk of falls. Relevant risk factors must be addressed promptly ... Under Steps in the Procedure After a Fall: ...8. Complete an incident report for resident falls no later that 24 hours after the fall occurs. The incident report form should be completed by the nursing supervisor on duty at the time and submitted to the Director of Nursing Services. Under Documentation When a resident falls, the following information should be recorded in the resident's medical record: ...6. Appropriate interventions taken to prevent falls. A review of the facility provided policy titled, "Care Plans-Baseline" with a revised date of March 2022, included the following: Under Policy Statement A baseline plan of care to meet the resident's immediate health and safety needs is developed	F 689		

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F 689	Continued From page 47 for each resident within forty-eight (48) hours of admission. Under Policy Interpretation and Implementation 1. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly car for the resident including but not limited to the following: a. Initial goals based on admission orders and discussion with the resident/representative; ... 2. The baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary per-centered comprehensive care plan (no later than 21 days after admission). The baseline care plan is updated as needed to meet the resident's needs until the comprehensive care plan is developed. 3. A comprehensive care plan may be used in place of the baseline care plan providing the comprehensive care plan is developed within 48 hours of the resident's admission and meets the requirements ... A review of the facility provided policy titled, "Care Plans, Comprehensive Person-Centered" with an edited date of 4/25/2022, included the following: ...13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 14. The Interdisciplinary Team must review and update the care plan: a. When there has been a significant change in the resident's condition; b. When the desired outcome is not met; c. When the resident has been readmitted to the facility from a hospital stay; ...	F 689		

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2. On 01/09/2023 at 10:11 AM, the surveyor observed Resident#132 in bed sleeping with the left side floor mat flipped up and leaning against the wall approximately five feet from the bed.

On 01/12/2023 at 9:54 AM, the surveyor observed the resident in bed sleeping. The left floor mat was located on the floor but was three feet from the edge of the bed.

On 01/17/2023 at 9:40 AM, the surveyor observed the resident in bed sleeping. The left floor mat was missing, and the right floor mat was down.

On 01/17/2023 at 9:45 AM, the surveyor observed the left floor mat on the other side of the room standing on its edge at the foot end of the roommate's bed.

The surveyor reviewed resident's medical records:

The AR indicated that the resident had diagnoses which included but not limited to Ex Order 26. 4B1 [redacted].

The MDS dated 12/13/2022 had a Ex Order 26. 4 score of [redacted] of 15 indicated that the resident's cognitive status was *Ex Order 26. 4B1* .

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F 689	Continued From page 49 The personalized care plan with an initiated date of 7/16/2021 and revised on 7/16/2021 reflected that the resident was at risk for [redacted] due to [redacted]. Interventions reflected NJ Exec. Order 26:4.b.1 initiated on [redacted] and revised on [redacted] A review of the incident and accident reports for falls revealed Resident #132 had three [redacted] dated NJ Exec. Order 26:4.b.1 [redacted]. All of which were unwitnessed [redacted] and reported no NJ Exec. Order 26:4.b.1 were indicated on the [redacted] incident. The resident had a Ex Order 26. 4B1 dated [redacted] indicated the order was active for [redacted] when resident in bed, and to check placement every shift. On 01/12/2023 at 10:03 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN). The LPN stated that [redacted] are used for safety because Resident #132 had severa[redacted] She further stated that when the resident is in bed they are supposed to be always down and the proper positioning for [redacted] was next to the bed. The LPN stated that the left one was not next to the bed probably when the aide was changing the resident. On 01/12/2023 at 10:12 AM, the surveyor interviewed the resident's Certified Nursing Aide (CNA). The CNA stated, "resident has the [redacted] to protect him/her from [redacted]. The mats should be on the floor next to bed on each side. When we change the resident we put them up, but we put them back down after. They should be	F 689		

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F 689	Continued From page 50 used while the resident is in bed. We pick them up, so they don't get dirty. We try not to step on them." On 01/12/2023 at 10:21 AM, the surveyor interviewed the Registered Nurse Unit Manager (RN/UM). The RN/UM stated nursing places the floor mats down once an order or intervention was received. She further stated that the mats get moved by housekeeping to clean the floor and then they get put back down when the floor dries. She indicated that nursing would move them to transfer the resident and the mats should not be moved at all for ADL care. A review of the Falls and Fall Risk, Managing, policy statement: section Resident-Centered approaches to managing falls and fall risk revealed, 1) the staff, with input of the attending physician, will implement a resident -centered fall prevention plan to reduce the specific factor of falls for each resident or with the history of falls. 7) In conjunction with the attending physician, staff will identify and implement relevant interventions as applicable to minimize serious consequences of falling. A review of the Certified Nursing Assistance Position Summary indicated under section, Essential Duties and Responsibilities; adhere to and practice safety, sanitation, and infection control practices. indicated under section; Daily Task section; Apply safety devices per physician's order following policy and procedure and follow established safety precautions in the performance of all duties. N.J.A.C. 8:39-27.1 (a)	F 689		

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F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility provided documents, it was determined that the facility failed to ensure that the Registered Nurse (RN) had the specific competencies and skill sets necessary to care for	F 726	F726 Element#1: Resident #15 was assessed by the [redacted] on 01-11-23 and resident was not negatively affected by	2/28/23

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F 726	Continued From page 52 residents' needs. This deficient practice was evidenced by the following: On 01/05/23 at 12:20 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who informed the surveyor that she was not sure if Resident #15 had facility-acquired [redacted]. On 01/05/23 at 12:28 PM, the surveyor observed the resident seated with *Ex Order 26. 4B1*. The surveyor reviewed Resident #15's [redacted]. The Admission Record (AR; or face sheet which included the admission summary) showed that the resident was admitted to the facility with diagnoses that included *Ex Order 26. 4B1* [redacted]. The Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of [redacted] showed a *Ex Order 26. 4B1* score of [redacted] out of 15 which indicated that the resident's cognitive status was *Ex Order 26. 4B1*. The [redacted] included that the resident had a *Ex Order 26. 4B1* [redacted]	F 726	the nurse deficient practice. Element#2: All residents with [redacted] have the potential to be negatively affected by the nurse deficient practice. Review of other residents with [redacted] on the unit revealed no other resident was identified as negatively affected by this deficient practice. Element#3: Registered Nurse/Unit Manager Received 1:1 education on the assessment of wounds by the facility educator. Registered Nurse/Unit Manager will receive 1:1 education by the Wound care nurse weekly X2. Competency assessment completed by the facility educator on 01-06-2023,and to be completed yearly by facility educator or designee. The Facility educator and designee conducted in-services for Nurse Managers, Supervisors and Nursing staff on wound care management on 01-17-23 in-servicing to be conducted yearly thereafter. The wound care Nurse or designee will observe 2 nurses every month performing a wound care treatment as part of their competency assessment till 100% compliance is reached. Don will provide oversight to ensure 100% of the nurses maintain competent in wound care management. Newly hired nurses will receive both in-services, and a competency assessment within their 90-day hire and yearly thereafter to include wound care management by the Wound care Nurse or designee.	

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F 726	Continued From page 53 The [redacted] showed that there was a [redacted] dated [redacted] to apply [redacted] every evening shift daily and PRN (as needed). Another [redacted] dated [redacted] for [redacted] every day and evening shift and dated 12/30/22 [redacted] apply to the [redacted] times a day for [redacted]. The personalized care plan did not reflect the actual [redacted] that the resident had on the [redacted]. [redacted] notes dated [redacted] showed the [redacted] were all [redacted]. The [redacted] notes included that the [redacted] was a [redacted]. A review of the [redacted]	F 726	Element #4 Director of Nursing or designee will audit 5 nursing staff a months X 6 months then 5 staff X 4 months then 3 staff X 1 month to ensure yearly competencies are completed. Director of Nursing or designee will review all new hired nurses education files for their completed wound care management competency assessment and training during their 90-day performance evaluation for completion every monthly X4 then Quarterly X2, the data will be reported to Quarterly QAPI for review of the findings for recommendations and follow-up.	

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F 726	Continued From page 54 was last done on [redacted] A review of the [name redacted] transcript record for RN/UM education that was provided by the Director of Nursing (DON) showed that the RN/UM had education about Pressure Injury Assessment, Interventions, and Prevention that was completed on 12/12/21. There was no education provided for pressure injury in 2022. On 01/09/23 at 11:22 AM, the RN/UM informed the surveyor that she was the assigned nurse to the resident. Both the surveyor and the RN went to the resident's room to observe the status of the resident's [redacted]. At that time, the RN/UM removed the [redacted] of Resident #15 and showed the [redacted] and [redacted] to the surveyor. The surveyor asked the RN/UM to describe the [redacted] including the stage of the [redacted]. The RN/UM was not able to describe the [redacted] and stated "I have to check the record first." On 01/09/23 at 11:50 AM, during an interview of the surveyor with the RN/UM, the RN/UM stated that the Wound Nurse (WN) left the facility, and the responsibility of weekly wound monitoring was now transferred to the RN/UM. She further stated that the responsibility of WN included once a week of rounding with the Wound Doctor (WD) and verifying wound staging and orders. The RN/UM was not able to state the exact date and approximation of when the WN left. On 01/10/23 at 9:12 AM, the surveyor interviewed the DON. The surveyor asked the DON what was the expectation for nurses with regard to wound	F 726		

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care and management. The DON stated that it was an expectation that nurses will be able to describe the wound that included the stage of the wound and its location. The surveyor notified the DON of the above findings.

On that same date and time, the DON stated that "I don't know what her (RN/UM) skill set was." The DON acknowledged that the RN/UM should be able to describe the wound as a nurse and an RN for her to notify the physician when a new wound developed, be able to suggest appropriate treatment, and not wait for the WD who comes once a week for the resident to get the treatment and care needed in the management of the wound.

At that same time, the DON informed the surveyor that the Ex Order 26. 4B1 were "probably Ex Order 26. 4B1," and not Ex Order 26. 4B1. The surveyor asked the DON if that was the case, and why the RN/UM did not verify that the Ex Order 26. 4B1 were not Ex Order 26. 4B1 since the Ex Order 26. 4B1 was identified on NJ Exec. Order 26:4.1, the DON had no answer.

On 01/17/23 at 01:20 PM, the survey team met with the LNHA and the DON and were made aware of the above findings. The surveyor followed up regarding the RN/UM's signed job responsibility, and the DON did not provide additional information.

On 01/18/23 at 9:42 AM, the surveyor met with the RN/UM in the presence of the Licensed Practical Nurse (LPN). The RN/UM stated that she was unable to remember that she did the competency for medication and treatment pass in the facility. The RN/UM further stated that she did

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F 726	Continued From page 56 not sign UM Job responsibility. Furthermore, the RN/UM stated that she was off from November 2022 and came back on January 3rd of 2023. She further stated that the resident was due on NJ Exec. Order 26:4.b.1 for a *Ex Order 26. 4B1* [redacted] and it was not done "probably" because she was pulled all over places and at times was assigned to the "cart", and "it was missed." The RN/UM further stated "honestly, it was not done," as it was supposed to be done quarterly. A review of the facility provided Unit Manager Essential Duties and Responsibilities (UMEDR) that was provided by the DON showed that the document was signed by the RN/UM on 01/18/23. The UMEDR was signed after the surveyor's inquiry. In addition, the UMEDR daily responsibilities included that the UM will review the following documentation for completion and identification of potential issues that included but were not limited to weekly head-to-toe skin assessments. On 01/18/23 at 02:16 PM, during the exit conference of the survey team with the LNHA and the DON, there was no additional information provided by the facility.	F 726		
F 730 SS=E	NJAC 8:39-27.1(a) Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service	F 730		2/28/23

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F 730	Continued From page 57 education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation, it was determined that the facility failed to ensure that the Certified Nursing Aide (CNA) received performance review for four of five CNA files reviewed. The deficient practice was evidenced by the following: On 01/12/23 at 12:50 PM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) the education, competencies and performance reviews for five CNA's. On 01/13/23, the facility provided the education and competencies for four of the five CNA's. The facility indicated that one of the five CNAs had resigned. The facility did not provide performance reviews for the five CNAs. On 01/17/23 at 01:45 PM, the surveyor, in the presence of the survey team and the Director of Nursing (DON), asked the LNHA to provide the performance reviews for the four CNAs. The facility did not provide performance reviews for the five CNAs. On 01/18/23 at 9:00 AM, the surveyor, in the presence of the survey team, asked the DON and LNHA for the performance reviews for the five CNAs. The DON stated that she would have to check with Human Resources again. On 01/18/23 at 12:51 PM, the surveyor, in front of	F 730	F0730 Element#1 All four of the current C.N.A's performance evaluations were completed by their Nurse Managers or designee by 01-31-23. Director of Nursing or designee will review all files to ensure compliance of completed 90-day performance review and annual performance review evaluations are done by February 28, 2023. Element#2 All residents have the potential to be affected by this deficient practice. No other residents identified were negatively affected by this deficient practice. Element#3 Facility educator or designee will in-service department heads & managers to complete their 90-day & annual performance evaluation for all employees. All employees will have their 90-day completed by the end of their probationary period, and annually thereafter by the Nurse Manager or designee. Human Resources or designee will provide a list via email of all employees due for their 90- day performance evaluations and annual performance review 14 days prior	

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F 730	Continued From page 58 the survey team and DON, asked the LNHA what the purpose of the performance review was. The LNHA stated that the purpose was to review the job expectations and to see if the staff were meeting the expectations. The surveyor then asked the LNHA how often the performance reviews should be done. The LNHA stated that it was done annually. The surveyor asked the LNHA if the performance reviews were done for the five CNAs. The LNHA stated that he did not know if they were done. The surveyor then asked who was responsible for the performance reviews. The DON stated that the unit managers did the performance reviews and that the documentation then goes to Human Resources. On 01/18/23 at 12:53 PM, the surveyor then asked the LNHA if he could provide the performance reviews for the five CNAs. The LNHA stated that he did not have the performance reviews "at this time." On 01/18/23 at 01:59 PM, the survey team met with the LNHA and DON to give them the opportunity to provide additional information. The LNHA stated that some processes needed to change. The LNHA did not provide the performance reviews for the five CNAs. On 01/18/23 at 02:04 PM, in the presence of the survey team. The LNHA asked the surveyor for the names of the five CNAs that the performance reviews were requested for. He stated that he had them [their performance reviews]. The LNHA left the conference room. On 01/18/23 at 02:06 PM, the LNHA entered the conference room and stated that he did not have the performance reviews.	F 730	to their due date to the department heads and Nurse managers. Director of Nursing or designee will provide oversight to audit and monitor Managers and Department heads compliance with completing employee 90-day and annual performance review evaluation by its due date monthly. Element#4 Director of Nursing or designee will audit 10 employee files a month X 4 then Quarterly X 3 for completed 90-day and yearly performance evaluations completion by due date. Review of the findings will be reported to the quarterly QAPI meeting for review and recommendations for follow-up if 100% compliance is not achieved.	

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F 730	Continued From page 59 A review of the facility provided undated policy titled, "Performance Evaluations" included the following: 1. A performance evaluation will be completed on each employee at the conclusion of his/her 90-day probationary period, and at least annually thereafter ...	F 730		
F 755 SS=E	N.J.A.C. 8:39-43.17 (b) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	F 755		2/28/23

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F 755	Continued From page 60 sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility provided documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure a) expired narcotic medications were removed from active inventory b) dispensed and received medication from the pharmacy were reconciled for accuracy which resulted in the wrong dosage stocked in the active inventory c) expired biological from 6/22 were removed from active inventory This deficient practice was identified for one of one of the electronic emergency (backup) machine [name redacted] observed and was evidenced as follows: 1. On 01/17/23 at 9:59 AM, the surveyor received the [name redacted] Inventory report from the Director of Nursing (DON). On 01/17/23 at 10:14 AM, during an interview with the surveyor, the Registered Nurse/Unit Manager (RN/UM) stated that as a supervisor, she was responsible for the reconciliation of the narcotic medications stored in the backup machine (cycle counts) with another supervisor. The Supervisors alternate days as assigned. The UM/RN also stated, "we do not reconcile the non-controlled substances". On 01/17/23 at 10:19 AM, the surveyor observed	F 755	F0755 Element#1: No residents were negatively affected by this deficient practice. All Expired Medications were removed from the back-up inventory on 01/17/2023. Element#2: All residents have the potential to negatively affected by this deficient practice. No residents identified were affected by this deficient practice. An audit was performed of all expired narcotics medications from the back-up machine was completed on 01/17/23 to reconcile if expired medication were ordered or removed from the back-up machine. The controlled Drug list generated from the Pharmacist dated back four month revealed no residents were affected. Element#3: Facility educator and designee provided education on checking for expired dates when removing medications from the medication back-up machine system to the nursing staff on 01-17-2023. Director of Nursing provided 1:1 education to Nursing Supervisor on 01-17-2023 to check for expired medications when	

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F 755	Continued From page 61 the RN/UM with the Licensed Practical Nurse (LPN) begin the cycle count for the controlled substance (narcotic) medications. At that time, the surveyor in the presence of the RN/UM and LPN, observed 15 of the 22 tablets for Lorazepam (medication used to treat anxiety) 0.25 milligram (mg) tablet that expired on 12/22/22. On 01/17/23 at 10:40 AM, the surveyor in the presence of the RN/UM and LPN observed one (1) of nine (9) tablets of Acetaminophen with Codeine (controlled pain medication) 300 mg/30 mg that expired on 12/15/22. At that time, the RN/UM stated expired medications should not have been in the backup machine. She informed the surveyor that during the narcotic cycle counts, the supervisors also checked for expiration, and it was missed. The RN/UM stated that she and the LPN were going to remove the expired narcotic medication, adjust the inventory, and notify the pharmacy. The removal was important to avoid administration to a resident who would not have received the full effect of the narcotic medication. 2. On 01/17/23 at 11:01 AM, the surveyor observed the RN/UM and the LPN begin the cycle count for the non-controlled substance medications. On 01/17/23 at 11:13 AM, in the presence of the RN/UM and LPN observed the compartment for Pramipexole (medication used to treat Parkinson disease) of 0.25 mg that contained six (6) tablets of Pramipexole 0.125 mg. Further review of the [name redacted] Inventory report reflected only a	F 755	performing the cycle count daily. All Nursing staff will be provided training on policy on procedure for checking for expired medications when performing cycle count or removing medications from the back-up machine. The Pharmacy will generate a list of all medications both controlled and non controlled in the Back-up machine to include expiration dates weekly for all the nursing supervisor and staff to reconcile daily during shift to shift count. The pharmacy generated list will be posted weekly by the Director of Nursing or designee. The Nursing Supervisor or designee will reconcile the list daily and remove all expired medication prior to it's expiration date. The Director of Nursing or designee will provide oversight and monitor the weekly pharmacy generated list for expired medications. Element#4: Director of Nursing or designee will audit the pharmacy generated back-up list against the back-up restock pharmacy slips weekly. against the pharmacy generated list for any expired medications Weekly X2 Monthly X2 then Quarterly X 2 and present findings to the Quarterly QAPI for review findings and recommendations to ensure a 100% compliance is achieved Element#1: No residents were negatively affected by this deficient practice. The wrong dosage	

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F 755	Continued From page 62 listing for Pramipexole 0.25 mg with a quantity on hand (QOH) of six. The RN/UM confirmed the same list did not include Pramipexole 0.125 mg and instructed the LPN to write the name of the medication name and the dose for further investigation. A review of the electronic Medical Record, Order Review Report dated 10/17/22 to 01/17/23. The report did not reveal Pramipexole 0.25 mg was ordered within the date range reviewed. 3. On 01/17/23 at 12:19 PM, in the presence of the RN/UM and LPN observed two (2) of four (4) syringes for Enoxaparin (medication used to prevent formation of clot) 30 mg that expired on 6/22. On 01/17/23 at 01:02 PM, during an interview with the surveyor, the RN/UM stated that the DON and the Assistant Director of Nursing (ADON) restocked the non-controlled medications. At that time, the surveyor received the [name redacted] Controlled Drug Count Record (CDCR) dated January 2023 from the RN/UM. The RN/UM stated that after the cycle count for the narcotic medications were completed each nurse signed the CDCR. The surveyor reviewed the CDCR dated 01/01/23 to 01/17/23 [up to the 7-3 AM shift] which reflected the dates reviewed were signed. A review of the facility provided CP Unit Inspection report in the past four months for the [name redacted] backup machine revealed the following:	F 755	medication was removed from the back-up machine on 01-17-2023. Element#2: All residents have the potential to negatively affected by this deficient practice. No residents identified were affected by this deficient practice. An audit was performed of all medications from the back-up machine was completed on 01/17/23 with a pharmacy generated list to reconcile medications in the backup pharmacy for the correct drug and dose by the Director of Nursing. The list generated from the Pharmacist dated back four months revealed no residents were affected. Element#3: Facility educator and designee will provide in-servicing to Nursing Supervisors, and Nursing staff on reconciling medications received from the pharmacy for restock in the back-up machine ongoing to be completed by 02-28-23. All Nursing staff will be provided training on the policy on procedure on restocking medications into the back-up machine. Education will include Two nurses must verify the correct drug and dosage of medication against the pharmacy generated packing slip sent prior to restocking all medications into the back-up machine. All restock packing slips will be placed in the Directors of Nursing office. The Director of Nursing or designee will review the slips weekly against pharmacy geberated list weekly and monitor for compliance.	

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F 755	Continued From page 63 10/11/22 -[name redacted] signature log, checked, indicated yes Back-up Box: -[name redacted] inventory par level (minimum and maximum quantity limits that was set for a certain item) checked, indicated not applicable -Comments: [name redacted] noted to have "unresolved discrepancies" at the time of inspection 11/8/22 -[name redacted] signature log checked, indicated yes Back-up Box -[name redacted] inventory par level checked, indicated not applicable 12/6/22 -[name redacted] signature log, checked, indicated yes Back-up Box -[name redacted] inventory par level checked, indicated not applicable -Comments: [name redacted] log missing counts 12/1, 12/3, 12/4, 12/5 and 12/6 1/9/23 -[name redacted] signature log, checked, indicated yes Back-up Box -[name redacted] inventory par level checked, indicated not applicable On 01/17/23 at 01:58 PM, the DON stated that the nursing supervisors checked the inventory counts and expiration of the narcotic medications daily while the Consultant Pharmacist (CP) checked the narcotic medication, and non-controlled medications once a month. The expired medications when found, was removed,	F 755	Element#4: Director of Nursing or designee will audit the restock pharmacy paxking slip against the weekly pharmacy generated list for any discrepancy in medications listed in the baxk-up machine Weekly X2 Monthly X2 then Quarterly X 2 and present findings to the Quarterly QAPI for review findings and recommendations to ensure a 100% compliance is achieved,	

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F 755	Continued From page 64 and the manager was informed. On 01/18/23 at 9:50 AM, the surveyor called and left a message with CP's office. On 01/18/23 at 12:30 PM, in the presence of the survey team, the DON stated that it was to her impression the CP checked the back up machine for expired medications. The Pharmacist from the provider pharmacy filled the medication in the machine. The DON also stated that the facility did not receive the medication that was placed in the back up machine. The DON stated our process involved the supervisors who checked for expiration date and reconciled the medications in the backup machine. The DON acknowledged the supervisors should have checked for narcotic medications and non-controlled medications. On 01/19/22 at 9:52 AM, the surveyor called the CP's office and was informed that the CP had returned the call to the facility yesterday and thought that the inquiry was resolved. On 01/19/22 at 10:11 AM, the CP returned the call of the surveyor. During the interview with the surveyor, the CP stated she was familiar with the facility but had only started a few months ago since the facility had a different CP. The CP explained her responsibilities which included drug regimen review, medication pass observation, and unit inspections. She clarified part of her role in the unit inspection was to check the shift-to-shift log, which indicated if the narcotic count was done and recorded. The CP stated that she had no access to the backup machine since that was the property of the provider pharmacy. The CP stated she had not checked the expiration dating of the medications contained in the [name	F 755		

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F 755	Continued From page 65 redacted] machine. She only checked expiration dating of medications in the carts or rooms. At that time, the CP stated that the unit inspection form had a section for back up box, the CP clarified that was not the backup machine. The CP stated the DON was new and LNHA was also fairly new and maybe there was a miscommunication. The backup machine was the property of the provider pharmacy and thought the maintenance of the backup machine would have been done through the provider pharmacy. A review of facility policy provided, "Storage of Medications" revised on 11/2020, included ... Policy Interpretation and Implementation under section 3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Section 4. Drug containers that have missing incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.	F 755		
F 812 SS=D	NJAC 8:39-29.3(a)6, 29.4 (g) 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,	F 812		2/10/23

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F 812	Continued From page 66 state or local authorities. (i) This may include food items obtained directly 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 pertinent documents, it was determined that the facility failed to maintain the kitchen in a sanitary manner as evidenced by the following: On 01/06/23 at 11:31 AM, the surveyor toured the kitchen on the second day with Food Service Director (FSD). The surveyor observed the food prep area with open food and kitchen staff preparing the lunch meal trays. Above the prep area were two kitchen tiles in between two air vents with an accumulation of black debris. At that time, the FSD stated that the black debris was an "accumulation of dust." The surveyor asked the FSD regarding the cleaning schedule of air vents and above kitchen tiles. The FSD informed the surveyor that the air vents and above tiles should be cleaned once a month by the night shift kitchen staff and that there was a log for cleaning. In addition, the surveyor asked the FSD to show the cleaning log and when was the last time it was cleaned.	F 812	What corrective action(s) will be accomplished for those residents affected by the deficient practice? The Vents were cleaned by the Food Service Director on 01-07-2023.No residents were adversely affected by this practice. How will you identify those residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents residing in the facility have the potential to be affected by this practice. No residents were negatively affected by this deficient practice. What measures will be put into place or what systemic changes you will make to	

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F 812	Continued From page 67 On that same date and time, the FSD was not able to provide documentation and log that the air vents and tiles were cleaned. The FSD stated that there were no cleaning logs. He further stated that the air vents and above tiles should have been cleaned and that there should be no accumulation of dust because it was directly below the food prep area with open food. A review of the facility's Sanitization Policy with an edited date of 12/29/22 that was provided by the FSD included that the food service area is maintained in a clean and sanitary manner and that all kitchens, kitchen areas are kept clean, free from garbage and debris, and protected from rodents and insects. On 01/17/23 at 01:20 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) and were made aware of the above findings. The LNHA stated that there was no additional information. NJAC 8:39-19.7 (d)	F 812	ensure the deficient practice will not recur? The Food Service Director in-serviced all staff on vent cleaning and removal of dust on 01-07-2023. The Food Service Director created a monthly log sheet for air vent cleaning. Food service director or designee will provide ongoing education to the staff regarding vent cleaning and the monthly log to enforce compliance. The food service director or designee will monitor the logs and vents for dust weekly to ensure 100% compliance is achieved. How the corrective actions will be monitored to ensure the deficient practice will not recur? (ie what quality assurance program will be put into place?) The Food Service Director or Assistant will perform random observational vent audit for dust and cleaning log for 3 months and report its findings to the Administrator and present at Quarterly QAPI meetings. TIME FRAME 02/10/2023	
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	F 880		2/28/23

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F 880	Continued From page 68 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other 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	F 880		

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	315306	A. BUILDING _____ B. WING _____	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT NEW MILFORD	**800 RIVER ROAD NEW MILFORD, NJ 07646**

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F 880	Continued From page 69 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 review of the facility documents, it was determined that the facility failed to: a) perform hand hygiene appropriately for two of eight staff and, b) properly dispose of PPE (personal protective equipment) for one of two staff observed in TBP (transmission based precautions) room in accordance with the Centers for Disease Control and Prevention guidelines for infection control to mitigate the spread of COVID-19. This deficient practice was evidenced by the following: According to the U.S. CDC guidelines Hand	F 880	F-880 Element#1 Resident #19 was not negatively affected by this deficient practice: Element#2 All residents have the potential to be negatively affected by this deficient practice: No other residents identified were negatively affected by this deficient practice. Element#3	

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F 880	Continued From page 70 Hygiene Recommendations, Guidance for Healthcare Providers (HCP) for Hand Hygiene and COVID-19, page last reviewed 1/8/2021 included that the HCP should perform hand hygiene before and after direct contact with the residents and immediately after glove removal. In addition, when cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers, and this should be done outside the water when rubbing your hands, then rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. 1. On 01/05/23 at 10:30 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The DON stated that the most recent COVID-19 outbreak was on 01/04/23 with three residents. On 01/06/23 at 8:38 AM, the surveyor observed Certified Nursing Aide#1 (CNA#1) picked up a plastic bag of garbage from Resident#119's room, walked outside the room with both gloves on, discarded the plastic bag in the covered bin in the hallway, removed and discarded the used gloves into the same covered bin, and entered the resident's room without performing hand hygiene. The resident's room was NJ Exec. Order 26:4.b.1 and there was NJ Exec. Order 26:4.b.1. On that same date and time, the surveyor observed inside the resident's room, CNA#1 placed a clean towel on top of the unmade bed,	F 880	C.N.A #1 received 1:1 education on standard based precautions the proper disposal of garbage when removing it from a resident on contact or droplet precautions on 01-06-23. CNA #1 received education and competency on hand hygiene and donning and doffing PPE on 01-06-2023. CNA #1 received education on hand hygiene before and after contact with residents and their surfaces on 01-06-23. C.N.A #2 Facility educator provided 1:1 education on standard based precautions, TBP, 01-06-23. CNA #2 received education and competency on hand hygiene and donning and doffing PPE on 01-06-2023, and ongoing. C.N.A. #3 received 1:1 education on standard based precautions the proper on 01-05-23. CNA #3 received education and competency on hand hygiene and donning and doffing PPE on 01-06-2023. Nurse #1 Received 1:1 education on standard based precautions, TBP, 01-17-23 received education and competency on hand hygiene and donning and doffing PPE on 01-06-2023. LPN #2:Received 1:1 education by facility educator on standard based precautions, TBP, 01-05-23 & received education and competency on hand hygiene, donning and doffing PPE and to intervene and reinforce staff on proper use of PPE.	

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F 880	Continued From page 71 transferred Resident#119 from a wheelchair into the bed, and CNA#1 exited the resident's room without performing hand hygiene. At that time, the surveyor interviewed and asked CNA#1 about hand hygiene and infection control. CNA#1 stated that she was educated about hand hygiene and infection control by the Nurse Educator (NE). She further stated that hand hygiene should be performed immediately after removing gloves, before exiting the resident's room, before and after direct contact with the resident, and there should be no gloves in use while in the hallway. The surveyor then asked CNA#1 if she performed hand hygiene according to what she explained when she took care of Resident #119, CNA#1 stated "I should have." CNA#1 acknowledged that she did not perform hand hygiene. On 01/06/23 at 8:55 AM, the surveyor observed CNA#2 did not perform hand hygiene before and after entering the [redacted] room [redacted] for less than one minute after picking up the tray. CNA#2 informed the surveyor that the room was in [redacted] for [redacted] and was aware that hand hygiene should be performed before and after going out of the room. There were signs outside the room for Contact/Droplet precautions and instructions to perform hand hygiene before entering and after leaving the room. CNA#2 performed hand hygiene with the use of ABHR after the surveyor's inquiry. At that same time, Licensed Practical Nurse#1 (LPN#1) informed the surveyor that the resident in room [redacted] was on [redacted] for [redacted], was negative from the most recent [redacted] testing, [redacted], and "just" waiting to complete the	F 880	All departments heads & staff received education on Standard based precautions, TBP. Also received education and competency on hand hygiene and donning and doffing PPE on 01-17-2023 and ongoing education will continue by facilitator educator or designee. Audits to be conducted on Mon-Wed-Fri by Infection Preventionist (IP) or designee Infection Control Practices. Element #4 DON or designee will perform direct observation audits on 5 staff on hand hygiene, PPE use, disposal of PPE weekly X 2 Monthly X2, then Quarterly X 3. Findings will be presented to the Quarterly QAPI meeting for Review and recommendations.	

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F 880	Continued From page 72 10th day of isolation. On 01/09/23 at 11:13 AM, the surveyor observed room [Ex Order] had no signs for [Ex Order 26] and no PPE hung outside the door. The Registered Nurse/Unit Manager (RN/UM) stated that the resident completed the 10 days of isolation and remained *Ex Order 26. 4B1*. On 01/11/23 at 12:11 PM, the survey team met with the LNHA and DON and were made aware of the above findings. On 01/17/23 at 8:40 AM, the surveyor in the presence of the survey team met and asked the DON who was also the Infection Preventionist Nurse (IPN) regarding facility protocol for hand hygiene and PPE use. The DON stated that "anytime" the staff enters the room, after direct care, or removal of PPE, staff should use ABHR (alcohol-based hand rub), and hand washing with soap and water after three to five direct care of residents. The DON further stated that "it does not matter if there's an isolation sign or not," before entering the room, staff should perform hand hygiene, remove gloves and immediately perform hand hygiene before exiting the room. On that same date and time, the DON stated that all facility staff received in-service about hand hygiene and PPE use, and that staff should know what to do. She further stated that the above protocol of the facility was based on CDC. The DON stated that she spoke with CNA#1 and #2 about the above findings and acknowledged that the two aides did not perform appropriate hand hygiene. The DON did not refute the surveyor's findings.	F 880		

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F 880	Continued From page 73 A review of the facility's Handwashing/Hand Hygiene Policy with a reviewed date of 02/28/20 that was provided by the DON included that all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitor. Hand hygiene is the final step after removing and disposing of PPE, the use of gloves does not replace hand washing/hand hygiene. In washing hands. 2. On 01/05/23 at 12:11 PM, the surveyor toured wing [redacted] of the [redacted] floor [redacted] floor. The surveyor observed room [redacted] with a sign that indicated the unsampled resident was on [redacted] and required a gown, gloves, N95 mask and eye protection to be donned (put on) prior to entering the room. On 01/05/23 at 12:14 PM, the surveyor observed CNA#3 exit room [redacted] with a yellow disposable gown on and doffed (take off) the gown and placed it in a covered garbage gown that was across the hallway. The surveyor then asked CNA#3 the reason she did not doff the gown before exiting the room. CNA#3 stated that she used the garbage can in the hallway because the garbage can was full in the room. On 01/05/23 at 12:18 PM, the surveyor interviewed LPN#2 that was in the hallway. The LPN confirmed that she observed CNA#3 doff the gown in the hallway. The surveyor asked the LPN what the process was to exit a [redacted] room. The LPN stated that the gown should be taken off and put in the garbage in the room before exit. On 01/17/23 at 01:41 PM, the surveyor, in the	F 880		

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F 880	Continued From page 74 presence of the survey team, notified the LNHA and DON the concern regarding the doffing of the gown in the hallway. On 01/18/23 at 12:31 PM, the DON, in the presence of the survey team and the LNHA, stated that the staff were educated on donning and doffing for [redacted]. She added that the gown should have been doffed inside the room. NJAC 8:39-19.4(a)(1)(n)	F 880		

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift and evening shift as mandated by the State of New Jersey. The facility was deficient in CNA (Certified Nursing Aide) staffing for 13 of 14 day shifts and deficient in CNAs to total staff on 2 of 14 evening 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	S 560	S560 Element#1 Staffing reports 12-18-22 to 12-25-2023 no residents were negatively affected based on CNA staffing deficiency. Element#2 All residents have the potential to be negatively affected by this deficient practice. for those residents identified during the CNA staffing deficiency report dates none were negatively affected by this deficient practice.	2/28/23

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

Electronically Signed | 02/10/23

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S 560	Continued From page 1 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 12/18/22 and 12/25/22, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff on 3 of 14 overnight shifts as follows: -12/18/22 had 16 CNAs for 179 residents on the day shift, required 22 CNAs. -12/19/22 had 15 CNAs for 177 residents on the day shift, required 22 CNAs. -12/20/22 had 17 CNAs for 177 residents on the day shift, required 22 CNAs. -12/21/22 had 21 CNAs for 177 residents on the day shift, required 22 CNAs. -12/22/22 had 21 CNAs for 177 residents on the day shift, required 22 CNAs. -12/23/22 had 20 CNAs for 177 residents on the day shift, required 22 CNAs. -12/23/22 had 12 total staff for 177 residents on the overnight shift, required 13 total staff. -12/24/22 had 16 CNAs for 181 residents on the day shift, required 23 CNAs. -12/24/22 had 11 total staff for 181 residents on	S 560	Element#3 Quarterly open house to be scheduled by 02-28-2023 for all nursing positions Increased Salary ratios for RN's LPN's & CNA's Sign-on Bonuses increased and implemented on 02-10-2023. Director of Nursing & facility educator to partner with local high schools and CNA programs to offer clinical rotation site Recruitment incentive program for employees. Continue to train and utilize hospitality aides to transition them to C.N.A within 120 days of hire. Administrator will review and daily the facility recruitment website and screen for appropriate C.N.A and nursing staff candidates. Administrator or designee will screen appropriate applicants and schedule for interview with the Director of Nursing or designee. Director of Nursing to offer 6-week staffing contracts with listed agencies to increase the consistency of C.N.A staffing ratios by end of February 2023. Licensed Practical Nurses will work as C.N.A. to meet the C.N.A staffing ratios when staffing permits. The Administrator or designee will review daily census with the Director of Nursing or designee to ensure patient needs can be met based on staffing. The director of Nursing or designee will review and monitor the staffing daily with staffing coordinator to ensure the facility is meeting mandatory staffing standards weekly X3 monthly X2 and Quarterly X2.	

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S 560	Continued From page 2 the overnight shift, required 13 total staff. -12/25/22 had 18 CNAs for 177 residents on the day shift, required 22 CNAs. -12/25/22 had 12 total staff for 177 residents on the overnight shift, required 13 total staff. -12/26/22 had 21 CNAs for 177 residents on the day shift, required 22 CNAs. -12/27/22 had 16 CNAs for 177 residents on the day shift, required 22 CNAs. -12/28/22 had 19 CNAs for 177 residents on the day shift, required 22 CNAs. -12/29/22 had 19 CNAs for 175 residents on the day shift, required 22 CNAs. -12/30/22 had 20 CNAs for 175 residents on the day shift, required 22 CNAs. -12/31/22 had 18 CNAs for 175 residents on the day shift, required 22 CNAs. On 1/10/23 at 9:28 AM, the surveyor interviewed the Staffing Coordinator (SC) who stated that she was responsible for the schedules for the nursing department. The SC added that she was aware of the requirement for the ratios of a CNA to resident for the 7 AM to 3 PM day shift was eight (8) CNA's, for the 3 PM to 11 PM evening shift was 10 CNA's and for the 11 PM to 7 AM night shift was 14 CNA's. The SC added that the facility was meeting the required ratios. The SC also stated that if the ratio was not being met then she would notify a nursing supervisor, the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA). On 1/11/23 at 9:35 AM, the surveyor interviewed the DON who stated that she was aware of the requirement for the CNA ratios. The DON added that she doubted that the facility was meeting the ratios every day because staff had been out sick with COVID-19.	S 560	Element#4 Director of Nursing or designee will monitor staff ratios weekly X2 monthly X2 and Quarterly X3 and present findings to QAPI meeting Quarterly for review and recommendations.	

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S 560	Continued From page 3 On 1/18/23 at 11:49 AM, in the presence of the survey team, the surveyor interviewed the LNHA who stated that he met with the SC every day to discuss the nursing staffing. The LNHA stated that he thought they were meeting the required CNA to resident ratios. The LNHA could not speak to what the required ratios were for each shift. On 1/18/23 at 12:28 PM, the survey team met with the LNHA and DON. The LNHA stated that he abided by the state regulations for the required ratios for CNA's. The DON stated that the required ratios were one (1) CNA to eight (8) residents for the 7 AM to 3 PM day shift, one (1) CNA to 10 residents for the 3 PM to 11 PM evening shift and one (1) CNA to 14 residents for the 11 PM to 7 AM night shift. The DON acknowledged that the CNA ratios were a regulation that the facility had to follow. The DON also stated that the facility assessment was usually done annually by the LNHA and the rest of the team. The LNHA and DON acknowledged that the facility assessment had not addressed the ratios. A review of the facility policy revised August 2022 titled, "Staffing, Sufficient and Competent Nursing" provided by the DON included the following policy statement: "Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment." Further review of the policy included that, "Staffing numbers and the skill requirements of direct care staff are determined by the needs of	S 560		

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S 560	Continued From page 4 the residents based on each resident's plan of care, the resident assessments and the facility assessment. In addition, "Minimum staffing requirements imposed by the state, if applicable, are adhered to when determining staff ratios but are not necessarily considered a determination of sufficient and competent staffing." A review of the facility policy revised August 2022 titled "Posting Direct Care Daily Staffing Numbers" included "Direct care staffing information is reported quarterly to CMS through the QIES payroll-based journal electronic reporting system in a uniform format designated by CMS." The facility provided policies did not include the required minimum direct care staff to resident ratios.	S 560		
S 830	8:39-9.3(b) Mandatory Administration (b) The facility shall make reasonable efforts to ensure that staff providing direct care to residents in the facility are in good physical and mental health, emotionally stable, of good moral character, and are concerned for the safety and well-being of residents; and have not been convicted of a crime relating adversely to the person's ability to provide care, such as homicide, assault, kidnapping, sexual offenses, robbery, and crimes against the family, children or incompetents, except where the applicant or employee with a criminal history has demonstrated his rehabilitation in order to qualify for employment at the facility. ("Reasonable efforts" shall include an inquiry on the employment application, reference checks, and/or criminal background checks where	S 830		2/28/23

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S 830	Continued From page 5 indicated or necessary.) This REQUIREMENT is not met as evidenced by: Based on interview and review of employee files, it was determined that the facility failed to obtain a Criminal Background (CB) check prior to the date of hire for new employees. This deficient practice was identified for four of five newly hired employees reviewed and was evidenced by the following: A review of the five randomly selected newly hired employee files included the following: A Hospitality Aide who was hired on [redacted], had a [redacted] entered (ordered) on [redacted] and completed (reported) on [redacted]. A Certified Home Health Aide who was hired on [redacted], had a [redacted] entered on [redacted] and completed on [redacted]2. A Registered Nurse who was hired on [redacted], had a [redacted] entered on [redacted] and completed on [redacted]. A Licensed Practical Nurse who was hired on [redacted], had a [redacted] entered on [redacted] and completed on [redacted]. On 01/18/23 at 10:01 AM, the surveyor entered the Director of Nursing's (DON) office and asked the DON who the staff member would be that the surveyor needed to speak to regarding the employee files. The DON stated that it might be the Vice President (VP). As the DON was looking for the phone number of the VP, the Registered Nurse/Clinical Support (RN/CS) stated that the	S 830	F830 Element#1 No resident were negatively affected by this deficient practice. Element#2 All resident have the potential to negatively affected by this deficient practice All resident identified were found not to be negatively affected by this deficient practice. Element#3 All newly hired employees will have a completed background check reviewed by Human Resources(HR) or designee prior to their date of hire. No employee will start prior to a completed and reviewed Background check by HR or designee. The Human Resource manager will send out a new hire Tracker form of all required documents to be completed prior to orientation to the Facility educator and Department heads for review weekly. The Director of Human Resources or designee will monitor each new hire employee files for a completed background check weekly X2, monthly x2 and Quarterly X 2. The Administrator or designee will review the new hire Tracker form and compare it with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060222	A. BUILDING: _____ B. WING _____	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 830	Continued From page 6 facility did not have a fulltime human resource staff member in the building. The RN/CS then stated, "didn't we give you the files." The surveyor then told the RN/CS that there were some questions regarding the employee files and their CB. On that same date and time, the surveyor asked the RN/CS what the process for the CB was. The RN/CS stated that it was normally done by the human resource department. She added that the person would sign a waiver to do the background check and that it was done as part of the hiring packet. The surveyor asked the RN/CS if the CB should be done prior to the date of hire. The RN/CS stated "yes." She added that she knew there were some changes and that she was not 100% sure and that the Human resource staff member that did the CB was out on medical leave. The RN/CS then called another staff member on the phone and stated that the person was coming up [to answer the questions]. On 01/18/23 at 10:13 AM, the surveyor interviewed the Regional Employment Coordinator (REC) regarding the new hire process and CB. The REC stated that she was covering for the regular Human Resource staff person who was fulltime at the facility. The REC stated that the process for a new hire was to obtain a CB. The REC confirmed that there were two dates on the CB and that one was when the CB was ordered and the other was when the results were done. She added that if the employee is not hired within 30 days of the report, then the facility would have to do another CB. At that same time, the REC stated that the date of hire is the date of orientation, and that the facility cannot hire an employee unless the CB is	S 830	employees scheduled for orientation monthly X3. Element#4 All new potential employee's files will be reviewed by HR or designee prior to hire date weekly X2 monthly X2 then quarterly X3 and findings presented to Quarterly QAPI for review and recommendations.	

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	060222	A. BUILDING: _____ B. WING _____	01/18/2023

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CAREONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

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S 830	Continued From page 7	S 830		

back with the results. The surveyor asked the REC if the date entered and date completed on the CB should be prior to the date of hire. The REC stated "yes." The surveyor then informed the REC that four of the new hire CB were done after their date of hire. The REC confirmed that the CB for the four new hires were done after the date of hire. The REC then stated that during COVID-19, staff were hired before the results of the CB were obtained and the reason was because the facility was in need of employees.

Furthermore, the REC added that the facility is now back to having the CB done first. The surveyor then asked the REC what the expectation was for when the CB should be done. The REC stated that the CB should be done before the date of hire but that it had been done after with the knowledge that if the result was not favorable that the facility would have a meeting and discuss it. The surveyor asked the REC what the purpose of the CB was prior to the date of hire. The REC stated that the purpose was to make sure there was no criminal background and to check their license. The surveyor asked the REC if the purpose of the CB was for resident safety. The REC confirmed that the purpose of the CB was for resident safety. She added "I am going by what I was told."

On 01/18/23 at 10:32 AM, the surveyor asked the DON if the expectation for a CB was to be done prior to the date of hire. The DON stated that it was expected to be done prior to the date of hire. The surveyor then told the DON the concern that four of the new hires reviewed had a CB done after their date of hire.

On 01/18/23 at 10:36 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) if

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S 830	Continued From page 8 the expectation for a CB was to be done prior to the date of hire. The LNHA stated that it was expected to be done prior to the date of hire. The surveyor then told the LNHA the concern that four of the new hires reviewed had a CB done after their date of hire. The facility did not provide any additional information. A review of the facility provided policy titled, "Pre-employment and Annual Background Checks" with a reviewed date of June 2007, included the following: Under Purpose To ensure the safety of [facility name redacted] employees and residents. Under Policy [facility name redacted] will comply with State and Federal requirements in regard to pre-employment and continued employment background checks. Criminal Record Information reports are requested for all new employees, independent contractors, volunteers and interns through a third party consumer reporting agency ... Under General Procedure for RMV, Professional Registry and Criminal Record Reports 1.) Employees, volunteers, interns and contractors will not perform work for [facility name redacted] until acceptable criminal record ...reports are obtained.	S 830		

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
315306 Y1	A. Building B. Wing Y2	3/21/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

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 F0553	Correction	ID Prefix F0585	Correction	ID Prefix F0656	Correction
Reg. # 483.10(c)(2)(3)	Completed	Reg. # 483.10(j)(1)-(4)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	02/28/2023	LSC	03/13/2023	LSC	02/28/2023
ID Prefix F0658	Correction	ID Prefix F0689	Correction	ID Prefix F0726	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.35(a)(3)(4)(c)	Completed
LSC	02/28/2023	LSC	02/28/2023	LSC	02/28/2023
ID Prefix F0730	Correction	ID Prefix F0755	Correction	ID Prefix F0812	Correction
Reg. # 483.35(d)(7)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	02/28/2023	LSC	02/28/2023	LSC	02/10/2023
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/28/2023	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? ☐ YES ☐ NO
1/18/2023	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060222 Y1	A. Building B. Wing Y2	3/21/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 02/28/2023	ID Prefix S0830 Reg. # 8:39-9.3(b) LSC	Correction Completed 02/28/2023	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	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
1/18/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING **01** B. WING _____	**01/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT NEW MILFORD	**800 RIVER ROAD** **NEW MILFORD, NJ 07646**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 1/09/2023, 1/10/2923 and 1/11/2023 and Care One at New Milford was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Care One at New Milford is a Three-story, Type II Un-Protected building that was built in January 1972. The facility is divided into 20 smoke zones.	K 000		
K 311 SS=D	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations and review of facility documentation on 01/09/2023, 01/10/2023 and 01/11/2023, in the presence of facility Management it was determined that the facility failed to ensure that one of sixteen exit access	K 311	311 1.How the corrective action will be accomplished for those residents found to have been affected by this practice.	2/10/23

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

Electronically Signed | 02/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 311	Continued From page 1 stairwell doors tested were capable of maintaining the 1-1/2 hour fire rated construction, as evidenced by the following: On 01/09/2023 during the survey entrance at 9:15 AM, a request was made to the Regional Environmental Services Director (RESD) and Director of Environmental Services (DEVS), to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified there are three (3) floors and a basement with four exit stairwells in the facility. Starting at 9:27 AM on 01/09/2023 and continued on 01/10/2023, in the presence of the facility's RESD and DEVS a tour of the building was performed. During the tour the surveyor performed closure tests of the sixteen (16) 1-1/2 hour fire rated corridor exit access doors (Illuminated exit signs above the doors) leading into stairwells with the following results, 1. On 01/09/2023 at approximately 9:50 AM, on the 3rd floor during a closure test of the exit access door leading into the stairwell next to resident room #330 when tested and allowed to self-close into its frame, the door did not positive latch into its frame. This test was repeated two additional times with the same results. The stairwell door would need to positive latch into its frame to maintain the fire rated	K 311	The 3rd floor stairwell by the room 330, was sanded down and latch was repaired on 01-09-2023. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All resident have the potential to be affected by the deficient practice. No residents or staff were identified as being negatively affected by this deficient practice. 3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not recur. The Environmental Sanded the door latch to ensure door positively latches into door frame. Environmental Services Director or designee will monitor & check all latches & stairwell doors using the environmental audit tool x 4 weeks for two months and then monthly thereafter. 4.How will the facility monitor its corrective actions to ensure that the deficient practice will not recur. what quality assurance program will be put into place. Environmental Services Director or designee will monitor stairwell to ensure latches are in compliance x 4 weeks then monthly X 3 thereafter and report findings to the Quarterly Quality Assurance Performance Improvement Committee as inspections are completed for	

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K 311	Continued From page 2 construction and to prevent fire, smoke and poisonous gases to enter the exit stairwell in the event of a fire. The RESD and DEVS confirmed the findings at the time of observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 01/11/2023 at approximately 12:15 PM. Fire Safety Hazard. NJAC 8:39- 31.2(e)	K 311	recommendations. Time frame: Completed on 1/12/2023	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops	K 321		2/10/23

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K 321	Continued From page 3 d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation on 01/09/2023 and 01/10/2023 in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was evidenced by the following: On 01/09/2023 during the survey entrance at 9:15 AM, a request was made to the Regional Environmental Services Director (RESD) and Director of Environmental Services (DEVS), to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. Starting at 9:27 AM on 01/09/2023 and continued on 01/10/2023, in the presence of the facility's RESD and DEVS a tour of the building was conducted. Along the two day tour of the facility the surveyor observed the following, 1) On 01/10/2023 at approximately 11:28 AM, an	K 321	K-0321 1. How the corrective action will be accomplished for those residents found to have been affected by this practice: Doors to Central supply and medical records were missing door closers. Door closers installed to meet requirements. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: The deficient practice was not in a resident care area but could affect the staff. 3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not recur. Installed new door closers as required. Environmental Services Director or designee will monitor Central supply/Medical records locations x 4 weeks for two months and then monthly thereafter. 4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur I.E., what quality assurance program will be put into place. Environmental Services Director or designee will monitor Central supply/Medical records locations x 4	

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K 321	Continued From page 4 inspection on the lower level Central Supply room was performed. The surveyor observed evidence that the automatic door closure to the room had been removed. The room was larger than 50 square feet and had multiple combustible cardboard boxes. 2) On 01/10/2023 at approximately 11:35 AM, an inspection of the lower level Medical Records storage room was performed. During a closure test of the corridor door leading into the Medical Records storage room when the door did not close. The surveyor observed the door had no means to self-close. The surveyor observed in the room five rolling racks filled with combustible paper resident medical records and other resident medical records on top of other filing cabinets in the room. The surveyor measured and recorded the room 8'-6" by 12" which is (102 square feet) which is larger than 50 square feet. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. The RESD and DEVS confirmed the findings at the time of observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 1/11/2023 at approximately 12:15 PM. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321	weeks for 2 months and monthly thereafter and report findings to the Quarterly Quality Assurance Performance Improvement Committee as inspections are completed Time frame: Completed on 1/13/2023	

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K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation on 01/09/2023, 01/10/2023 and 01/11/2023, in the presence of facility management, it was determined that the facility failed to inspect the range-hood fire suppression system semi-annually (every six months) in accordance with NFPA 96. The deficient practice was evidenced by the	K 324	What corrective action(s) will be accomplished for those residents affected by the deficient practice? The range hood suppresion system was inspected on 1=01-06-23. How will you identify those residents	2/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING **01** B. WING _____	**01/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT NEW MILFORD	**800 RIVER ROAD** **NEW MILFORD, NJ 07646**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 6 following: On 01/09/2023 during the survey entrance at 9:15 AM, a request was made to the Regional Environmental Services Director (RESD) and Director of Environmental Services (DEVS), to provide all mandatory inspections from 06/01/21 to 1/08/2023 for review. Review of the facility's range-hood fire suppression system inspections for the previous 19 months identified the system had two (2) semi-annual inspections on the following dates, 02/24/2022 and 10/06/2022 (8 months between semi-annual inspections) and no inspections provided for June. July, August, September, October, November and December (7 months) 2021. Later at approximately 11:50 AM, a request was made to the RESD and DEVS if they can provide a semi-annual inspection for kitchen suppression systems for 2021. On 01/10/2023 during an interview with the RESD and DEVS, the surveyor asked if they had a semi=annual Kitchen suppression system inspection for 2021. The RESD told the surveyor that he contacted the vendor and was told that the inspection had been canceled. The RESD provided an email from the vendor who performs the semi-annual inspections of the kitchen suppression system dated 01/05/2023 that reads in part, "It appears that inspection was not completed, and was canceled." The facility did not semi-annually inspect the	K 324	having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by this practice. No residents were adversely affected by this deficient practice. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur? The Kitchen suppression system was last inspected 10/6/2022. Next inspection system testing will be held April 2023. Hood inspection will be scheduled every 6 months. Food Service Director, Maintenance Director or designee will monitor for completion utilizing the environmental audit tool the inspection every 6 months. The Administrator will monitor the audit tool every 3 months for compliance. How the corrective actions will be monitored to ensure the deficient practice will not recur? (ie what quality assurance program will be put into place? The Director of Maintenance or designee will ensure testing is conducted of the hood every 6-months X2. The Director of Maintenance or Assistant will report to the Administrator and submit for review at the Quarterly QAPI meetings.	

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K 324	Continued From page 7 kitchen suppression system for the seven months in 2021 and went eight months in between inspections in 2022. The RESD and DEVS confirmed the findings. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 1/11/2023 at approximately 12:15 PM. NFPA 101, NFPA 96 NJAC 8:39-31.2(e)	K 324	TIME FRAME 2/10/2023	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 01/09/2023, 01/10/2023 and 01/11/2023, in the	K 351	1.What corrective action(s) will be accomplished for those residents affected	3/15/23

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K 351	Continued From page 8 presence of facility management it was determined that the Facility failed to properly install sprinklers, as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition, and as required by the New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. The deficient practice is evidenced by the following, On 01/09/2023 during the survey entrance at 9:15 AM, a request was made to the Regional Environmental Services Director (RESD) and Director of Environmental Services (DEVS), to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified there are three (3) floors and a basement in the facility. Starting at 9:27 AM on 01/09/2023 and continued on 01/10/2023, in the presence of the facility's RESD and DEVS a tour of the building was performed. Along the two day tour of the facility the surveyor observed the following locations that failed to provide proper fire sprinkler coverage: On 01/09/2023: 1) At approximately 10:10 AM, the surveyor observed inside Resident room #349 two (2)	K 351	by the deficient practice? Sprinkler head in vestibule to be completed by 03-15-23 2. How will you identify those residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents residing in the facility have the potential to be affected by this deficient practice. No other residents were affected by this deficient practice. Sprinkler head to be installed by 03-15-23 3.What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur Maintenance Director or designee will monitor existing sprinklers on a monthly basis to assure all are adequate & functioning properly. All negative findings will be addressed and replaced. 4. Environmental Service Director or designee once installed will monitor once installed the sprinkler monthly X 6 months and report findings to the Quarterly QAPI meeting for review and recommendations. 1. Room #349 sprinkler head were replaced with 2 escheon sprinkler caps on 1/12/2023. No other residents were adverse affected by this deficient practice. Environmental Service Director checked all sprinklers no other residents were identified a being affected. 2.All residents have the potential be affected by this deficient practice. No	

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K 351	Continued From page 9 closets that the 2 fire sprinklers had no escheon caps for the sprinklers heads. This left an approximately 1/2 gap around the sprinkler heads. With the opening in the ceilings, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system the surveyor observed. 2) At approximately 10:14 AM, the surveyor observed inside Resident room #342 one (1) closet, had blue painters tape covering the frangible glass head of the sprinkler. This would not allow the fire sprinkler to function properly in the event of a fire. On 01/10/2023: 3) At approximately 11:14 AM, the surveyor observed no evidence of sprinkler coverage inside the 13 feet by 8 feet Main Entrance Vestibule. At this time the surveyor made a request to the RESD, "Do you have a fire sprinkler in the Vestibule." The RESD looked up and around and said, No. He then told the DEVS, we have to install a dry system in here. 4) At approximately 12:03 PM, during an inspection inside the main kitchen the surveyor observed in the water storage area six (6) drop ceiling tiles were missing. With the opening in the ceilings and ceiling tiles, in the event of a fire the heat would by pass the	K 351	other residents were negatively affected by this deficient practice 3. The Environmental Service Director or designee will monitor existing sprinklers on a monthly basis to be sure all are adequate & functioning properly. All negative findings will be addressed and replaced. 4. Environmental Service Director or designee will monitor all the sprinkler head monthly X 6 months and report findings to the Quarterly QAPI meeting for review and recommendations. 1. On 1/12/2023 Environmental Service Director removed the blue painters tape from sprinkler head in room 342. No other residents were affected by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. No other resident were affected by this deficient practice. All sprinkler heads were audited no other tape found. 3. The Environmental Service Director will monitor all sprinkle head for proper functioning and no tape monthly for compliance. 4. The Environmental Service Director will monitor all sprinkle head for proper functioning and no tape weekly X4 then monthly X 2 for compliance and report findings to the Quarterly QAPI for review	

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K 351	Continued From page 10 fire sprinkler in the area and not activate the fire sprinkler system. The RESD and DEVS confirmed the findings at the time of observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 1/11/2023 at approximately 12:15 PM.. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351	and recommendations. 1. In the main kitchen water storage area six drop ceiling tiles were replaced on 1/12/2023. No other resident were affected by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. All are of the kitchen checked for missing ceiling tile by Environmental Service Director, No other issues identified. 3.The Environmental Service Director or designee will monitor the kitchen for missing tiles monthly to ensure compliance. 4.The Environmental Service Director or designee will monitor weekly X 4 months and report the findings to the Administrator and present at the quarterly QAPI meetings for review findings and recommendations. TIME FRAME Please see attached waiver	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for	K 363		2/10/23

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K 363	Continued From page 11 at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 01/09/2023 and 01/10/2023, in the presence of facility management it was determined that the facility failed to ensure that 5 of 32 corridor doors inspected and tested, were able to resist the passage of smoke in	K 363	Element #1 Resident # 361 was not adversely affected by this deficient practice Resident #361 Corridor door latch was replaced on 01-12-23	

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K 363	Continued From page 12 accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. The evidence includes the following, On 01/09/2023 during the survey entrance at 9:15 AM, a request was made to the Regional Environmental Services Director (RESD) and Director of Environmental Services (DEVS), to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified there are three (3) floors and a basement in the facility. Starting at 9:27 AM on 01/09/2023 and continued on 01/10/2023, in the presence of the facility's RESD and DEVS a tour of the building was performed. During the tour the surveyor performed closure tests of the thirty two (32) doors in the corridors with the following results, On 01/09/2022: 1. At approximately 9:40 AM, on the 3rd. floor Social Services office, when the door was in the closed position in the doors frame there was an approximately 1/4 of an inch gap along the top of the door. 2. At approximately 9:45 AM, on the 3rd. floor Resident room #361 during a closure test of the corridor door it did not positive latch into its frame and opened approximately 2 inches.	K 363	Element # 2 How will you identify those residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents residing in the facility have the potential to be affected by this practice. On 01-10-2023. The Maintenance Director and Administrator performed rounds on all corridor latches doors no other issues were identified. Element #4 What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur? The Maintenance Director or Assistance will make rounds throughout the facility incorporating the Environmental audit tool on a weekly basis to ensure all facility resident rooms are latching. The Administrator will review the audits weekly. Element #3 How the corrective actions will be monitored to ensure the deficient practice will not recur? (ie what quality assurance program will be put into place? Element #4 The Director of Maintenance or Assistant will monitor the environmental audit tool for 6 months. The results of the Environmental audit tool findings will be presented at the Quarterly Quality Assurance Performance Improvement	

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K 363	Continued From page 13 This closure test was repeated two additional times with the same results. 3. At approximately 10:05 AM, on the 3rd. floor Resident room #349 during a closure test of the corridor door it did not positive latch into its frame and opened approximately 3 inches. This closure test was repeated two additional times with the same results. On 01/10/2023: 4. At approximately 10:09 AM, on the first floor Oxygen storage room the surveyor observed an approximately 1 inch by 8 inch section of the bottom of the door was broken and missing. 5. At approximately 10:31 AM, on the 1st. floor Residents Lounge during a closure test of the corridor door it did not positive latch into its frame and opened approximately 2-1/2 inches. This closure test was repeated two additional times with the same results. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. Review of facility posted emergency evacuation diagrams identify that you would need to pass these areas as the primary and secondary exit access route to reach an exit. The RESD and DEVS confirmed the findings at the time of observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on	K 363	Committee for review and recommendations. Element # 1 Resident# 349 was not adversely affected by this deficient practice. Resident #349 corridor door latch was replaced on 01-12-2023. Element # 2 How will you identify those residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents residing in the facility have the potential to be affected by this deficient practice. On 01-10-2023. The Maintenance Director and Administrator performed rounds on all resident corridor doors latches No other Residents doors were identified by this deficient practice. Element# 3 What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur? The Maintenance Director or Assistance will make rounds throughout the facility incorporating the Environmental audit tool on a weekly basis to ensure all facility resident rooms corridors doors are latching. The Administrator will review the audits weekly. Element #4	

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K 363	Continued From page 14 1/11/2023 at approximately 12:15 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	How the corrective actions will be monitored to ensure the deficient practice will not recur? (ie what quality assurance program will be put into place? The Director of Maintenance or Assistant will monitor the environmental audit tool for 6 months to ensure doors are latching. The results of the Environmental audit tool findings will be presented at the Quarterly Quality Assurance Performance Improvement Committee for review and recommendations. Element #1 No Resident were adversely affected by this deficient practice Residents lounge corridor door latch was replaced on 01-12-2023. Element #2 How will you identify those residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents residing in the facility have the potential to be affected by this practice. On 01-10-2023. The Maintenance Director and Administrator performed rounds on all residents lounge corridor doors latches. No other issues were found or residents to be adversely affected by this deficient practice. Element # 3 What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur?	

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K 363	Continued From page 15	K 363	The Maintenance Director or Assistance will make rounds throughout the facility incorporating the Environmental audit tool on a weekly basis to ensure all facility resident lounge corridor doors are latching. The Administrator will review the audits weekly. Element # 4 How the corrective actions will be monitored to ensure the deficient practice will not recur? (ie what quality assurance program will be put into place? The Director of Maintenance or Assistant will monitor the environmental audit tool for 6 months. The results of the Environmental audit tool findings will be presented at the Quarterly Quality Assurance Performance Improvement Committee for review and recommendations. Element #1 What corrective action(s) will be accomplished for those residents affected by the deficient practice? No resident were adversely affected by this deficient practice The first floor bottom of the Oxygen storage room door was replaced on 01-12-2023. Element #2 How will you identify those residents having the potential to be affected by the same deficient practice and what	

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K 363	Continued From page 16	K 363	corrective action will be taken? All residents residing in the facility have the potential to be affected by this deficient practice. On 01-10-2023. The Maintenance Director and Administrator performed rounds on all Oxygen storage room doors no other issues were identified. Element # 3 What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur? The Maintenance Director or Assistance will make rounds throughout the facility incorporating the Environmental audit tool on a weekly basis to ensure all Oxygen storage rooms doors are not missing any parts. The Administrator will review the audits weekly. Element #4 How the corrective actions will be monitored to ensure the deficient practice will not recur? (ie what quality assurance program will be put into place? The Director of Maintenance or Assistant will monitor the environmental audit tool for 6 months. The results of the Environmental audit tool findings will be presented at the Quarterly Quality Assurance Performance Improvement Committee for review and recommendations.	

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K 363	Continued From page 17	K 363	Element # 1 No Residents or staff were adversely affected by this deficient practice. The Social Service door latch was repaired on 01/12/2023. Element # 2 All staff offices have the potential to be affected by this deficient practice. On 01-10-2023, The Maintenance Director and Administrator performed rounds on all non resident offices room doors no other issues were identified. Element# 3 The Maintenance Director or Assistance will make rounds throughout the facility incorporating the Environmental audit tool on a weekly basis to ensure all non resident offices door are not broken. The Administrator will review the audits weekly. Element#4 The Director of Maintenance or Assistant will monitor the environmental audit tool for 6 months. The results of the Environmental audit tool findings will be presented at the Quarterly Quality Assurance Performance Improvement Committee for review and recommendations.	
K 541 SS=F	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry	K 541		2/10/23

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K 541	Continued From page 18 Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 01/09/2023 and 01/10/2023, it was determined that the facility failed ensure the fire and smoke resistant integrity and 1-hour fire protection rating of one of eight laundry/Linen chute doors. This deficient practice was evidenced by the following findings: On 01/09/2023 during the survey entrance at 9:15 AM, a request was made to the Regional Environmental Services Director (RESD) and Director of Environmental Services (DEVS), to	K 541	What corrective action(s) will be accomplished for those residents affected by the deficient practice? Mag lock installed and test button installed near the laundry chute on 01-12-20. No residents were adversely affected by this practice. 2. How will you identify those residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING **01** B. WING _____	**01/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT NEW MILFORD	**800 RIVER ROAD** **NEW MILFORD, NJ 07646**

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K 541	Continued From page 19 provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified there are three (3) floors and a basement in the facility. On 01/10/2023 (day two of survey) at approximately 11:50 AM, an inspection of the basement level garbage chute room was performed. The surveyor observed the magnetic door hold open device (that would release with the fire alarm activation) had evidence of being removed. The surveyor also observed that the chute door was tied in the open position with a yellow extension cord. This would allow passage of smoke, fire and fumes from the basement to the three floors above. The RESD and DEVS confirmed the findings at the time of observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 1/11/2023 at approximately 12:15 PM. NFPA 101:2012 - 19.5.4 and 9.5 NJAC 8:39-31.2(e)	K 541	All residents residing in the facility have the potential to be affected by this practice. 3.What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur? New Magnet installed on 01-12-23 , the Environmental Service director will monitor & inspect all magnet for functioning monthly for compliance. 4. The Environmental Service Director will monitor the linen chute to ensure the magnet lock is functioning properly X 4 weeks them monthly X 2 and report findings to the Quarterly QAPI for review and recommendations. TIME FRAME 2/10/2023	
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99	K 911		2/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING **01** B. WING _____	**01/18/2023**

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CAREONE AT NEW MILFORD	**800 RIVER ROAD** **NEW MILFORD, NJ 07646**

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K 911	Continued From page 20 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 01/09/2023 and 01/10/2023, in the presence of facility management, it was determined that the facility failed to ensure that two of ten electrical outlets located next to a water source (with-in 6 feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: On 01/09/2023 during the survey entrance at 9:15 AM, a request was made to the Regional Environmental Services Director (RESD) and Director of Environmental Services (DEVS), to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified there are three (3) floors and a basement in the facility. Starting at 9:27 AM on 01/09/2023 and continued on 01/10/2023, in the presence of RESD and DEVS a tour of the facility a tour of the facility was conducted. During the second day tour of the facility, the surveyor observed and tested ten (10) electrical outlets (with-in 6 feet of a sink) in wet locations	K 911	What corrective action(s) will be accomplished for those residents affected by the deficient practice? No residents were adversely affected by this practice. How will you identify those residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents residing in the facility have the potential to be affected by this practice. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur? Two electrical outlets were installed with Ground-Fault Circuit Interrupter (GFCI) protection on 1/11/2023. One electrical (GFCI) installation on the 2nd floor Soiled Utility Room. One installation on 2nd floor Nurse Station Pantry room. The Director of Maintenance or designee will test the electrical outlets monthly to ensure they are up to code. The Maintenance Director will use the environmental audit tool to	

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	315306	A. BUILDING **01** B. WING _____	**01/18/2023**

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K 911	Continued From page 21 with a GFCI tester to de-energize the outlets. The surveyor observed the following, 1. On 01/09/2023 at approximately 10:28 AM, an inspection inside the 2nd. floor Soiled Utility room identified that when the surveyor tested a the Duplex electrical outlet located 36 inches to the right of the Bed Pan Hopper (large sink) with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. 2. On 01/09/2023 at approximately 10:47 AM, an inspection inside the 2nd. floor Nurse Station Pantry room identified that when the surveyor tested a the Duplex electrical outlet located 18 inches to the left of the sink with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. The RESD and DEVS confirmed the findings at the time of observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 1/11/2023 at approximately 12:15 PM. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911	monitor for compliance. The administrator will review the audit tool weekly for compliance. How the corrective actions will be monitored to ensure the deficient practice will not recur? (ie what quality assurance program will be put into place?) The Director of Maintenance or Assistant will monitor the outlets for compliance and audit tool for two months and report findings to the Administrator and present at quarterly QAPI meetings for review and recommendations.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315306 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/21/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0311	02/10/2023	LSC K0321	02/10/2023	LSC K0324	02/10/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	03/15/2023	LSC K0363	02/10/2023	LSC K0541	02/10/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0911	02/10/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/18/2023	☐ YES ☐ NO