STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	**2150 ROUTE 38 CHERRY HILL, NJ 08002**

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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 Complaint NJ #: 159857; 160366; 162880; 164425; 165322; 165640 STANDARD SURVEY: 7/28/23 CENSUS: 101 SAMPLE SIZE: 25 + 3 + 1 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 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the	F 583		9/7/23

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

Electronically Signed | 08/11/2023

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F 583	Continued From page 1 residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to protect the confidentiality of a resident's health related information. This deficient practice was identified for 1 of 4 residents observed during medication pass (Resident #78), and was evidenced by the following: On 7/21/23 at 9:00 AM, during the medication pass observation on Nelson-5 nursing unit, the surveyor observed the Licensed Practical Nurse (LPN) walk away from the medication cart leaving the Medication Administration Record (MAR) for Resident #78 opened to full view. The MAR was displayed on a fixed laptop attached to the top of the medication cart located in the hallway. The medication cart was locked, but the LPN was not	F 583	Tag 0583 Element One Corrective Actions The fixed laptop was immediately closed by our Facility Educator to protect Resident #78 personal privacy and confidential medical record. Agency Licensed Practical Nurse (LPN) in question was immediately relieved of her shift and no longer works at the facility. Element Two Identification of at Risk Residents All Residents under the care of the Agency Licensed Practical Nurse (LPN) in question were at risk for having failure of the facility to protect the confidentiality of a resident's health related information.	

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F 583	Continued From page 2 near the cart. At that time, the Staff Educator/LPN (SE/LPN) walked up to the medication cart and acknowledged the open MAR, and closed the screen removing Resident #78's health information from view. The LPN did not return to the medication cart and left the building. On 7/21/23 at 9:01 AM, the surveyor interviewed the SE/LPN who confirmed that the MAR should not have been left opened. No residents or visitors were near the opened MAR at the time of the observation. The surveyor then reviewed the MAR for Resident #78 which included the following information: the resident's name, date of birth, medical diagnoses, allergies, diet, and medications. On 7/27/23 at 9:32 AM, the Executive Director in the presence of the Licensed Nursing Home Administrator (LNHA), Acting Director of Nursing (ADON), Regional Registered Nurse, SE/LPN, and survey team acknowledged that personal identifying health information should not be left on the computer screen for other's to view. A review of the facility's "Medication Storage- Med Cart" policy dated 6/2020 included...during medication pass, the MAR will be closed when not being accessed by the nurse so that information is not visible or accessible to unauthorized individuals.... NJAC 8:39 - 4.1(a)(18)	F 583	Immediatley rounds were performed to assure no other resident health related information was exposed throughout the facility on medication cart laptops. No other deficienes noted. Element Three Systemic Change The facility "Medication Storage-Med Cart" policy was reviewed which addresses appropriate measures for prevention of exposing resident's health related information. Nursing staff were re-educated regarding the policy by the Facility Educator. Nursing staff were re-educated that during medication pass, the MAR will be closed when not being accessed by the nurse so that information is not visible or accessible to unauthorized individuals. Element Four Quality Assurance The Unit Managers or Designee will conduct rounds 2 times per shift to ensure no resident health related information is visible or accessible to unauthorized individuals for one week and then weekly for three months. Results will be provided to the Director of Nursing (DON) who will review the findings and provide direction as appropriate to assure 100 percent compliance. If findings are not 100 percent compliant further education and or discipline will be provided. The DON will report the findings in aggregate at the monthly QAPI meeting x 3 months. Facility Educator will be responsible for maintaining education for staff on protecting resident health related	

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F 583	Continued From page 3	F 583	information. The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 09/07/2023 to ensure the deficient Tag 0583 will not reoccur.	
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 - (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	F 656		9/7/23

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F 656	Continued From page 4 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 observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to a.) implement care plan interventions of NJ Exec. Order 26:4.b.1 for a resident with a history of [redacted] and b.) develop a care plan for a resident who received NJ Exec. Order 26:4.b.1. This deficient practice was identified for 2 of 25 residents reviewed for comprehensive care plans (Resident #62 and #85), and the evidence was as follows: 1. On 7/24/23 at 10:05 AM, the surveyor observed Resident #85 receiving morning (AM) care. At that time, the surveyor did not observe any [redacted] in the room. The surveyor reviewed the medical record for Resident #85. A review of the Admission Record face sheet (an	F 656	Tag 0656 Element One Corrective Actions #1. Resident #85 The [redacted] were immediately properly placed on either side of the bed for Resident #85 when in bed and are stored under the bed when Resident #85 is out of bed. The nursing staff that did not properly place the Ex.Order 26.4(b)(1) [redacted] were immediately counseled and re-educated about proper placement when Resident #85 was receiving morning (AM) care. #2 Resident #62 The Facility immediately updated Resident #62 Individualized Comprehensive Care Plan (ICCP) to reflect the physician order to include the Ex.Order 26.4(b)(1). All nursing staff were	

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F 656	Continued From page 5 admission summary) reflected the resident was admitted to the facility in NJ Exec. Order 26:4.b.1 with diagnoses which included NJ Exec. Order 26:4.b.1 [redacted] A review of the most recent quarterly Minimum Data Set (MDS), and assessment tool dated 6/12/23, reflected the resident had a brief interview for mental status (BIMS) score of [redacted] out of 15, which indicated a NJ Exec. Order 26:4.b.1 [redacted] A review of the quarterly MDS dated 3/13/23, reflected in "Section J. Heath Conditions", included the resident had NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1) which included NJ Exec. Order 26:4.b.1 [redacted] since admission to the facility. A review of the resident's individualized comprehensive care plan (ICCP) included a focus area initiated on 9/12/22, for the resident had actual [redacted] and was at risk fo NJ Exec. Order 26:4.b.1 [redacted]. Interventions included [redacted] at all times when resident is in bed; check for placement every shift. A further review of the ICCP included a focus area initiated on 2/28/23, for ensure my [redacted] are in place to [redacted] of bed for my safety. Interventions included to check placement of [redacted] every shift. A review of the Order Summary Report dated	F 656	immediately counseled and re-educated about the important of a Resident's Individualized Comprehensive Care Plan (ICCP) to reflect all physician orders that include medication, treatment and care. Element Two Identification of at Risk Residents #1 Resident #85 All Residents that are at risk for physician orders for Ex.Order 26.4(b)(1) have the potential to be affected by this practice. All residents with orders for Ex.Order 26.4(b)(1) were reviewed to assure proper use per physician orders. No deficiencies noted upon review #2 Resident #62 All Residents that are at risk for physician orders have the potential to be affected by this practice. All residents with physician orders for Ex.Order 26.4(b)(1) were reviewed to assure proper documentation was carried over onto the Resident's Individualized Comprehensive Care Plan (ICCP). No deficiencies noted upon review Element Three Systemic Change #1 Resident #85 The facility "Falls Prevention" policy was reviewed which addresses appropriate measures for prevention of injury such as use of [redacted]. Nursing staff were re-educated regarding the policy. Nursing staff were re-educated about the proper placement of Ex.Order 26.4(b)(1) including noting this on the care plan and care Kardex used by the CNAs.	

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F 656	Continued From page 6 active orders as of 7/26/23 included a physician's order (PO) dated 1/27/23, for NJ Exec. Order 26:4.b.1 to NJ Exec. Order of bed for safety when resident is in bed. Check placement every shift. On 7/24/23 at 1:00 PM, the surveyor received the requested investigations from the Executive Director (ED), and the surveyor reviewed the unwitnessed incident reports dated 1/19/23 and 2/14/23 reflected the following: Dated 1/19/23, included care plan interventions related to this incident included NJ Exec. Order 26:4.b.1. Dated 2/14/23, included the resident was found on the floor, assessed, and found a NJ Exec. Order 26 4.b.1 A review of the Supervisor Fall Incident Investigation dated 2/14/23, reflected if fall [was] from bed, was [the] bed in [the] lowest position? "Yes" and was NJ Exec. Order 26:4.b.1 A review of the Treatment Administration Record (TAR) from 1/27/23 to 7/25/23 included physician's orders for NJ Exec. Order 26:4.b.1 to NJ Exec. Order 26:4.b.1 of bed for safety when resident is in bed and check placement every shift was signed as administered. On 7/24/23 at 10:19 AM, the surveyor interviewed the Certified Nursing Assistant (CNA #1) who stated she was not that familiar with Resident #85, but she knew that the resident was nice. CNA #1 stated she was unsure if the resident was a NJ Exec. Order 26:4 On 7/25/23 at 09:55 AM, the surveyor interviewed CNA #2 who stated that she was the aide for	F 656	#2 Resident #62 The facility "Care Planning Process and Care Conference" policy was reviewed which addresses all Resident care and intervention must be carried out per the Care Plan. The facility "Physician Orders, Verbal and Telephone" policy was reviewed which addresses updating the care plan as necessary based upon the physician order. Nursing staff were re-educated regarding both policies. Nursing staff were re-educated on the importance of following the physician order and ensuring it carries over onto the Resident's Individualized Comprehensive Care Plan (ICCP). Element Four Quality Assurance #1 Resident #85 The Unit Managers or Designee will conduct daily rounds per shift and audit the proper placement of ex.Order 26.4(b)(1) for Residents with orders for one week and then weekly for three months to assure proper placement of ex.Order 26.4(b)(1). Results will be provided to the Director of Nursing (DON) who will review the findings and provide direction as appropriate. The Director of Nursing (DON) will report the findings in aggregate at the monthly QAPI meeting for further action as required. Facility Educator will be responsible for maintaining education for staff on ex.Order 26 nd the Director of Nursing (DON) for the correction of deficiency #2 Resident #62 The Facility Educator or Designee will	

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F 656	Continued From page 7 Resident #85 today (7/25/23). CNA #2 stated that the resident was a [NJ Exec. Order 26] as she knew the resident could [NJ Exec. Order 26:4.b.1] by themselves and that the resident could NJ Exec. Order 26:4.b.1. The surveyor asked if the resident had [NJ Exec. Order 26:4.b.1], and CNA #2 replied, "I did not see any [NJ Exec. Order 26:4.b.1] today (7/25/23)." She explained she only had the resident twice and was unsure if the resident was supposed to have [NJ Exec. Order 26:4.b.1] as she was not normally on the Nelson-5 nursing unit or on that end of the unit. On 7/25/23 at 10:09 AM, the surveyor interviewed Licensed Practical Nurse (LPN #1) who stated that today (7/25/23) was her first day back to the facility in years. LPN #1 stated that she was not familiar with Resident #85, and that she was just making her way to see the resident to administer the medications. LPN #1 stated she was unsure if the resident was supposed to have [NJ Exec. Order 26:4.b.1]. At that time, LPN #1 looked in the electronic medical record (EMR) and stated the resident had a PO for [NJ Exec. Order 26:4.b.1]. On 7/25/23 at 10:11 AM, the surveyor observed Resident #85 lying in bed waiting for the CNA to get NJ Exec. Order 26:4.b.1 The resident stated he/she was feeling pretty good today (7/25/23). At that time, the surveyor did not observe any [NJ Exec. Order 26:4.b.1] in the room. On 7/25/23 at 10:17 AM, the surveyor interviewed LPN #2 who stated Resident #85 had a history of [NJ Exec. O] and "believed that the resident had [NJ Exec. Or] She stated that the resident was NJ Exec. Order 26:4.b.1 and was a [NJ Exec. Order 26 4.b.1] On 7/25/23 at 11:10 AM, the surveyor still did not	F 656	conduct a random audit of 5 residents three times a week to review physician orders regarding Ex.Order 26.4(b)(1) weekly for three months to assure they are being carried over to the Resident's Care Plan. Results will be provided to the Director of Nursing (DON) who will review the findings and provide direction as appropriate. The Director of Nursing (DON) will report the findings in aggregate at the monthly QAPI meeting. Facility Educator will be responsible for maintaining education for staff on Care Planning Process and the Director of Nursing (DON) for the correction of deficiency The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 09/07/2023 to ensure the deficient Tag 0656 will not reoccur.	

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observe [NJ Exec. Order 26:4.b.1] anywhere in the resident's room.

On 7/26/23 at 8:57 AM, the surveyor observed Resident #85 oob in the hallway in front of their room. At that time, the surveyor did not observe [NJ Exec. Order 26:4.b.1] anywhere in the room.

On 7/26/23 at 9:02 AM, the surveyor interviewed CNA #3 who stated that she was the regular aide for Resident #85 and that the resident was a [NJ Exec. Order 26:4.b.1]. CNA #3 stated that Resident #85 was a [NJ Exec. Order 26] and was not allowed in the room by themselves when oob. She further stated that when the resident was in bed, the bed had to be in the lowest position. When asked was there any other NJ Exec. Order 26:4.b.1? CNA #3 stated when she started with the resident on the Nelson-6 nursing unit, the resident had [NJ Exec. Order 26:4.b.1] but now since the resident moved to Nelson-5 nursing unit, she had not seen the [NJ Exec. Order 26:4.b.1]. CNA #3 stated that if she knew the resident was supposed to have them, then she should inform the nurse. CNA #3 stated that she only worked the 7:00 AM to 3:00 PM shift, but when she gets the resident oob "there are no [NJ Exec. Order 26:4.b.1] while the resident was in the bed."

On 7/26/23 at 9:08 AM, the surveyor re-interviewed LPN #2 who stated that the resident had [NJ Exec. Order 26:4.b.1] but was "not sure where they were." The surveyor asked did staff have to sign in the TAR for the [NJ Exec. Order 26:4.b.1] being in place, and she responded "yes." At that time, the surveyor and LPN #2 went into the resident's room to look for the [NJ Exec. Order 26:4.b.1] The LPN looked all around in the resident's room and stated she did not see the [NJ Exec. Order 26:4.b.1], but stated "they was there before." The surveyor asked LPN #2 the

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last time she saw the [NJ Exec. Order 26:4.b.1], and she was unable to confirm the last time she seen them.

On 7/26/23 at 9:14 AM, the surveyor interviewed Unit Manager/Licensed Practical Nurse (UM/LPN #1) regarding the [NJ Exec. Order 26:4.b.1] having a PO and on the care plan. UM/LPN #1 stated that she just completed an audit on Monday 7/24/23, on which residents had [NJ Exec. Order 26:4.b.1], and that Resident #85 was not on her list for having [NJ Exec. Order 26:4.b.1] She stated that the resident changed rooms on 2/17/23 from Nelson-6 to Nelson-5 nursing unit. At that time, the surveyor and UM/LPN #1 looked in the EMR at the PO and confirmed the [NJ Exec. Or] When asked should the nurses sign for the [NJ Exec. Order 26:4.b.1] if they were not in place, UM/LPN #1 responded that the nurses should not be signing if the [NJ Exec. Order 26:4.b.1] were not in place. She explained when they were signing off on it, it meant that the [NJ Exec. Order 26:4.b.1] were in place. She then stated, "obviously they were not in place and that was incorrect documentation." UM/LPN #1 stated the care plan "painted a picture of the resident needs and it included what we hope to do for them and the goals for that resident." She stated that if staff saw that the resident needed [NJ Exec. Order 26:4.b.1] and they were not in place, then they should have informed the supervisor, maintenance or housekeeping to get them.

On 7/26/23 at 9:27 AM, the surveyor interviewed the Acting Director of Nursing (ADON) who stated that Resident # 85 should have had the [NJ Exec. Order 26:4.b.1] while in bed, and that they just placed them in the room after surveyor inquiry. The ADON stated the importance of following the PO was because it was for the care of the resident as well as for their health and safety. She stated that the care plan was a quick snapshot of the care that the resident

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needed, and that it was important to follow and update as things changed to reflect what the care should be. The ADON stated that at one point, Resident # 85 had the [redacted] and was unsure of when they disappeared and what happened to them. The ADON stated again that the [redacted] were now in place, but acknowledged the [redacted] have been in place since there was a PO and it was care planned. The ADON stated that staff should not be signing for them if they were not in place because if they did not do it then they should not be documenting that they were there. She stated that if the staff seen there was no [redacted] and needed to obtain them, they could inform the maintenance department.

On 7/27/23 at 9:01 AM, the surveyor observed the [redacted] in place for resident #85 after surveyor inquiry.

On 7/27/23 at 9:03 AM, the Staff Educator/Licensed Practical Nurse (SE/LPN) in the presence of the Licensed Nursing Home Administrator (LNHA) and the surveyor stated that staff must follow the PO and care plan. She stated that it was important to follow them because it was for the resident's safety, and it showed how to care for the resident. She further stated that nurses should be signing every shift that the [redacted] were in place. The SE/LPN explained that signing in the EMR indicated "that the [redacted] were actually there" and that the order and care plan was in place. The SE/LPN acknowledged that staff should not be signing for them if the [redacted] were not in place. She stated that if staff knew the resident needed the [redacted] and did not see them, they should have contacted any supervisor, and they would be able to get the [redacted]. When asked if the

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Ex.Order 26.4(b)(1) were ordered and care planned for after the January 2023 Ex.Orde should they have been in place during the second Ex.Orde in February 2023, the SE/LPN replied, yes, if it was ordered and care planned.

On 7/27/23 at 9:07 AM, the LNHA in the presence of the SE/LPN and surveyor stated that staff should be following the PO and care plan because it was for the safety of the resident. He further stated that the care plan was resident center as it indicated the individualized care of the resident and to ensure that they were getting their specific care. The LNHA stated that "it was missed" and that the Ex.Order 26.4(b)(1) should have been in place. The LNHA stated that staff should be not signing in the EMR if the Ex.Order 26.4(b)(1) were not in place. He stated that staff "should only be signing if they are in place." The LNHA acknowledged that staff should be following the PO and the care plan.

On 7/28/23 at 9:42 AM, the SE/LPN in the presence of the LNHA, the ED, the Regional Nurse and the survey team acknowledged that staff should be following the PO and the care plan.

2. On 7/20/23 at 10:08 AM, the surveyor observed the Resident #62 in bed with covers over his/her head. There was a Ex.Order 26.4(b)(1) on the side table with connected tubing that was dated 7/18/23. The tubing was connected to a Ex.Order 26.4(b)(1) cup that was resting on the side table. There was a cell phone resting next to the Ex.Order 26.4(b)(1)

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a cup of applesauce resting near Ex.Order 26.4(b)(1) and a brown paper bag resting near the Ex.Order 26.4(b)(1).

The surveyor reviewed the medical record of Resident #62.

A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility in Ex.Order 26.4(b)(1) with diagnoses which included Ex.Order 26.4(b)(1)

A review of the July 2023 Order Summary Report included a physician's order dated 6/23/2023, for Ex.Order 26.4(b)(1)

A review of the July 2023 Medication Administration Record (MAR) reflected the above physician's order and was documented as administered.

A review of the resident's individualized comprehensive care plan (ICCP) did not include a focus area, goals, or interventions for Ex.Order 26.4(b)(1).

On 7/21/23 at 9:44 AM, the surveyor interviewed

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CNA #4 who stated it was the first time that she cared for the resident, and she received a verbal report from the previous CNA, and a paper report from the nurse as to the type of care the resident required.

On 7/25/23 at 11:38 AM, the surveyor interviewed the Registered Nurse (RN) caring for Resident #62 who stated an ICCP was a plan for the resident's specific needs that was created by the admission nurse when the initial assessment was done. The RN stated that an ICCP can change and be updated and that Ex.Order 26.4(b)(1) should have been on an ICCP, but that she had not seen many ICCPs.

On 7/25/23 at 12:26 PM, the surveyor interviewed UM/LPN #2 who stated that an ICCP was the "bible" for the resident and that it would tell the entire team how to care for the resident. UM/LPN #2 stated that nursing, social worker, therapists, CNA, dietician, MDS Coordinator, and the LNHA all had access to the ICCP and could have updated it. UM/LPN #2 stated the ICCP may not have specifically contained Ex.Order 26.4(b)(1), but may have said Ex.Order 26.4(b)(1) treatment.

On 7/25/23 at 1:04 PM, the surveyor interviewed the ADON who stated an ICCP was a picture of the care that the resident received, and that any discipline would have been able to access the ICCP and would have known what kind of care the resident required. The ADON stated that the admission nurse started the basic ICCP and then the unit manager oversaw it to ensure it was updated. The ADON stated that she would have expected to see Ex.Order 26.4(b)(1) on the ICCP with a Ex.Order 26.4(b)(1) diagnosis on the goals and Ex.Order 26.4(b)(1) under the interventions.

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F 656	Continued From page 14 On 7/25/23 at 1:45 PM, the surveyors met with the Administration team and informed them the Ex.Order 26.4(b)(1) was not on Resident #62's ICCP. At this time, the surveyor inquired with the Administration team if a Ex.Order 26.4(b)(1) r was ordered, where would the surveyor expect to see documentation, and no one from Administration answered. The surveyor then inquired where else in the medical record Ex.Order 26.4(b)(1) would have been documented, and he ADON stated that a Ex.Order 26.4(b)(1) should be on the ICCP under a medical reason that included an intervention of a Ex.Order 26.4(b)(1) The LNHA then stated an ICCP was a plan specific to the resident's care and needs. The Staff Educator/LPN confirmed that the Ex.Order 26.4(b)(1) should have been on the ICCP. A review of the facility provided "Care Planning Process and Care Conference" policy dated reviewed 7/2023, included...all resident/patient care and interventions must be carried out per the Care Plan... A review of the facility provided "Falls Prevention and Management" policy dated reviewed 6/2023, included Fall Injury Prevention - Post fall: assess the resident and immediately implement appropriate measures to prevent injury. a. examples may be, but not limited to: ...low bed, perimeter mattress, fall mats, positioning devices in bed/chair ... A review of the facility provided "Physician Orders, Verbal and Telephone" policy dated reviewed 6/2023, included...to secure physician orders for care and services for residents...physician orders will include the medication, treatment and or care requiring	F 656		

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F 656	Continued From page 15 physician orders...update care plan as necessary based on physician orders... NJAC 8:39-27.1(a)	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Complaint # NJ165640	F 657	Tag 0657 Element One Corrective Actions	9/7/23

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F 657	Continued From page 16 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to revise comprehensive care plans in a timely manner for a.) two residents (Resident #59 and #67) with Ex.Order 26.4(b)(1) and b.) a resident (Resident #45) with a change in Ex.Order 26.4(b)(1). This deficient practice was identified for 3 of 25 resident reviewed for revision of comprehensive care plans (Resident #45, #59, and #67), and the evidence was as follows: 1. On 7/18/23 at 12:14 PM, the surveyor observed Resident #59 seated in their Ex.Order 26.4(b)(1) watching television. Resident #59 reported that they had an unintentional Ex.Order 26.4(b)(1) due their dislike of the facility's food. The surveyor reviewed the medical record for Resident #59. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility in Ex.Order 26.4(b)(1), with diagnoses which included Ex.Order 26.4(b)(1) [redacted] A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 4/18/23, reflected a brief interview for mental status (BIMS) score of Ex.Order 26.4(b) of 15, which indicated a Ex.Order 26.4(b)(1).	F 657	#1 Resident #59 The Care Plan for Resident #59 was immediately updated to reflect the Resident's trending Ex.Order 26.4(b)(1) and the Ex.Order 26.4(b)(1) The facilities Ex.Order 26.4(b)(1) and Meal Ticket were also immediatley updated to reflect Resident #59 upgrade to a Ex.Order 26.4(b)(1) The Registered Dietician was immediatley counseled and re-educated about timingly revisions to a Resident's Care Plan to reflect trending Ex.Order 26.4(b)(1) and correct Ex.Order. The Registered Dietician and the Food Service Director were both immediatley counseled and re-educated regarding updating resident meal tickets and the facilities Ex.Order 26.4(b)(1) in a timely and effective manner. #2 Resident #67 The Care Plan for Resident #67 was immediately updated to reflect the Resident's trending Ex.Order 26.4(b)(1) and the correct Ex.Order The Registered Dietician was immediatley counseled and re-educated about timingly revisions to a Resident's Care Plan to reflect trending Ex.Order 26.4(b)(1) and correct Ex.Order #3 Resident #45 The Care Plan for Resident #45 was immediatley updated to indicate the resident was Ex.Order 26.4(b)(1) The Interdisciplinary Team was immediatley counseled and re-educated about timingly revisions to a Resident's Care Plan to reflect the most update to date Ex.Order 26.4(b)(1) status.	

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F 657	Continued From page 17 A review of the resident's current Order Summary Report included the following physician's orders (PO): A PO dated 6/7/23, Ex.Order 26.4(b)(1) [redacted] A review of the Progress Notes included a Nutrition Dietary note dated 5/9/23 at 10:53 AM, which indicated that the resident was recently Ex.Order 26.4(b)(1) and returned with Ex.Order 26.4(b)(1). The May monthly Ex.Order 26.4(b)(1) that suggested a Ex.Order 26.4(b)(1) times one month. The resident returned from the Ex.Order 26.4(b)(1) on a downgraded Ex.Order 26.4(b)(1) [redacted]. The resident was ordered health shakes three times a day, Ex.Order 26.4(b)(1)) twice a day, and required Ex.Order 26.4(b)(1) due to Ex.Order 26.4(b)(1) and encouragement. A review of an additional Nutrition Dietary note dated 6/8/23 at 11:04 AM, identified Resident #59 had a Ex.Order 26.4(b)(1). This weight suggested Ex.Order 26.4(b)(1) times one month and Ex.Order 26.4(b)(1) times six months. The resident was continued on Ex.Order 26.4(b)(1) and the Ex.Orde was upgraded to Ex.Order 26.4(b)(1) yesterday (6/7/23). A review of the individualized comprehensive care plan (ICCP) included a focus area revised on 4/27/23, that the resident had a Ex.Order 26.4(b)(1) problem or potential Ex.Order 26.4(b)(1) problem related to Ex.Order 26.4(b)(1) [redacted]. Interventions included Ex.Order as ordered (Refer to Physician's Order Sheet for current) Ex.Order 26.4(b)(1)	F 657	Element Two Identification of at Risk Residents #1 Resident #59 All Residents that are at risk for trending Ex.Order 26.4(b)(1) and changes to their Ex.Orde to be affected by this practice. All residents with trending Ex.Order 26.4(b)(1) were reviewed to assure it is reflected on their care plan along with interventions. All Resident curren Ex.Order 26 were reviewed to assure it is reflected on their care as well. No deficiences noted. #2 Resident #67 All Residents that are at risk for trending Ex.Order 26.4(b)(1) and changes to their Ex.Order to be affected by this practice. All residents with trending Ex.Order 26.4(b)(1) were reviewed to assure it is reflected on their care plan along with interventions. All Resident current Ex.Order 26 were reviewed to assure it is reflected on their care as well. No deficiences noted. #3 Resident #45 All Residents that are at risk for Ex.Order 26.4(b)(1) to be affected by this practice. All Resident Ex.Order 26.4(b)(1) assure the accuary on their care plans. No deficiences noted. Element Three Systemic Change #1 Resident #59 The facility "Weight Assessment and Interventions" policy was reviewed which addresses if a Ex.Order 26.4(b)(1) meets the definition of significant and care plan interventions. The Interdisciplinary Team /	

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F 657	Continued From page 18 Ex.Order 26.4(b)(1) [redacted] . Upon further review of Resident #59's ICCP it did not include their change in condition regarding the Ex.Order 26.4(b)(1) and corresponding interventions, including correct Ex.Orde and level of need. On 7/21/23 at 8:46 AM, the surveyor observed Resident #59 independently eating breakfast. The surveyor observed that the resident's meal ticket identified them as a Ex.Order 26.4(b)(1) The surveyor reviewed the Daily Assignment Binder which did not identify the Resident as a Ex.Order 26.4(b)(1) for 7/21/23, but the surveyor did observe the resident's name on Nelson-5 nursing unit's Ex.Order 26.4(b)(1) On 7/21/23 at 8:52 AM, the surveyor interviewed Certified Nursing Assistant (CNA #1) who confirmed that the resident was "mostly independent" and did Ex.Order 26.4(b)(1) with Ex.Order 26.4(b)(1) CNA #1 reported that the resident required Ex.Order 26.4(b)(1) approximately four months ago, but did not Ex.Order 26.4(b)(1) [redacted] " CNA #1 confirmed the resident's name on the Nelson-5 nursing unit's Ex.Order 26.4(b)(1) and meal ticket that identified the resident as a Ex.Order 26.4(b)(1). When asked who was responsible for updating these lists CNA #1 responded, the Registered Dietitian (RD). On 7/21/23 at 9:12 AM, the surveyor interviewed Director of Rehabilitation (DOR), in the presence of the resident's Ex.Order 26.4(b)(1) who confirmed that Resident #59's Ex.Order was upgraded to Ex.Order 26.4(b)(1), and they did not "need to	F 657	Registered Dietician were re-educated regarding the policy. The Interdisciplinary Team were re-educated regarding the importance updating meal tickets and the Ex.Order 26.4(b)(1) #2 Resident #67 The facility "Weight Assessment and Interventions" policy was reviewed which addresses if a Ex.Order 26.4 t loss meets the definition of significant and care plan interventions. The Interdisciplinary Team / Registered Dietician were re-educated regarding the policy. #3 Resident #45 The facility "Care Planning" and "Care Planning Process and Care Conference" policy was reviewed which addresses needs such as the Activities of Daily Living (ADLS), Ex.Order 26.4(b)(1), revisions based on the results of the Residents assessment and change of condition to develop a comprehensive residents centered plan of care. The Interdisciplinary Team / Registered Dietician were re-educated regarding the policy. Element Four Quality Assurance #1 Resident #59 The Registered Dietician or Designee will conduct one daily audit of the Ex.Order 26.4(b)(1) for Residents with orders for one week and then weekly for three months to assure proper accuracy. The Registered Dietician will conduct a weekly audit of disired or undesired residents to review	

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F 657	Continued From page 19 have any type of Ex.Order 26.4(b)(1) When asked who was responsible for updating the meal ticket and the unit Ex.Order 26.4(b)(1) responded, the RD. On 7/24/23 at 10:48 AM, the surveyor interviewed the RD who confirmed that she was responsible for updating the care plan. The RD reported that the Food Service Director or herself were responsible for updating the meal tickets. When asked how nutritional interventions were put into the place, the RD responded that the care plan was updated, and nursing would be advised through communication. The surveyor inquired how often the care plan should be updated. The RD confirmed that the care plan should be updated to reflect any changes, including Ex.Order 26.4(b)(1) and that Resident #59's Ex.Order 2 should have been identified as Ex.Order 26.4(b)(1) On 7/25/23 at 10:17 AM, the surveyor interviewed the Acting Director of Nursing (ADON) who confirmed that Resident #59's care plan was not a comprehensive personal care plan for Ex.Order 26.4(b)(since it did not include the trending Ex.Order 26.4(b)(1) with the corresponding dates and the correct Ex.Order 2 On 7/26/23 at 1:17 PM, Regional Registered Nurse #1, in the presence of the Licensed Nursing Home Administrator (LNHA), Regional Registered Nurse #2, ADON, Executive Director, Staff Educator, and the survey team, confirmed that Resident #59's care plan was not comprehensive since did not include the trending Ex.Order 26.4(b)(1) and the interventions that were put into place. 2. On 7/18/23 at 11:10 PM, the surveyor observed Resident #67 seated in a Ex.Order 26.4(b)(1) in the dining	F 657	the care plan to assure correct Ex.Orde and any trending Ex.Order 26.4(b)(1) for three months. Results will be provided to the Director of Nursing (DON) who will review the findings and provide direction as appropriate. The Director of Nursing (DON) will report the findings in aggregate at the monthly QAPI meeting for further action as required. The Staff Educator will be responsible for maintaining education for staff on Ex.Order 26.4(b) and Interventions and Director of Nursing (DON) correction of deficiency #2 Resident #67 The Registered Dietician or Designee will conduct a audit of 5 residents with Ex.Orde changes two times a week to review the care plan to assure correct Ex.Orde and any trending Ex.Order 26.4(b)(1) for three months. Results will be provided to the Director of Nursing (DON) who will review the findings and provide direction as appropriate. The Director of Nursing (DON) will report the findings in aggregate at the monthly QAPI meeting for further action as required. The Staff Educator will be responsible for maintaining education for staff on Ex.Order 26.4(b) nd Interventions and Director of Nursing (DON) correction of deficiency #3 Resident #45 The Unit Manager or Designee will conduct a random audit of 5 residents two times a week to review the care plan to assure correct Ex.Order 26.4(b)(1) status for three	

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F 657	Continued From page 20 room being pushed to a table. The surveyor reviewed the medical record for Resident #67. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility in Ex.Order 26.4(b)(1), with diagnoses which included Ex.Order 26.4(b)(1) [redacted] A review of the most recent significant change MDS dated 6/15/23, reflected a BIMS score of [redacted] out of 15, which indicated a Ex.Order 26.4(b)(1) cognition. According to the Swallowing/Nutritional Status (Section K) Resident #67 was identified as having a Ex.Order 26.4(b)(1) or more in the last month or Ex.Order 26.4(b)(1) in the last six months. A review of the current Order Summary Report included the following physician's orders (PO): A PO with start date of 6/21/23, Ex.Order 26.4(b)(1) [redacted] A review of the Progress Notes included a Ex.Order 26.4(b)(1) note dated 5/8/23 at 7:53 AM, which indicated that the resident triggered for Ex.Order 26.4(b)(1) times one month, and [redacted] times six months. The note further indicated that the resident has had multiple medication changes due to Ex.Order 26.4(b)(1). The resident was started on Ex.Order 26.4(b)(1). An additional Nutrition Dietary note dated 5/18/23 at 10:50 AM, included May Ex.Order 26.4(b)(1) pounds, which suggested a Ex.Order 26.4(b)(1) times one month and Ex.Order 26.4(b)(1) six months. The resident was continued on Ex.Order 26.4(b)(1) and [redacted]	F 657	months. Results will be provided to the Director of Nursing (DON) who will review the findings and provide direction as appropriate. The Director of Nursing (DON) will report the findings in aggregate at the monthly QAPI meeting for further action as required. The Staff Educator will be responsible for maintaining education for staff on the Care Planning Process and Director of Nursing (DON) correction of deficiency The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 09/07/2023 to ensure the deficient Tag 0657 will not reoccur.	

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	315183	A. BUILDING _____ B. WING _____	C 07/28/2023

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Ex.Order 26.4(b)(1)) three times a day to Ex.Order 26.4(b)(1)

A Nutrition Dietary note dated 5/25/23 at 8:40 AM, included that the resident continued to show ongoing Ex.Order 26 with medication adjustments.

A Nutrition Dietary note dated 6/13/25 at 10:40 AM, included that the resident Ex.Order 26.4(b) continue to trend Ex.Order 26.4(b)(1) two-three months. The June Ex.Order 26.4(b) was identified as Ex.Order 26.4(b)(1) that suggested a Ex.Order 26.4(b)(1) times one month and Ex.Order 26.4(b)(1)) twice a day and Nurse Practitioner (NP) would review medications for possible Ex.Order 26.4(b)(1) as medically appropriate.

A Nutrition Dietary note dated 7/18/23 at 10:02 AM, included that the resident's Ex.Order 26.4(b)(1) pounds that suggested Ex.Order 26.4(b)(1) times one month and Ex.Order 26.4(b)(1) times six months. Speech Therapy had Ex.Order 26.4(b)(1). The resident's medications continued to be adjusted due to Ex.Order 26.4(b)(1), and trends were continued to be monitored.

A review of the individualized comprehensive care plan (ICCP) included a focus area revised on 12/7/21, that the resident had a Ex.Order 26.4(b)(1) related to Ex.Order 26.4(b)(1) Refer to Physician's Order Sheet for current) diet type: Ex.Order 26.4(b)(1)

Upon further review of the ICCP, it did not include

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F 657	Continued From page 22 the resident's change in condition regarding the Ex.Order 26.4(b)(1) and corresponding interventions, including Ex.Order 26.4(b)(1) On 7/24/23 at 10:48 AM, the surveyor interviewed the Registered Dietitian (RD) who confirmed that they were responsible for updating the care plan. When asked how nutritional interventions are put into the place, the RD responded that the care plan was updated, and nursing would be advised through communication. The surveyor inquired how often the care plan should be updated. The RD confirmed that the care plan should be updated to reflect any changes, including Ex.Order 26.4(b)(1). The RD reported the Resident #67's care plan had been updated to reflect Ex.Order 26.4(b)(1), but confirmed that it was updated after the surveyor brought it to the facilities attention. On 7/25/23 at 10:17 AM, the surveyor interviewed the Acting Director of Nursing (ADON) who confirmed that Resident #59's care plan was not a comprehensive personal care plan for nutrition since it did not include the trending Ex.Order 26.4(b)(1) with the corresponding dates and the correct Ex.Order 2 On 7/26/23 at 1:17 PM, Regional Registered Nurse #1, in the presence of the Licensed Nursing Home Administrator (LNHA), Regional Registered Nurse #2, Executive Director, Staff Educator, and survey team, confirmed that Resident #67's care plan was not up to date and comprehensive, since Ex.Order 26.4(b)(1) should have been updated, including trending Ex.Order 26.4(b)(1) and the interventions that were put into place.	F 657		

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F 657	Continued From page 23 3. On 7/25/23 at 9:30 AM, the surveyor observed Resident #45 lying in bed. The resident stated that he/she depended on staff to Ex.Order 26.4(b) his/her Ex.Order 26.4(b)(1) The surveyor reviewed the medical record for Resident #45. A review of the Admission Record face sheet reflected the resident had diagnoses which included Ex.Order 26.4(b)(1) A review of the admission Bowel and Bladder Assessment dated 11/15/22, included the resident was Ex.Order 26.4(b)(1). A review of the resident's admission MDS dated Ex.Order 26.4(b)(1) included the resident had a BIMS score of Ex.Or out of 15, which indicated the resident's cognition Ex.Order 26.4(b)(1). Further review of the MDS included the resident was Ex.Order 26.4(b)(1) of Ex.Order 26.4(b)(1). A review of the resident's most recent quarterly MDS dated 4/30/23, included the resident was occasionally Ex.Order 26.4(b)(1). A review of the resident's Bladder Continence record for the month of 4/2023, indicated the resident was Ex.Order 26.4(b)(1). A review of the resident's Bowel Continence record for the month of 4/2023 indicated the resident was Ex.Order 26.4(b)(1) Review of the resident's individualized comprehensive care plan (ICCP) included a focus	F 657		

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F 657	Continued From page 24 area last revised 11/24/22, the resident was Ex.Order 26.4(b)(1) with interventions that included to report episodes of Ex.Order 26.4(b)(1) to nurse. On 7/25/23 at 10:25 AM, the surveyor interviewed CNA #2 who stated Resident #45 was Ex.Order 26.4(b)(1) CNA #2 further stated that the resident called for assistance when he/she needed to be Ex.Order 26.4(b)(1) On 7/25/23 at 1:00 PM, the surveyor interviewed the Registered Nurse (RN) who stated Resident #45 was Ex.Order 26.4(b)(1) at times. The RN further stated the resident was Ex.Order 26.4(b)(1) and called for assistance when he/she needed to be Ex.Order 26.4(b)(1) On 7/26/23 at 9:27 AM, the surveyor interviewed the Unit Manager/LPN (UM/LPN) who stated Resident #45 was Ex.Order 26.4(b)(1) . The UM/LPN further stated that resident's care plans were initiated upon the resident's admission to the facility and revised "any time there is a need for updates." The UM/LPN explained that the care plan was revised by each department depending on the care plan focus area, and that there was no time frame for revising the care plan. On 7/26/23 at 11:23 AM, the surveyor interviewed the Assistant MDS Coordinator (AMDSC) who stated that each month, the MDS department provided each department with a calendar of which residents were due for their comprehensive or quarterly MDS assessments. The AMDSC further stated that each department knew which	F 657		

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care plans were due to be reviewed and revised based on that calendar. The AMDSC explained that a resident's care plan should be revised as soon as there was a change in the resident's condition, however, if it is missed, it should be revised during the next quarterly review when the resident was due for an MDS assessment. The AMDSC stated that the importance of a care plan was to guide the staff on how to care for the resident and she verified that Resident #45's care plan should have been revised to reflect the resident's Ex.Order 26.4(b)(1)

On 7/26/23 at 12:04 PM, the surveyor interviewed the ADON who stated that resident care plans were initiated on admission, and should be revised any time there was a change in the resident's condition. The ADON further stated the care plan should be revised during the quarterly review, however, if there was a change in condition, it should be revised within 24 hours. The ADON stated the importance of a care plan was it, "tells providers and staff how to take care of that resident." The ADON then verified that Resident #45's care plan should have been revised when the resident had a change from being Ex.Order 26.4(b)(1)

A review the facility provided "Weight Assessment and Interventions" policy that was last reviewed April 2023, included...if a weight loss meets the definition of significant, the Dietitian should discuss with the Interdisciplinary Team if a significant change MDS is necessary; care plan interventions will consider: severity of change; medical diagnosis; [Activities of Daily Living] status; medications; psychological status; family input; resident preferences; and input from direct

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F 657	Continued From page 26 care givers.... A review the facility provided "Care Planning" policy that was last reviewed July 2017, included...include such initial needs/problems such as [Activities of Daily Living], falls, skin tears, risk for skin breakdown, nutritional status, behaviors, pacemaker, anticoagulants, psychotropic medication use, etcetera. Include a care plan related to the resident's primary diagnosis...the interdisciplinary team will meet within 21 days of admission, readmission, when a change of condition occurs, and annually to develop the comprehensive, resident centered plan of care for each resident...when the problem, goal, approach or target date is change or resolved, it is indicated on the care plan...resident care and interventions must be carried out per the Care Plan (example adaptive equipment, such as braces, restraints, dentures, hearing aids)... Review of the facility's Care Planning Process and Care Conference policy, dated revised 7/03/23, included...care plan development, renewal and revision will be based on the results of the resident assessment...the interdisciplinary team will meet within 21 days of admission, readmission, when a change of condition occurs and annually to develop the comprehensive, resident centered plan of care for each resident...	F 657		
F 658 SS=E	NJAC 8:39-27.1(a) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility,	F 658		9/7/23

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F 658	Continued From page 27 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 review of pertinent facility documents, it was determined that the facility failed a.) to clarify a physician's order from 10/2/21 until 7/26/23 for Ex.Order 26.4(b)(1) b.) to apply and remove Ex.Order 26.4(b)(1) as ordered by the physician; c.) administer Ex.Order 26.4(b)(1) accordance to a physician's order; and d.) document on the Medication Administration Record and Treatment Administration Record for residents in accordance with professional standards of practice. This deficient practice was identified for 4 of 25 residents reviewed for professional standards of practice (Resident #62, #65, #66, and #79). This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title	F 658	Tag 0658 Element One Corrective Actions #1 Resident #66 Resident #66 was immediately assessment by Ex.Order 26.4(b)(1). Nursing staff was immediatley educated on documenting compliance regarding the Treatment Administration Record (TAR). #2 Resident #65 The facility immediately called to clarify the order with the physician for Resident #65. The physician approved and updated the order to reflect Ex.Order 26.4(b)(1) . The nurse that did not properly clarify the order was re-educated that if the facility does not have a dosage order they have to reach out to the physician for clarity. #3 Resident #66 & #4 Resident #79 The facility immediatley notified the resident's physician and responsible party regarding the gaps in the Medication Administration Record (MAR) for Resident #62 and Resident #79. Nursing staff was immediatley educated on compliance when documenting on the Medication Administration Record (MAR). Element Two Identification of at Risk Residents	

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F 658	Continued From page 28 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 7/24/23 at 11:47 AM, the surveyor observed Resident #66 sitting up in bed. The surveyor interviewed the resident who stated that the facility's nursing staff left Ex.Order 26.4(b)(1) on his/her Ex.Order [illegible] for a couple days the week of 7/17/23 (could not give specifics dates that the Ex.Order 26.4(b)(1) remained on) and did not take them off at night causing him/her to have Ex.Order 26.4(b)(1) on their Ex.Order 26 [illegible] The surveyor inquired from the resident as to how often the resident was supposed to wear the Ex.Order 26.4(b)(1) and the resident indicated that he/she was supposed to have the Ex.Order 26.4(b)(1) applied in the morning and removed at night. The resident stated that he/she had a history of Ex.Order 26.4(b)(1) [illegible] and Ex.Order 26.4(b)(1) of the Ex.Order 26 [illegible]. The surveyor asked the resident if he/she told the nursing staff that the Ex.Order 26.4(b)(1) needed to be removed at night, and they stated that it was their job to know, so he/she was not going to remind them. The surveyor asked the resident if he/she reported the incident to the administration, and they could not provide the surveyor with any names of the administration that he/she told. The resident then stated that Licensed Practical Nurse (LPN #1) was aware of	F 658	#1 Resident #66 All Residents that are at risk for receiving treatments have the potential to be affected by this practice. The facility reviewed all current Treatment Administration Record (TAR) to assure 100 percent compliance. No deficiencies noted upon review #2 Resident #65 All Residents that are at risk for receiving supplemented dosages have the potential to be affected by this practice. Facility review was conducted to ensure all medicaiton orders matched what is being provided to the residents. No deficiencies noted upon review #3 Resident #66 & #4 Resident #79 All Residents that are at risk for receiving medications have the potential to be affected by this practice. Facility review was condcuted to ensure all current Medication Administration Record (MAR) to assure 100 percent compliance. No deficiencies note upon review. Element Three Systemic Change #1 Resident #66 The facility "Medication Administration/Dispostion" policy was reviewed which addresses appropriate measures to assure proper documentation. Nursing staff were re-educated regarding the policy. Nursing staff were re-educated treatments are to be administered in a accurate manner and the nurse is to document by initialing on the electronic medical record.	

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F 658	Continued From page 29 what happened and could provide the surveyor with more details. The surveyor reviewed the medical record for Resident #66. The Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in Ex.Order 26.4(b)(1) with the diagnoses which included Ex.Order 26.4(b)(1) [redacted] A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 6/27/23, reflected that the resident had a brief interview for metal status (BIMS) score of [redacted] out of 15, which indicated Ex.Order 26.4(b)(1) cognition. A further review indicated that the resident required Ex.Order 26.4(b)(1) with activities of daily living (ADLs). A review of the Treatment Administration Record (TAR) for July 2023, included a physician's order dated 9/22/22, for Ex.Order 26.4(b)(1) to be applied in the morning (AM) and removed at night (PM) for the diagnoses o Ex.Order 26.4(b)(1). A further review revealed there were blanks for the corresponding order on 7/9/23, 7/16/23, and 7/19/23 that included no nurses signatures. On 7/9/23, there was no nurse's signature on the TAR that indicated that the Ex.Order 26.4(b)(1) were applied. On 7/16/23 and 7/19/23, there were no nurses' signatures on the TAR that indicated that the [redacted] were removed. A further review of the TAR included a physician's order dated 10/2/21, to Ex.Order 26.4(b)(1) on in	F 658	#2 Resident #65 The facility "Medication Administration/Dispostion" policy was reviewed which addresses the written physicians oder. Nursing staff were re-educated regarding the policy. Nursing staff were re-educated on medications being administered in accordance with the written physician's order. #3 Resident #66 & #4 Resident #79 The facility "Medication Administration/Dispostion" policy was reviewed which addresses appropriate measures to assure proper documentation. Nursing staff were re-educated regarding the policy. Nursing staff were re-educated medications are to be administered in a accurate manner and the nurse is to document by initialing on the electronic medical record. Element Four Quality Assurance #1 Resident #66 The Unit Managers or Designee will conduct daily audits per shift to assure 100 percent compliance on the Treatment Administration Record (TAR) for every shift from the prior day for one week and then weekly for three months to assure all treatments were provided. Results will be provided to the Director of Nursing (DON) who will review the findings and provide direction as appropriate. The Director of Nursing (DON) will report the findings in aggregate at the monthly QAPI meeting for further action as required.	

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F 658	Continued From page 30 the Ex.Order 26.4(b)(1)" and a Ex.Order 26.4(b)(1) er schedule". The physician's order did not specify what a Ex.Order 26.4(b)(1) was or where it should be "put in". The physician's order was unclear. On 7/24/23 at 11:54 AM, the surveyor interviewed LPN #1 who stated that she had been employed through Agency staffing and had been coming to the facility for approximately one year, and she was very familiar with Resident # 66. LPN #1 revealed that there had been occasions when she came in during the morning hours, and found that the resident's Ex.Order 26.4(b)(1) had Ex.Order 26.4(b)(1) from the night before. She stated that it did not happen all the time, but occasionally occurred. LPN #1 stated that on 7/20/23, she had observed that there was Ex.Order 26.4(b)(1) the Ex.Order 26.4(b)(1), and then observed that the resident had Ex.Order 26.4(b)(1) on their Ex.Order 26.4(b)(1). She stated that resident already had Ex.Order 26.4 on their Ex.Order 26.4(b)(and it appeared as though the Ex.Order 26.4(had come off, so she put in a Ex.Order 26.4 consultation order, and notified the Nurse Practitioner (NP). She then added that the resident had a lengthy history of Ex.Order 26.4(b)(1) She explained that on the morning of the 7/20/23, the resident did not have the Ex.Order 26.4(b)(1) on when she came into apply the Ex.Order 26.4(b)(1), and noticed there was Ex.Order 26.4 on the Ex.Order 26.4(b) LPN #1 stated that she called the NP who was in the building, and requested for her to come to the unit to see the resident's reopened wounds. LPN #1 stated that she performed the treatment to the resident's wound prior to applying the ace wraps. At this time, the surveyor in the presence of LPN #1 reviewed the resident's July 2023 TAR, and	F 658	Facility Educator will be responsible for maintaining education on proper TAR completion and the Director of Nursing (DON) for the correction of deficiency #2 Resident #65 The Unit Managers or Deisgnee will conduct daily random audits per shift to assure medicaition that is being provided to that resident matches exactly to the physician order for one week and then weekly for three months to assure medication being provide matches the physician orders. Results will be provided to the Director of Nursing (DON) who will review the findings and provide direction as appropriate. The Director of Nursing (DON) will report the findings in aggregate at the monthly QAPI meeting for further action as required. Facility Educator will be responsible for maintaining education on Physician Orders and the Director of Nursing (DON) for the correction of deficiency #3 Resident #66 & #4 Resident #79 The Unit Managers or Designee will conduct daily audits per shift to assure 100 percent compliance on the Medication Adminstration Record (MAR) log for every shift from the prior day for one week and then weekly for three months to assure proper placement of floor mats. Results will be provided to the Director of Nursing (DON) who will review the findings and provide direction as appropriate. The Director of Nursing	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 CHERRY HILL, NJ 08002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 31 the surveyor questioned LPN #1 regarding the blanks in the signature section of the TAR. LPN #1 stated that she did not know why there were blanks in the TAR for 7/9/23, 7/16/23 and 7/19/23, and she would go and find out. LPN #1 then returned after a couple minutes and stated that she checked with the Regional Registered Nurse (RRN #1) regarding the blank areas on the signature section of the TAR, and that RRN #1 informed her that a blank in the signature section of the TAR meant that the nurse did not sign the TAR that they had completed the treatment as ordered by the physician. The surveyor reviewed the NP's Clinical Note dated 7/20/23 at 10:37 AM, which indicated that the resident had Ex.Order 26.4(b)(1) on his/her Ex.Order and frequent Ex.Order 26.4(b)(1). The NP documented that the Ex.Order 26.4(b)(1) were very Ex.Order 26.4(b)(1) looked like Ex.Order 26.4(b)(1) with Ex.Order 26.4(b)(1) on top, no signs of Ex.Order 26.4(b)(1) and local care was ordered. On 7/24/23 at 12:19 PM, the surveyor interviewed LPN #2 who stated she had worked at facility through Agency staffing and was familiar with Resident #66. LPN #2 stated that she had worked day shift and evening shift on 7/22/23 and day shift on 7/24/23. LPN #2 stated that she went to see Resident #66 on day shift 7/22/23, and Resident #66 told her that he/she did not get his/her Ex.Order 26.4(b)(1) anymore because he/she had Ex.Order 26.4(b)(1) on his/her Ex.Order LPN #2 continued to explain that the resident told her that staff had left the Ex.Order 26.4(b)(1) intact to his/her Ex.Order for a couple days without taking them off. LPN #2 stated that she did not report what the resident told her because the resident indicated that the issue was being taking care of.	F 658	(DON) will report the findings in aggregate at the monthly QAPI meeting for further action as required. Facility Educator will be responsible for maintaining education on proper MAR completion and the Director of Nursing (DON) for the correction of deficiency The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 09/07/2023 to ensure the deficient Tag 0658 will not reoccur.	

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On 7/24/23 12:30 PM, the surveyor interviewed Certified Nursing Assistant (CNA #1) who stated that she had been employed on the day shift since May. She stated that she had observed "maybe twice" since employment that Resident #66 still had Ex.Order 26.4(b)(1) on in the morning when she came in. She stated that the Ex.Order 26.4(b)(1) were never left on days in a row. She explained that she would let the nurse know when this happened. She continued to add that the resident recently expressed concerns that the Ex.Orde left on overnight on 7/19/23, because when she came in on 7/20/23, the Ex.Order 26.4(b)(1) were still on the resident's Ex.Order 26 She stated that she reported the resident's concerns to the nurse.

The surveyor continued to review the medical record for Resident #66.

A review of the July 2023 TAR which included a physician's order which indicated the following: please Ex.Order 26.4(b)(1) per schedule. According to the TAR, the Ex.Order 26.4(b)(1) was to be applied at 9:00 AM and removed at 5:59 PM. The surveyor reviewed the TAR and there were blanks in the signature slots for 7/9/23, which indicated that the Ex.Order 26.4(b)(1) were not put on and on 7/16/23 and 7/19/23, which indicated that the Ex.Order were not removed as ordered by physician.

A review of the Progress Notes included a Clinical Nurses' Notes (CNN) dated 7/16/23 at 10:42 AM, which indicated that the nurse went into the resident's room and noted that the Ex.Order 26.4(b)(1) were still on the resident and not Ex.Order 26.4(b)(1) the previous night; the resident requested to have them Ex.Order 26.4(b)(1).

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F 658	Continued From page 33 On 7/25/23 at 9:44 AM, the surveyor interviewed Unit Manager/LPN (UM/LPN #1) who stated that Resident #66 was Ex.Order 26.4(b)(1) and was very particular regarding his/her care. She stated that the resident required Ex.Order 26.4(b)(1) of one staff member and had Ex.Order 26.4(b)(1) She continued to add that the resident had Ex.Order 26.4(b)(1) UM/LPN #1 continued to add that Resident #66 had a physician's order for Ex.Order 26.4(b)(1) She stated that when the nurse performed a treatment, they signed the TAR to indicate that the treatment was performed. She revealed that if the signature slot was blank, then it indicated that the treatment was not performed. She also stated that when a nurse obtained a physician's order the order, they should include specific directions including times, frequency, indications, and diagnoses. UM/LPN #1 confirmed that the treatment order for Resident #66 was not signed out on the TAR on 7/9/23, 7/16/23, and 7/19/23, which indicated that the treatment was not completed as ordered. At this time, the surveyor and UM/LPN #1 reviewed the treatment physician's orders, and UM/LPN #1 confirmed that the treatment physician's order dated 10/2/21, for Ex.Order 26.4(b)(1) was an incomplete order and should be more specific. She also confirmed that the treatment physician's Ex.Order 26.4(b)(1) was an incomplete order. UM/LPN #1 stated that they needed to be clarified.	F 658		

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F 658	Continued From page 34 On 7/25/23 at 10:14 AM, the surveyor interviewed LPN #3 who stated that she worked day shift on 7/16/23, and noticed that Resident #66 still had Ex.Order 26.4(b)(1) to their Ex.Order 26.4(b)(1) [redacted]. LPN #3 stated that the Ex.Order 26.4([redacted] should have been removed the night before, and when she Ex.Order 26.4(b)(1), the resident's Ex.Order 2 [redacted] She continued to explain that the resident had Ex.Order 26.4(b)(1) on and off. LPN #3 stated the resident's Ex.Order 26.4(b)(1) [redacted] but had improved over time. She confirmed that when a nurse did not sign the TAR, then it meant that the treatment was not done. LPN #3 also confirmed that the treatment physician's orders dated 10/2/21, that indicated Ex.Order 26.4(b)(1) [redacted]" was an incomplete order, and should be more specific. LPN #3 also confirmed that the treatment order in the TAR dated 10/2/21, which indicated Ex.Order 26.4(b)(1) [redacted] per schedule" was an incomplete order. On 7/25/23 at 11:40 AM, the surveyor interviewed the Acting Director of Nursing (ADON) who confirmed that if a nurse did not sign the signature slot on the TAR, then it meant that the nurse did not complete the treatment. The ADON stated that nurses should always document on the TAR to indicate whether a treatment was completed or not. The ADON also confirmed that the treatment orders dated 10/2/21, that indicated Ex.Order 26.4(b)(1) [redacted] as an incomplete order, and should be more specific. She also confirmed that the treatment physician's order in the TAR dated 10/2/21, which indicated Ex.Order 26.4(b)(1) [redacted] per schedule" was an	F 658		

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incomplete order. The ADON confirmed both physician's orders needed clarification and correction.

On 7/26/23 at 1:19 PM, the surveyor interviewed the facility's RRN #1 who stated that if the signature section slots in the TAR were blank, it indicated that the treatment was not performed, "You would not be able to tell if the treatment was done or not."

On 7/26/23 at 1:33 PM, the Licensed Nursing Home Administrator (LNHA) was interviewed in the presence of the survey team, and the LNHA stated that "if it was not documented, it was not done" regarding signature slots on the Medication Administration Record (MAR) and TAR.

On 7/27/23 at 9:32 AM, the Executive Director in the presence of the LNHA, ADON, Staff Educator/LPN, RRN #2, and survey team confirmed the blanks in the July 2023 TAR, and stated that the facility clarified the incomplete treatment physician's orders which were for the resident's Ex.Order 26.4(b)(1) The Executive Director confirmed the treatment physician's orders should have been clarified by the nurse at the time the orders were given.

2. On 7/21/23 at 9:13 AM, the surveyor observed LPN #4 preparing to administer medications to Resident #65. The surveyor observed LPN #4 pour Ex.Order 26.4(b)(1) into a medication cup. At that time, the surveyor asked LPN #4 to review the Medication Administration Record (MAR). The MAR reflected a physician's order (PO) dated 6/27/22, for Ex.Order 26.4(b)(1)

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Ex.Order 26.4(b)(1)
LPN #4 and the surveyor reviewed the label on the bottle of Ex.Order 26.4(b)(1) which indicated each tablet of Ex.Order 26.4(b)(1) The LPN acknowledged that she should contacted the physician to clarify the above order.

The surveyor reviewed the medical record for Resident #65.

A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in Ex.Order 26.4(b)(1), with diagnoses which included Ex.Order 26.4(b)(1)

A review of the Order Summary Report included a PO dated 6/27/22, for Ex.Order 26.4(b)(1) day for Ex.Order 26.4(b)(1)

On 7/21/23 at 9:01 AM, the surveyor accompanied by LPN #4 interviewed the Staff Educator/LPN who confirmed that LPN #4 cannot substitute Ex.Order 26.4(b)(1) The Staff Educator/LPN stated the nurse should have called the primary care physician to clarify the order if the facility only had Ex.Order 26.4(b)(1)

On 7/27/23 at 9:32 AM, the Executive Director in the presence of the LNHA, ADON, Staff Educator/LPN, RRN #2, and the survey team confirmed nurses should administer medication per physician's order; if the facility did not have the dosage ordered, they should call the

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physician.

3. On 7/19/23 at 11:29 AM, the surveyor observed Resident #62 lying in bed with the sheet covering his/her head. The resident responded when spoken to and said he/she was "okay" and recovered their head with the sheet.

The surveyor reviewed the medical record of Resident #62.

A review of the Admission Record face sheet (an admission summary) reflected that resident was admitted to the facility in Ex.Order 26.4(b)(1) with diagnoses which included Ex.Order 26.4(b)(1) [redacted]

A review of the July 2023 Order Summary Report included a physician's order (PO) dated 6/16/23, for Ex.Order 26.4(b)(1) [redacted]

A review of the corresponding July 2023 Medication Administration Record (MAR) revealed blanks on 7/10/23 at 9:00 PM for the

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F 658	Continued From page 38 administration of the Ex.Order 26.4(b)(1). A review of the July 2023 Order Summary Report included a PO dated 6/16/2023, for Ex.Order 26.4(b)(1) [redacted] A review of the corresponding July 2023 MAR revealed blanks on 7/10/23 at 9:00 PM for the Ex.Order 26.4(b)(1). A review of the July 2023 Order Summary Report included a PO dated 6/16/2023, for Ex.Order 26.4(b)(1) [redacted] A review of the corresponding July 2023 MAR revealed blanks on 7/10/23 at 5:30 PM for the Ex.Order 26.4(b)(1). A review of the July 2023 Order Summary Report included a PO dated 6/24/2023, for Ex.Order 26.4(b)(1) [redacted] A review of the corresponding July 2023 MAR revealed blanks on 7/10/23 at 5:00 PM for the Ex.Order 26.4 [redacted] A review of the July 2023 Order Summary Report included a PO dated 6/16/2023, for Ex.Order 26.4(b)(1) [redacted] before meals.	F 658		

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F 658	Continued From page 39 A review of the corresponding July 2023 MAR revealed blanks on 7/10/23 at 5:00 PM for the Ex.Order 26.4(b)(1). A review of the July 2023 Order Summary Report included a PO dated 6/23/23, for Ex.Order 26.4(b)(1) [redacted] times a day for Ex.Order 26.4(b)(1)). A review of the corresponding July 2023 MAR revealed blanks on 7/10/23 at 5:00 PM and at 9:00 PM. A review of the July 2023 Order Summary Report included a PO dated 6/16/2023, for Ex.Order 26.4(b)(1) [redacted] A review of the corresponding July 2023 Treatment Administration Record (TAR) revealed blanks on 7/7/23 at 5:00 PM, 7/9/23 at 9:00 AM, 07/10/23 at 5:00 PM, 7/14/23 at 9:00 AM, 7/16/23 at 5:00 PM, and 7/19/23 at 5:00 PM for the Ex.Order 26.4(b)(1) [redacted] On 7/25/23 at 11:38 AM, the surveyor interviewed the Registered Nurse (RN) who cared for the resident. The RN stated that once the physician's orders were entered into the electronic medical record (EMR), that the order would show up on the MAR. The RN stated that she would not expect to see blank spots because that would mean that the medication was not administered. At this time, the surveyor with the RN reviewed Resident #62's July 2023 physician's orders with	F 658		

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the corresponding MAR and TAR, and the RN acknowledged the blanks.

On 7/25/23 at 12:26 PM, the surveyor interviewed UM/LPN #1 who stated that once the physician's orders were entered into the EMR, that the order would show up on the MAR. UM/LPN #1 stated that the nurse signed the MAR each time a medication was given and if there was a blank spot, that it meant an omission of a medication and that she expected to see a follow up progress note in the EMR. At this time, the surveyor with UM/LPN #1 reviewed Resident #62's July 2023 physician's orders with the corresponding MAR and TAR, and UM/LPN #1 acknowledged the blanks. The surveyor with UM/LPN #1 reviewed the July Progress Notes, and UM/LPN #1 acknowledged that she did not see any progress notes that would have explained why there would be blank spaces on the MAR and TAR. UM/LPN #1 stated, "If it is not signed, it is not given."

On 7/25/23 at 1:04 PM, the surveyor interviewed the Acting Director of Nursing (ADON) who stated that when the nurse administered the medications, that they signed their initials in the block on the MAR, and that there would be a drop-down box for the nurse to document the reason the medication was not given. The ADON stated that if a block was empty on the MAR, that it meant that the medication was not administered, and that it was important to fill out the MAR correctly for accountability of what medications the resident received.

On 07/25/23 at 1:45 PM, the surveyors met with the Administration team who were made aware of the blanks on the resident's MAR and TAR.

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On 7/26/23 at 1:33 PM, the surveyor in the presence of the survey and Administration teams, interviewed the LNHA who stated that on the MAR and TAR, initials in the blocks meant that a medication was administered. The LNHA further stated, "if it was not documented, it didn't happen," and that all of the blocks on the MAR should have been filled in.

4. On 7/19/23 at 11:36 AM, the surveyor observed Resident #79 seated in Ex.Order 26.4(b)(1) in the common area. The resident was alert, calm, and quiet and wore a Ex.Order 26.4(b)(1) on his/her right Ex.Order 26.4

The surveyor reviewed the medical record of Resident #79.

A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility in Ex.Order 26.4(b)(1) with diagnoses which included Ex.Order 26.4(b)(1)

A review of the July 2023 MAR revealed a PO with start date 6/28/2023, for Ex.Order 26.4(b)(1) The MAR revealed blanks on 7/10/23 at 9:00 PM.

A review of the July 2023 MAR revealed a PO with start date 6/28/2023, for Ex.Order 26.4(b)(1) The MAR revealed blanks on 7/10/23 at 9:00 PM.

A review of the July 2023 Medication Review

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F 658	Continued From page 42 Report included a PO dated 4/11/2023, for Ex.Order 26.4(b)(1) [redacted] A review of the corresponding July 2023 MAR revealed blanks on 7/10/23 at 4:00 PM for the Ex.Order 26.4(b)(1) [redacted] A review of the July 2023 MAR revealed a PO with start date 6/28/2023, for Ex.Order 26.4(b)(1) [redacted] MAR revealed blanks on 7/10/23 at 5:00 PM. A review of the July 2023 MAR revealed a PO with start date 4/12/2023, for Ex.Order 26.4(b)(1) [redacted] The MAR revealed blanks on 7/10/23 at 9:00 PM. A review of the July 2023 MAR revealed a PO with start date 6/22/2023, for Ex.Order 26.4(b)(1) [redacted]. The MAR revealed blanks on 7/10/23 at 9:00 PM. On 7/25/23 at 11:38 AM, the surveyor interviewed the RN who cared for the resident. The RN stated that once the physician's orders were entered into the electronic medical record (EMR), that the order would show up on the MAR. The RN stated that she would not expect to see blank spots because that would mean that the medication was not administered. At this time, the surveyor with the RN reviewed Resident #79's	F 658		

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July 2023 physician's orders with the corresponding MAR and the RN acknowledged the blanks.

On 7/25/23 at 12:26 PM, the surveyor interviewed UM/LPN #1 who stated that once the physician's orders were entered into the EMR, that the order would show up on the MAR. UM/LPN #1 stated that the nurse signed the MAR each time a medication was given, and if there was a blank spot, that it meant an omission of a medication, and that she expected to see a follow up progress note in the EMR. At this time, the surveyor with UM/LPN #1 reviewed Resident #79's July 2023 physician's orders with the corresponding MAR and UM/LPN #1 acknowledged the blanks. The surveyor with UM/LPN #1 reviewed the July Progress Notes, and UM/LPN #1 acknowledged that she did not see any progress notes that would have explained why there would be blank spaces on the MAR. UM/LPN #1 stated, "If it is not signed, it is not given."

On 7/25/23 at 1:04 PM, the surveyor interviewed the ADON who stated that when the nurse administered the medications, that they put their initials in the block on the MAR, and that there would be a drop-down box for the nurse to document the reason the medication was not given. The ADON stated that if a block was empty on the MAR, that it meant that the medication was not administered, and that it was important to complete the MAR correctly for accountability of what medications the resident received.

On 7/25/23 at 1:45 PM the surveyors met with the Administration team who were made aware of the resident's blanks on the MAR .

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F 658	Continued From page 44 On 7/26/23 at 1:33 PM, the surveyor in the presence of the survey and Administration teams interviewed the LNHA who stated that on the MAR, initials in the blocks meant that a medication was administered. The LNHA further stated, "if it was not documented, it didn't happen," and that all of the blocks on the MAR should have been filled in. A review of the facility's "Medication Administration/Disposition" policy dated revised 7/1/23 included... Medications must be administered in accordance with the written physician's order... and the individual administering the medications must check the label three times to verify the right resident, right medication, right dosage, right time and right method of administration before giving the medication... A review of the facility provided "Medication Administration Treatment Guidelines" policy dated October 2017, included...treatments would be administered in a safe and accurate manner... the nurse would document was done by initialing on the electronic medical record... A review of the facility provided "Physician Orders, Verbal and Telephone" policy dated 7/1/23, included the policy intent was to secure physician orders for care and services for residents as required by state and federal law...treatment orders will include specific treatment ordered and reason or purpose. Unclear or incomplete written orders will be reviewed with the physician and any clarification will be documented... the facility would confirm accuracy of physician orders based on facility	F 658		

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F 658	Continued From page 45 guidelines when monthly orders and recaps are due to be renewed. A review of the facility policy, "Medication Administration/Disposition," last date revised 7/1/23, revealed Procedure...medications must be administered in accordance with the written physician order(s), including any required time frame...if a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and use the corresponding code on the EMAR to indicate the medication was not given and the reason for not administering; the individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones; as required or indicated for a medication, the individual administering the medication will record in the resident's medical record: a. the date and time the medication was administered...the signature and the title of the person administering the drug. NJAC: 8:39-27.1(a); 29.2(d)	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		9/7/23

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F 684	Continued From page 46 by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) perform complete and accurate Ex.Order 26.4(b)(1) and b.) develop and implement an individualized comprehensive care plan with interventions for a resident's Ex.Order 26.4(b)(1) This deficient practice was identified for 1 of 3 residents reviewed for Ex.Order 26.4 (Resident #80) and was evidenced by the following: On 7/18/23 at 11:02 AM, the surveyor observed Resident #80 in bed wearing a hospital gown. The surveyor observed a Ex.Order 26.4(b) on the Ex.Order 26.4(b) The resident stated to the surveyor he/she Ex.Order 26.4(b)(1) hat the nurse did Ex.Order 26.4(b)(1) he area, but that would be a good idea. The surveyor reviewed the medical record for Resident #80. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in Ex.Order 26.4(b)(1), with diagnoses which included Ex.Order 26.4(b)(1) A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 6/8/23, reflected that the resident had a brief interview for mental status (BIMS) score of Ex.Ord out of 15, which indicated Ex.Order 26.4(b)(1) cognition. A review of the most recent Psychiatric Progress Note dated 6/26/23, indicated the resident had	F 684	Tag 0684 Element One Corrective Actions The facility immediately performed a Ex.Order for Resident #80 Ex.Order 26.4(b)(1). The facility immediately updated Resident #80 Individualized Comprehensive Care Plan to reflect the residents Ex.Order 26.4(b)(1) The nurses and Certified Nursing Aides (CNA) under the patients care from 07/14/23 til 07/26/23 were all educated on the importance of updating the daily task report for any Ex.Order d documenting any resident Ex.Order 26.4(b)(1) that it can be reflected on their care plan. Element Two Identification of at Risk Residents All Residents with behaviors of Ex.Order 26.4(b)(1) for having failure of an accurate patient centered care plan. All residents were assessed for any new undocumented Ex.Order 26.4(b)(1). No deficiences noted. Element Three Systemic Change The facility "Weekly Ex.Orde n Observation-Licensed Staff" policy was reviewed which addresses weekly Ex.Order 26.4(b observations of the resident from head to toe for any visualizations of the Ex.Order. The facility "Care Planning" policy was reviewed which addresses developing a comprehensive, resident centered care plan for each and every resident within the facility based upon the results of the residents assessment. Nursing staff were re-educated regarding both policies. The	

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F 684	Continued From page 47 diagnoses of Ex.Order 26.4(b)(1) The note did not include Ex.Order 26.4(b)(1) A review of the Certified Nurse Aide (CNA) daily task report for July 2023, for Ex.Order 26 Observation: Document new Ex.Order 2 areas identified, report all findings to the nurse, from 7/14/23 until 7/26/23, the CNAs did not document the resident had any Ex.Order 26.4(b)(1) identified. A review of the Weekly Ex.Order 26.4(b)(1) report dated 7/24/23, the nurse indicated that the resident had Ex.Order 26.4(b)(1). A review of the individualized comprehensive care plan (ICCP) revised 5/23/23, reflected a focus area for Ex.Order 26.4(b)(1) with interventions which included continue all other Ex.Order 26.4(b)(1) s as ordered. The ICCP did not include the resident's Ex.Order 26.4(b)(1) or the resident's Ex.Order 26.4(b)(1) bserved by the surveyor and confirmed by the resident. On 7/19/23 at 12:54 PM, the surveyor interviewed Resident Representative (RR #1) for Resident #80 who was visiting the resident. RR #1 stated he/she did not visit often, but had been visiting weekly for about a month because RR #2 who came more regularly was unavailable. When asked about the Ex.Order 26.4(b) on the resident's Ex.Order 26.4 RR #1 stated they had seen the resident Ex.Order 26.4(b) but the Ex.Order 26.4(b) was new, he/she had not seen the Ex.Order 26.4(b) last week when they visited. When asked if this was a Ex.Order 26.4(b)(r the resident regularly exhibited, RR #1 stated he/she was	F 684	interdisciplinary team will now be meeting weekly to discuss all new Ex.Order 26.4(b)(1) from the prior week to oberve any possible trends. If trends or Ex.Order 26.4(b)(1 s are noted the Individualized Comprehensive Care Plan will be updated immediately to reflect this. Element Four Quality Assurance The Unit Managers or Designee will audit weekly Ex.Order 26.4(b)(1) to assure if any residents have new undocumented Ex.Order on their unit for one week and then weekly for three months to assure all Ex.Order 26.4(b)(1) are being documented. Results will be provided to the Director of Nursing (DON) who will review the findings and provide direction as appropriate. The Director of Nursing (DON) will report the findings in aggregate at the monthly QAPI meeting for further action as required. Facility Educator will be responsible for maintaining education for staff on documenting skin injuries and the Director of Nursing (DON) for the correction of deficiency The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 09/07/2023 to ensure the deficient Tag 0684 will not reoccur.	

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F 684	Continued From page 48	F 684		

unsure.

On 7/20/23 at 12:42 PM, the surveyor observed the resident in bed, staff had just brought in the resident's lunch tray. The surveyor observed the Ex.Order 26.4(b) on the resident's Ex.Order 26.4(b)(1) had begun to Ex.Order 26.4(b)(1) and was approximately Ex.Order 26.4(b)(1)

On 7/24/23 at 11:53 AM, the surveyor observed the resident in bed with Ex.Order 26.4(b)(1) on their Ex.Order 26.4(b) which appeared to be the same as the previous observation. The surveyor again asked the resident about their Ex.Order 26.4(b)(1), and the resident stated the Ex.Order 26.4(b) had been there a few weeks now, and again stated he/she Ex.Order 26.4(b)(1) The resident further stated neither the nurse nor the aides asked him/her about the Ex.Order 26.4(b)(1), and they did not Ex.Order 26.4(b)(1) any way.

On 7/24/23 at 12:34 PM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) assigned for the day who stated she had washed and dressed the resident that day, brushed their hair and had performed mouth care. The CNA stated part of washing a resident's body was to Ex.Order 26.4(b)(1) . The CNA stated she had not observed any Ex.Order 26.4(b)(1) on the resident's Ex.Order 26.4(b)(1) today.

On 7/24/23 at 12:44 PM, the surveyor interviewed the resident's Registered Nurse (RN) who stated the resident had a history of Ex.Order 26.4(b)(1) and had been in Ex.Order 26.4(b)(1) lately. The RN stated the resident had a Ex.Order 26.4(b)(1) that he/she had a small

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F 684	Continued From page 49 Ex.Order 26.4(b) on their Ex.Order 26.4(b)(1) The RN stated the resident had been diagnosed with Ex.Order 26.4 and stated to the nurse that he/she had exhibited this Ex.Order 26.4(b)(1) The RN stated nursing had been putting a Ex.Order 26.4(b)(1) on the site, but the resident kept Ex.Order 26.4(b)(1). The RN then stated the Ex.Order 26.4(b)(1) team had been notified to evaluate the resident's Ex.Order 2 about two weeks ago. The RN could not find if an evaluation had been done by the Ex.Order 26.4(b)(1) team. The RN further stated he had checked the resident's Ex.Order 2 today, and that it looked better today than it had last week. When the surveyor along with the RN reviewed the electronic medical record (EMR) for the resident, there were no physician's orders (PO) for a treatment to the resident's Ex.Order 26.4(or an order to Ex.Order 26.4(b)(1) either. The RN stated that was because the Ex.Order 26.4(b)(1) was just a Ex.Order 26.4(b)(1) On 7/24/23 at 12:59 PM, the surveyor along with the RN entered the resident's room where RR #2 was visiting. On 7/24/23 at 1:02 PM, the surveyor interviewed RR #2 who stated the resident had been Ex.Order 26.4(b) ages. RR #2 also stated the resident had a history of Ex.Order 26.4(b)(1) in the past, he/she had brought in Ex.Order 26.4(b)(1) to cover the Ex.Order 26.4(, but the resident continued to Ex.Order 26.4(b)(1) . On 7/25/23 at 10:31 AM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) who stated when a resident was admitted to the facility, there was a Ex.Order . The nurse assessed for any Ex.Order 26.4(b)(1) , or	F 684		

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unusual Ex.Order 26.4(b)(1) including Ex.Order 26.4(b) The CNAs every day when performing daily care, again checked for Ex.Order 26.4(b)(1) and notified the nurse if they observed an irregularity. The UM/LPN stated nurses then performed a weekly Ex.Order 26 completed on the resident's shower day, and if a Ex.Order 26.4(b)(1) was identified, then an incident report would be generated to determine the cause, and the family and the physician would be notified. The UM/LPN stated if new orders were obtained if needed, the Ex.Order 26.4(b) eam would be notified if needed as well. The UM/LPN stated the resident was Ex.Order 26.4(b)(1) but did not have Ex.Order 26.4(b)(1) that she was aware of. The UM/LPN stated that 7/24/23, was the first time someone had made her aware of the Ex.Order 26.4(b) on the resident's Ex.Order 26 and after she had been made aware, the resident's family and physician were notified; new orders for treatment were obtained; and the Ex.Order 26.4(b)(1) team had been contacted to do an evaluation.

On 7/25/23 at 1:16 PM, the surveyor interviewed the facility's Registered Nurse/Wound Nurse (RN/WN) who stated nurses should do Ex.Order 26.4(b) and the CNAs when providing daily care were supposed to report any new Ex.Order 26 .

On 7/25/23 at 1:23 PM, the surveyor and the RN/WN together entered the resident's room to visualize the resident's Ex.Order 26 The RN/WN stated she believed the Ex.Order 26.4(b) was more of a Ex.Order 26.4(b)(1) or a Ex.Order 26.4(b)(1) The RN/WN stated she had been informed by nursing that the resident had been Ex.Order 26.4(b)(1). The RN/WN stated both the nurse and the CNA should have assessed the resident and reported a new Ex.Order

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change. The RN/WN stated that if the resident was Ex.Order 26.4(b)(1) and causing Ex.Order 26.4(b)(1) then there should be a care plan for that Ex.Order 26.4(b)(1) with interventions put in place.

On 7/25/23 at 1:37 PM, the surveyor re-interviewed the resident's RN who acknowledged both himself and the CNA should have recognized the resident's Ex.Order 26.4(b) on their Ex.Order 26.4(b)(1) the Ex.Order 26.4(b) The RN further acknowledged the resident's care plan should have been updated to include the Ex.Order 26.4(b) on the resident's Ex.Order as well as the resident's Ex.Order 26.4(b)(1) of Ex.Order 26.4(b)(1), that they had "dropped the ball and spent a lot of time putting out fires."

On 7/25/23 at 1:42 PM, the surveyor re-interviewed the UM/LPN who stated a care plan was a "bible" for the resident, it included everything you needed to know to care for the resident and the goals that were set for the resident. The UM/LPN acknowledged the resident's care plan should have been updated for the current Ex.Order 26.4(b) on the resident's Ex.Order as well as the resident's Ex.Order 26.4(b)(1)

On 7/25/23 at 1:55 PM, the surveyor interviewed the Acting Director of Nursing (ADON) who stated nurses were required to assess a resident's Ex.Order weekly and the CNA daily usually during morning care. The ADON stated if the CNA noticed a Ex.Order alteration, they needed to make the nurse aware, and the physician was contacted, and new orders obtained if necessary, and the care plan needed to be updated to include the Ex.Order 26.4(b)(1). The ADON confirmed the resident's care plan should have been updated to reflect the actual Ex.Order

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F 684	Continued From page 52 Ex.Order 26.4(b)(1) as well as the Ex.Order 26.4(b)(1). On 7/27/23 The survey team met with the facility Administration which included the ADON who stated a Ex.Order 26.4(b)(1) should have been completed as soon as the Ex.Order 26.4(b)(1), and the care plan should have been updated to reflect the Ex.Order 26.4(b) on the resident's Ex.Order as well as the Ex.Order 26.4(b)(1) The ADON further stated the resident had been evaluated by the Ex.Order 26.4(b) care Nurse Practitioner, the resident's primary physician was notified, and new orders were obtained to cleanse the resident's Ex.Order 26.4(b) with Ex.Order 26.4(b)(1) and the care plan had been updated for Ex.Order 26.4(b)(1) and Ex.Order 26.4(b) A review of the facility's "Weekly Skin Observation-Licensed Staff" policy dated and reviewed 4/2023, included... the facility will complete a weekly Ex.Order 26.4(b) observation of resident. This observation includes a head-to-toe visualization of the resident's Ex.Order 26.4 A review of the facility's "Care Planning" policy dated and revised 7/2017, included that...the facility will develop a comprehensive, resident centered care plan for each resident... based upon the results of the resident assessment...	F 684		
F 755 SS=E	NJAC 8:39-27.1 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	F 755		9/7/23

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F 755	Continued From page 53 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 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 pertinent facility documents, it was determined that the facility failed to a.) properly dispose of a medication that fell on a contaminated surface and was previously cited during last standard survey and b.) ensure mediation was not left unattended at a resident's bedside. This deficient practice was identified for 1 of 4 residents reviewed during medication pass observation	F 755	Tag 0755 Element One Corrective Actions The Facility Educator immediately opened the medication cart and placed the improperly disposed medication in the drug buster and retrieved the Ex.Order 26.4(b)(1) [redacted] n the chamber that was left at bedside for Resident #13's roommate. The agency nurse that did not	

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F 755	Continued From page 54 (Resident #13), and was evidenced by the following: On 7/21/23 at 8:39 AM, the surveyor during medication pass observation observed the Licensed practical Nurse (LPN) on Nelson-5 nursing unit prepare medication for administration for Resident #13 which included Ex.Order 26.4(b)(1) [redacted] During the preparation of the medications, the LPN dropped the Ex.Order 26.4(b)(1) on the contaminated medication cart. The surveyor observed the LPN pick up the Ex.Order 26.4(b)(1), and throw them away into the garbage receptacle attached to the medication cart. The LPN then finished preparing the medications and entered the resident's room. The LPN administered the oral medications and then opened the canister on the Ex.Order 26.4(b)(1) and poured in the Ex.Order 26.4(b)(1) into the chamber. The resident was in the middle of eating their breakfast so the LPN stated to the resident she would wait to give them their mediations until they had finished eating. She then proceeded to take the Ex.Order 26.4(b)(1) [redacted] and placed it in the resident's bedside table drawer and returned to the medication cart to prepare medications for Resident # 13's roommate. On 7/21/23 at 8:52 AM, the surveyor interviewed the LPN who stated that [redacted] was not a controlled substance and did not require disposal in a dedicated disposal container with another nurse as witness. When the surveyor questioned the safety of disposing of a medication in the garbage receptacle, the LPN stated she	F 755	properly dispose of medication and ensure medication was not left unattended at resident's bedside was immediately sent home and no longer works at the facility. Element Two Identification of at Risk Residents All Residents that are at risk for improper medication disposal physician orders for Ex.Order 26.4(b)(1) have the potential to be affected by this practice. All residents rooms were checked for Ex.Order 26.4(b)(1) [redacted] at bedside and no defiences discovered. All nurses were asked and how to properly dispose of medication to which no defiences were noted. Element Three Systemic Change The facility "Drug Buster" policy was reviewed which addresses properly disposing of medication within the facility by placing all medication into the drug buster container, invert and swish the bottle twice and finally replacing the cap. Nursing staff were re-educated regarding this policy. The facility updated their "Medication Administration/Disposition" policy to address never leaving medication unattended at the resident's bedside. Nursing staff were re-educated regarding this policy. Element Four Quality Assurance The Facility Educator or Designee will observe one nurse nurse per shift while they complete a med pass for one week and then weekly for three months to assure proper disposal of medication and	

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F 755	Continued From page 55 supposed someone could take the mediation out and consume it. The surveyor then asked the LPN if she should leave the Ex.Order 26.4(b)(1) that contained Ex.Order 26.4(b)(1) in the bedside table and the LPN stated, it was okay because the resident could not get out of the bed, and that she was had not left the room. On 7/21/23 at 9:01 AM, the surveyor interviewed the Staff Educator/LPN who stated that all medications should be disposed of properly in the dedicated disposal container which could be located on each unit in the medication room. The Staff Educator/LPN stated there should also be a container on each mediation cart, and proceeded to open the medication cart on the Nelson-5 nursing unit that serviced Resident #13's room which revealed a drug disposal container, and acknowledged the LPN should not have discarded the fish oil in the garbage receptacle attached to the mediation cart. The Staff Educator/LPN then stated that a nurse should never have left medication in a Ex.Order 26.4(b)(1) and walk away, even to attend another resident in the same room; that leaving a Ex.Order 26.4(b)(1) at bedside was never okay. On 7/27/23 at 9:39 AM, the Acting Director of Nursing (ADON) in the presence of the Licensed Nursing Home Administrator (LNHA), Staff Educator/LPN, Regional Registered Nurse, Executive Director, and survey team who confirmed that for safety reasons, there should never be medications left at a resident's bedside and medications should be disposed of properly in the designated disposal container and not in the garbage. At this time, the LNHA acknowledged that the facility was previously cited for disposing of medication in the garbage	F 755	unattended medication at bedside. Results will be provided to the Director of Nursing (DON) who will review the findings and provide direction as appropriate. The Director of Nursing (DON) will report the findings in aggregate at the monthly QAPI meeting for further action as required. Facility Educator will be responsible for maintaining education for staff on properly handling medication and the Director of Nursing (DON) for the correction of deficiency The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 09/07/2023 to ensure the deficient Tag 0755 will not reoccur.	

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F 755	Continued From page 56 receptacle and not the drug buster during the facility's last standard survey. A review of the facility provided "Medication Administration/Disposition" policy dated revised 7/1/23, included...disposition should prevent diversion and/or accidental exposure... The policy did not address leaving medications unattended at a resident's bedside... A review of the facility provided "Drug Buster" policy dated last reviewed 6/2023, included...place medication into the Drug Buster container, invert and swish the bottle twice, replace the cap... A review of the facility provided "Hand Held Ex.Order 26.4(b)(1) " policy dated last reviewed 3/2023, did not include leaving medications unattended at the bedside. NJAC 8:39-29.4(h)	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure all medications were administered without an error of 5% or more. During the medication observation on 7/21/23, the surveyor observed three (3) nurses	F 759	Tag 0759 Element One Corrective Actions The facility immediately called the physician for clarification on Ex.Order 26.4(b)(1) [redacted] for Resident #65 and they changed the order to Ex.Order 26.4(b)(1).	9/7/23

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F 759	Continued From page 57 administer medications to four (4) residents. There were 35 opportunities, and three (3) errors were observed which calculated a medication administration error rate of 8.5%. This deficient practice was identified for 1 of 4 residents (Resident #65) that were administered medications by 1 of 3 nurses. The deficient practice was evidenced as follows: On 7/21/23 at 9:13 AM, the surveyor observed the Licensed Practical Nurse (LPN) prepare medications for Resident #65 which included, Ex.Order 26.4(b)(1) [redacted] At this time, the LPN stated the resident took their medications crushed in applesauce and proceeded to crush the medications and placed them into applesauce. The LPN then proceeded to enter the resident's room to administer the medications. At this time, the surveyor asked the LPN to hold the medications and step outside the resident's room. Upon returning to the cart, the surveyor reviewed the Medication Administration Record (MAR) with the LPN. The MAR revealed a physician's order (PO) for Ex.Order 26.4(b)(1) [redacted]. The surveyor asked the LPN if these medications could be crushed, and the LPN stated no, delayed release tablets should not be crushed. The LPN confirmed she needed to call the physician to clarify the orders. (ERROR #1, #2 and #3).	F 759	Pharmacy was also made aware immediately and sent over the new medication. The nurse was also immediately educated on crushing delayed release tablets. Element Two Identification of at Risk Residents All Residents that have delayed release tablets are at risk to be affected by this practice. All residents with orders for delayed release tablets were reviewed. Nursing staff re-educated on proper medicaiton administration on proper delayed released medication. No defiences noted. Element Three Systemic Change The facility "Medication Administration/Disposition" policy was reviewed which address nursing having access to a current drug handbook for reference and updated to reflect delayed release tablets should not be crushed and the physician should be reached for clarity on the order. Nursing staff were re-educated regarding the policy. Element Four Quality Assurance The Facility Educator or Designee will observe one nurse per shift while they complete a med pass for one week and then weekly for three months to assure proper administration of delyaed released medications. Results will be provided to the Director of Nursing (DON) who will review the findings and provide direction as appropriate. The Director of Nursing (DON) will report the findings in aggregate	

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F 759	Continued From page 58 On 7/21/23 at 9:33 AM, the LPN and surveyor went to the nurse's station on Nelson-6 nursing unit. The Staff Educator/LPN confirmed that the above medications could not be crushed, and she needed to call the resident's physician for clarification. The surveyor reviewed the medical record for Resident #65. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility Ex.Order 26.4(b)(1), with diagnoses which included Ex.Order 26.4(b)(1) [redacted] A review of the Order Summary Report included the following physician's orders: A PO dated 5/23/20, Ex.Order 26.4(b)(1) unless contraindicated. A PO dated 6/2/21, for Ex.Order 26.4(b)(1) [redacted] A PO dated 7/11/23, for Ex.Order 26.4(b)(1) [redacted] mes a day. A PO dated 7/11/23, for Ex.Order 26.4(b)(1) [redacted] times a day. On 7/27/23 at 9:37 AM, the survey team met with the facility administration including the Acting Director of Nursing (ADON) who acknowledged that both Ex.Order 26.4(b)(1) should not be crushed. A review of the facility provided "Medication Administration/Disposition" policy dated reviewed	F 759	at the monthly QAPI meeting for further action as required. Facility Educator will be responsible for maintaining education for staff on proper medicaton administration and the Director of Nursing (DON) for the correction of deficiency The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 09/07/2023 to ensure the deficient Tag 0759 will not reoccur.	

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F 759	Continued From page 59 6/2023, included...nurses will have access to a current Drug Handbook for reference of medications if necessary... NJAC 8:39-11.2(b); 29.2(d)	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) properly label opened	F 761	Tag 0761 Element One Corrective Actions The multidose medications were	9/7/23

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F 761	Continued From page 60 multi-dose medications, b.) ensure that out of date medications were removed from the medication carts where other current in use medications were stored, and c.) maintain proper temperature ranges for the medication refrigerators. This deficient practice was identified for 2 of 4 medication carts and 2 of 2 medication refrigerators on 2 of 2 nursing units (Nelson-5 and Nelson-6) and was evidenced by the following: 1. On 7/25/23 at 11:47 AM, the surveyor inspected the Nelson-5 nursing unit medication cart identified as "Cart 3 & 4," in the presence of Licensed Practical Nurse (LPN #1). There was an opened multi-dose insulin lispro pen that was not labeled with an opened date. The date on the bag for the insulin lispro pen was 6/1/23. There was a second opened multi-dose insulin lispro pen that was labeled with an opened date of 5/29/23. When asked about the two insulin pens, LPN #1 stated she was not sure how long the pens were good for after opening and would give the insulin pens to the Unit Manager. On 7/25/23 at 12:01 PM, the surveyor inspected the Nelson-5 nursing unit medication cart identified as "Cart 1 & 2," in the presence of LPN #2. There was an opened multi-dose inhaler (Incruse Ellipta) that was not labeled with an opened date. The date on the box for the inhaler was "04/22," and there were instructions on the inhaler box to discard six weeks after opening. LPN #2 acknowledged the inhaler was no longer good and removed it from the medication cart. 2. On 7/25/23 at 12:13 PM, the surveyor inspected the Nelson-6 nursing unit medication room in the presence of the Registered Nurse	F 761	immediately discarded by the facility. The facility immediately notified maintenance regarding the temperatures of the medication refrigerators. Maintenance review both refrigerators and adjusted the internal temperature dial and afterwards both refrigerators reflected 38 degrees F. The nursing staff that did not properly discard the mutlidose medications were immediately counseled and re-educated about properly dating and discarding opened multidose medications. Element Two Identification of at Risk Residents All Residents that are at risk for receiving multidoese medications have the potential to be affected by this practice. All medication carts were reviewed for any non labeled medications and/or out of date medications. No defiences noted. Element Three Systemic Change The facility "Insulin Pen" policy was reviewed which addresses appropriately dating opened pens and using the manufacturers recommendations regarding the number of days it is viable before needing to be discarded. The facility "Inhalants and Nebulizer Medications" policy was updated to reflect dating inhalers upon opening and the proper time frame to discard as per the manufacturer. Nursing staff were re-educated regarding these policies. The facility "Medication Storage" policy was reviewed which addresses the appropriate temperatures for the medication refridgerators (36-46 degrees F).	

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F 761	Continued From page 61 (RN). Upon opening the medication refrigerator, the internal temperature was 48 degrees Fahrenheit (F), and there was clear liquid dripping from the freezer section of the refrigerator onto sealed plastic bags of medications. The RN stated the night shift (11:00 PM to 7:00 AM) nurse was responsible for checking the refrigerator temperatures. According to the refrigerator temperature log for July 2023, the temperature was not recorded that morning (7/25/23). On 7/25/23 at 12:42 PM, the surveyor inspected the Nelson-5 nursing unit medication room in the presence of Unit Manager/LPN (UM/LPN #1). Upon opening the medication refrigerator, there were two thermometers; one in the door and one on a shelf inside the refrigerator. The door thermometer had a temperature of 34 F, and the shelf thermometer had a temperature of 32 F. UM/LPN #1 stated she was unsure what the temperature inside the medication refrigerator should be. On 7/25/23 at 12:45 PM, the surveyor interviewed UM/LPN #1 who stated that insulin pens and inhalers should be labeled on the bag, box, or actual medication device, and were good for 30 days after opening. UM/LPN #1 also stated that the medication refrigerator temperature should be between 36 F and 46 F. On 7/25/23 at 12:55 PM, the surveyor interviewed UM/LPN #2 who stated nurses dated the actual insulin pen upon opening and it was good for 28 days. UM/LPN #2 further stated that nurses dated the actual inhaler upon opening and followed the directions on the label to determine when to discard the inhaler. When asked about the medication refrigerator, UM/LPN #2 stated	F 761	Nursing staff were re-educated regarding these policy. The 11-7 nursing staff were re-educated on accurately and consistentcy documenting the refrigerator temperature log every morning. Element Four Quality Assurance The Unit Managers or Desginee will conduct daily rounds per shift and audit the refrigerator temperature log and the medication carts for opened undated and/or expired multidose medications to assure 100 percent compliance for one week and then weekly for three months to assure all refridgerators are at optimal temperatures and all medication carts are free of undated/expired multidose medications. Results will be provided to the Director of Nursing (DON) who will review the findings and provide direction as appropriate. The Director of Nursing (DON) will report the findings in aggregate at the monthly QAPI meeting for further action as required. Facility Educator will be responsible for maintaining education for staff on temperature log / dating multidose medications and the Director of Nursing (DON) for the correction of deficiency The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 09/07/2023 to ensure the deficient Tag 0761 will not reoccur.	

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F 761	Continued From page 62	F 761		

she was unsure of the temperature range, but if the refrigerator was out of range, the nurse was expected to move the medications into a different refrigerator and notify maintenance. UM/LPN #2 further stated that medications should be kept at the correct temperature to ensure efficacy.

On 7/26/23 at 12:04 PM, the surveyor interviewed the Acting Director of Nursing (ADON) who stated that multi-dose medications should be labeled with the opened date on the actual device (pen/inhaler). The ADON further stated that insulin pens were good for 28 days after opening and inhalers were good for 14 to 21 days after opening depending on the specific inhaler. The ADON stated that all nurses on the medication carts were responsible for checking the medication cart for out-of-date medications because expired medications may not be as effective. The ADON then verified the insulin pen and inhaler should have been labeled with an opened date on the actual device in case the bag or box was misplaced, and that they should have been discarded when they were past their use-by date. When asked about the medication refrigerator temperatures, the ADON was unsure what the proper temperature range was, but stated that if the refrigerator was out of range, the nurse was expected to call maintenance to prevent the medications from losing their effectiveness.

A review of the manufacturer recommendations, provided by the facility, for insulin lispro pens, dated revised 4/2020, included...throw away the [insulin lispro] pen you are using after 28 days, even if it still has insulin left in it...

A review of the manufacturer recommendations,

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F 761	Continued From page 63 provided by the facility, for the Incruse Ellipta inhaler, dated revised 6/2019, included...discard Incruse Ellipta 6 weeks after opening the foil tray... A review of the facility provided "Insulin Pens) policy, dated 2/4/22, included...once opened, insulin pens may be stored in med carts and must be labeled with "Date Opened' and using manufacturer recommendation for number of days for room temp storage, "Discard Date"... A review of the facility provided "Inhalants and Nebulizer Medications" policy dated 10/2017, did not include a policy related to dating inhalers upon opening or when to discard inhalers. A review of the facility provided "Medication Storage" policy dated revised 3/2021, included...the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed... A review of the facility provided "Medication Refrigerator Temperatures Monitoring" dated reviewed 2/2023, included...any deviation from acceptable range (36-46 degrees F) will result in the medications being moved to another refrigerator and a work order sent to Maintenance Department for repair... NJAC: 8:39-27.1(a); 29.4(g)	F 761		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink	F 804		9/7/23

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F 804	Continued From page 64 Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Complaint NJ#: 164425 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to ensure safe and appetizing temperatures of food for 4 of 4 entree meals observed during 1 of 1 meal observations (breakfast). This deficient practice was evidenced by the following: On 7/21/23 at 10:35 AM, the surveyor conducted a Resident Council meeting which included nine residents (Resident #2, #21, #43, #47, #66, #100, #103, #104, and #564). All nine residents informed the surveyor during the meeting that all meals served at the facility were cold, and that the facility did not offer to warm up cold food. Resident #21 stated if you asked staff to warm up your food, staff gave you "an attitude." The residents stated that food will sit on the floor for at least ten minutes before staff will start to pass out meal trays. All nine resident confirmed the food tasted terrible and "they wouldn't even give to their dogs." On 7/25/23 at 7:11 AM, the surveyor informed the Food Service Director (FSD) they wanted to observe the breakfast meal for the day including food temperatures. The surveyor asked the FSD	F 804	Tag 0804 Element One Corrective Actions The facility immediately discarded Fat Free and Whole Milk and new milk at proper temperature for the residents was provided within the facility. The dietary staff were immediately counseled and re-educated about proper hot and cold food temperature. The facility administrator held an impromptu resident council to discuss utilizing more frequent test trays moving forward to assure proper food temperature. Element Two Identification of at Risk Residents All Residents that are at risk for receiving meals have the potential to be affected by this practice. Element Three Systemic Change The facility "Cold Food" policy was reviewed which addresses appropriate serving temperatures of 41 degree or below and witholding potentially hazardous foods to be served off tray line or dining room service. The facility "Food Temperature" policy was reviewed which addresses proper hot and cold food	

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F 804	Continued From page 65 to calibrate two digital thin probe thermometers in their presence; which the FSD completed using an ice bath, and the thermometers reached 32 degrees Fahrenheit (F). On 7/25/23 at 7:49 AM, the surveyor asked the FSD and the Registered Dietitian (RD) what the minimum temperature should be for hot food and what the maximum temperature should be for cold food. The RD stated hot food should be at 135 degrees Fahrenheit (F) or above, which the FSD agreed, and the FSD stated cold food should be 41 F or below. At this time, the surveyor observed the FSD using one of the thermometers calibrated to 32 F and took the following temperatures for the breakfast meal: Scrambled eggs 161 F Pureed eggs 166 F Pureed sausage 162 F Pureed bread 158 F Oatmeal 189 F Gravy 189 F Toast 123 F Ground sausage 154 F Chopped sausage 144 F Biscuits 174 F Pancakes (alternative regular meal) 197 F Fried eggs 137 F Cheese omelet 145 F Fat free milk 53 F; the Regional FSD put additional ice on top of the milk in the basin. Fat free lactose milk 54 F; the Regional FSD put additional ice on top of the milk in the basin. Yogurt 60 F; the Regional FSD put ice on top of the yogurts in the basin. On 7/25/23 at 8:02 AM, the surveyor observed the first plate of food Nelson-6 nursing unit be	F 804	temperatures and transporting food as quickly as possible to maintain temperatures for delivery. Dietary staff were re-educated regarding these policies. The dietary staff was educated on a new meal temperature log that was introduced to dietary in which food temperatures must be documented prior to leaving the kitchen and on the floor for every meal to assure proper temperatures throughout the facility. Element Four Quality Assurance The Dietary Director or Designee will conduct daily audits of the food temperature logs every morning and test trays for one meal per day too assure 100 percent compliance for one week and then weekly for three months to assure proper food temperatures. Results will be provided to the Licensed Nursing Home Administrator (LNHA) who will review the findings and provide direction as appropriate. The Licensed Nursing Home Administrator (LNHA) will report the findings in aggregate at the monthly QAPI meeting for further action as required. Facility Educator will be responsible for maintaining education for staff on proper food temperatures and the Licensed Nursing Home Administrator (LNHA) for the correction of deficiency The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 09/07/2023 to ensure the deficient Tag 0804 will not reoccur.	

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F 804	Continued From page 66	F 804		

plated. The surveyor observed the facility utilize a plate warmer, a device used to heat the plates prior to serving, and plastic insulated domes and bases.

On 7/25/23 at 8:19 AM, the Dietary Aide informed the surveyor that the first cart for Nelson-6 was completed and ready to leave the kitchen. At this time, the surveyor informed the FSD that they would like to the obtain a temperature on the floor of the first resident's trays that plated which included a regular meal, alternative regular meal, pureed meal, and chopped meal.

On 7/25/23 at 8:25 AM, the first meal cart arrived on Nelson-6 nursing unit.

On 7/25/23 at 8:29 AM, the first resident's meal tray was served and the FSD obtained the following meal temperatures from the test trays:

Regular meal texture:
Scrambled eggs 132 F
Biscuit 120 F
Oatmeal 140 F
Coffee 109 F
Fat free milk 63 F
Whole milk 61 F
Orange juice 35 F

Alternative meal texture:
Pancake 125 F

Pureed meal texture:
Pureed eggs 123 F
Pureed bread 124 F
Pureed sausage 124 F

Chopped meal texture:

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F 804	Continued From page 67 Chopped eggs 132 F Chopped biscuit 126 F At this time, the FSD confirmed all the food and beverages besides the orange juice and oatmeal were not at acceptable temperatures. The cold food was above 41 F, and the hot foods were below 135 F. On 7/25/23 at 8:40 AM, the surveyor accompanied by the FSD inspected the milk walk-in refrigerator and observed the ambient temperature was at 35 F. The FSD obtained a temperature of a fat free milk located inside the walk-in refrigerator and the temperature was 41 F. The surveyor asked the FSD if the residents had ever complained of cold food, and the FSD confirmed this past Resident Council meeting, residents complained of cold food. The FSD stated the facility offered residents a new plate of food versus reheating the food, and the facility used heated plates and insulated dome lids and bases to maintain temperature. On 7/25/23 at 11:45 AM, the surveyor asked Resident #564 and an Unsampled Resident how their breakfast was that morning, and both residents stated breakfast was "not good." Both residents stated they were served eggs for breakfast that were cold. On 7/25/23 at 9:32 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Acting Director of Nursing (ADON), Executive Director, Staff Educator, Regional Registered Nurse, and survey team acknowledged that the sampled test trays were not at acceptable temperatures. The LNHA stated hot food should be at 135 F or above, and cold food should be at	F 804		

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F 804	Continued From page 68 41 F or below. The LNHA stated that kitchen staff took the temperatures of each meal on the tray line in the kitchen, and test trays on the floor were not consistently being done. A review of the facility provided "Cold Foods Policy" dated revised 5/8/22, included...potentially hazardous foods must be held and served off tray line or dining room service at 41 degrees Fahrenheit or below... A review of the facility provided "Food Temperatures" policy dated revised 6/2022, included all hot food items must be cooked to the appropriate internal temperatures, held and served at a temperature of at least 135...all cold food items must be maintained and served at a temperature of 41 F or below; temperatures should be taken periodically to assure hot foods stay above 135 F and cold foods stay below 41 F during the portioning, transporting and delivery process until received by the individual recipient; foods should be transported as quickly as possible to maintain temperatures for delivery and service... NJAC 8:39-17.4(a)(2)	F 804		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14	F 809		9/7/23

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F 809	Continued From page 69 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to serve residents a nourishing snack when there was more than a fourteen-hour span of time between the dinner and breakfast mealtimes. This deficient practice was identified for 10 of 10 residents sampled for bedtime snacks (Resident #2, #21, #43, #45, #47, #66, #100, #103, #104, and #564), and was evidenced by the following: During initial tour of the facility on 7/18/23 at 11:58 AM, Resident #45 informed the surveyor that he/she felt there was a long-time span between dinner and breakfast meals. The resident continued that he/she should receive breakfast around 8:00 AM, but usually received breakfast around 8:30 AM or 9:00 AM. On 7/21/23 at 10:35 AM, the surveyor conducted a Resident Council meeting which included nine residents (Resident #2, #21, #43, #47, #66, #100, #103, #104, and #564). All nine residents informed the surveyor during the meeting that bedtime (HS) snacks were not offered every	F 809	Tag 0809 Element One Corrective Actions The dietary department immediately put together snack trays that were to be served between meals throught the day. The dietary staff were immediately counseled and re-educated regarding providing a nourishing snack to all resident when meal times eclipse 14 hours and offering snacks throughout the day between meals. Element Two Identification of at Risk Residents All Residents that are at risk for eclipsing 14 hours between meals and requesting snacks between meals have the potential to be affected by this practice. The Licensed Nursing Home Admministrator held an impromptu resident council to inform the residents that snacks are offered throughout the day between meals and they can request a standing order for a snack at their request. All residents with a diagnosis were given standing orders	

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F 809	Continued From page 70	F 809		

night; they were given "leftover sandwiches" or crackers that the kitchen had sometimes around 8:00 PM. All nine residents stated it would be nice if the facility automatically provided each resident with a HS snack because the meals were "terrible." The residents all confirmed dinner was served between 5:00 PM and 6:00 PM, and breakfast was served between 8:00 AM and 9:00 PM.

The surveyor reviewed the "Cart Delivery Log" provided by the facility upon entrance conference, which indicated the first dinner cart was served to Nelson-6 nursing unit at 5:00 PM, and the first breakfast cart was served to Nelson-6 nursing at 7:45 AM. This was a fourteen-hour and forty-five minutes time span between dinner and breakfast.

On 7/24/23 at 11:10 AM, the surveyor interviewed the Registered Dietitian (RD) who stated the facility did not have designated snack times throughout the day, including evenings. The RD stated the kitchen will send snacks to the nursing units at night, but not every resident was provided with a snack. When asked what a nourishing snack was, the RD responded snacks could be anything from cookies to graham crackers, juice, anything the resident wanted to eat, there was no definition of a nourishing snack or what would be considered a sufficient snack at night.

On 7/25/23 at 7:13 AM, the surveyor interviewed the Food Service Director (FSD) who stated that residents could request throughout the day sandwiches, graham crackers, cookies, and chips. The FSD stated at night, the kitchen brought to the nursing units sandwiches, ice cream, cookies, milk, and yogurt, that was kept in a refrigerator on the nursing unit. The FSD stated

for a snack and all other residents were interview to see if they would as well like a standing order. Residents satisfied with new protocol discussed.

Element Three Systemic Change
The facility "ADL Care; Dining - Snack" policy was reviewed which addresses providing snacks three times daily between meals based on their individual needs or request that will be delivered to the nursing units labeled with the resident's name. The facility "ADL Care; Dining - Snack" policy was also updated to reflect providing all residents with a nourshing snack if the time span between dinner and breakfast exceeds more then fourteen hours. Nursing and Dietary staff were re-educated regarding the policy. Nursing and Dietary staff were re-educated about providing labeled snacks based up the needs or request of the resident and to also encourage the other residents to particpate in the snack trays that are provided to each healthcare unit between meals throughout the day.

Element Four Quality Assurance
The Food Service Director will conduct daily rounds and audit labeled and provided snacks for one week and then weekly for three months to assure residents are receiving their snacks. The Registered Dietician will condcut daily audit on the timeframe between lunch and Dinner for one week and then weekly for three months to assure residents are not eclisping a fourteen hour window without a nourshing snack. The Night Nursing

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F 809	Continued From page 71 snacks were available upon request only, residents were not automatically served a snack. The FSD confirmed the first dinner cart was served at 5:00 PM, and the first breakfast cart was served at 7:45/7:50 AM. On 7/25/23 at 10:09 AM, the surveyor interviewed the Certified Nursing Aide (CNA) who stated she worked on all three nursing shifts; day, evening, and night. The CNA stated that residents' snacks for the evening were provided as their dessert on their dinner meal tray, and the aide documented in the "CNA Task" section of the electronic medical record how much dessert the resident ate. The CNA stated the time indicated on the "CNA Task" was not necessarily the time the resident ate the snack; it was time the CNA completed their documentation which could be at the end of their shift. The CNA stated that after dinner, the kitchen brought to the floor additional food of sandwiches, juice, yogurt, cookies, and chips that were placed in the refrigerators on the nursing units if a resident requested a snack. The CNA stated usually during the night shift (11:00 PM to 7:00 AM) some residents requested food to snack on. The CNA confirmed there were no HS snacks provided to each resident, snacks were only provided upon request. On 7/25/23 at 10:17 AM, the surveyor interviewed the Acting Director of Nursing (ADON) who stated in the nursing unit pantries, the kitchen stored juice, soda, crackers, and cookies that residents could ask for. The ADON stated at nighttime, she thought there were labeled snacks for resident who were diabetic, and any resident who wanted a snack at night could request one. The ADON stated an HS snack was considered at hour of sleep and not the dessert on the dinner meal tray.	F 809	supervisor will conduct nightly rounds to ensure snacks are being provided for one week and then weekly for three months to assure residents are receiving their snacks. Results will be provided to the Licensed Nursing Home Administrator (LNHA) who will review the findings and provide direction as appropriate. The Licensed Nursing Home Administrator (LNHA) will report the findings in aggregate at the monthly QAPI meeting for further action as required. Facility Educator will be responsible for maintaining education for staff on snacks and the Licensed Nursing Home Administrator (LNHA) for the correction of deficiency The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 09/07/2023 to ensure the deficient Tag 0809 will not reoccur.	

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F 809	Continued From page 72	F 809		

The ADON stated she did not think everyone received a HS snack, but she would follow-up. At this time, the surveyor requested a copy of the "CNA Task" for HS snacks for the past thirty days for the nine residents from the Resident Council meeting plus Resident #45.

On 7/25/23 at 12:40 PM, the surveyor reviewed the HS Snack Task reports from the past thirty days for the ten requested residents. The reports indicated that none of the residents consistently received a HS snack. The reports also indicated that staff were documenting at times HS snacks were consumed in the 4:00 PM, 5:00 PM, and 6:00 PM hours.

On 7/27/23 at 9:32 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the ADON, Executive Director, Regional Registered Nurse, Staff Educator, and survey team acknowledged all residents were not being served a HS snack, that staff were provided to residents at night upon request only. At this time, the ADON stated and the LNHA confirmed, that a nourishing snack was considered food that contained protein such as a sandwich, yogurt, fruit, nuts, and not just a cookie or a bag of chips.

A review of the facility provided "ADL Care; Dining - Snacks" policy dated reviewed 2/2023, included the Food Service will provide between meal snacks for prescribed patients/residents three times daily based on their individual nutritional needs; snacks will be delivered to the nursing units labeled with resident's name. In addition, the unit will be stocked with bulk food items for residents as needed... The policy did not include all residents will receive a nourishing HS snack if the time span between dinner and breakfast meal

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F 809	Continued From page 73 was greater than fourteen hours. NJAC 8:39-17.2 (f)(1)(i-ii)	F 809		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly 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 facility documents, it was determined that the facility failed to a.) maintain multi-use food-contact surfaces in a manner to prevent bacterial growth; b.) store potentially hazardous foods to prevent food-borne illness; c.) cool potentially hazardous foods in a manner to prevent food-borne illness; d.) maintain kitchen equipment in a sanitary manner; and e.) maintain cold food items to prevent food-borne illness. This deficient practice was evidenced by the	F 812	Tag 0656 Element One Corrective Actions #1 All items in the walk-in refrigerator was immediately discarded. All ice accumulation on the condenser unit was removed so it would not interfere with the refridgerator reaching the proper temperature. The dietary staff were immediately counseled and re-educated about proper refrigerator temperatures	9/7/23

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F 812	Continued From page 74 following: 1. On 7/18/23 at 11:03 AM, the surveyor toured the kitchen with the Food Service Director (FSD) and observed along the tour, the meat walk-in refrigerator's door was left ajar. The surveyor and FSD proceeded into the walk-in refrigerator and observed the ambient temperature to be 55 degrees Fahrenheit (F). The FSD stated refrigerators should be maintained at 41 F or below, and cold food should be held at 41 F or below. At this time, the FSD calibrated two thin probed digital thermometers in an ice bath to 32 F. The surveyor requested and observed the FSD obtain food temperatures from the following items: Hot dogs 50 F; the FSD stated the kitchen staff just returned the hot dogs to the walk-in refrigerator after preparing for lunch, and the surveyor observed hot dogs on the tray line. Bowl of marinated chicken breasts 55 F. The chicken was dated 7/18/23, and the FSD stated Cook #1 just prepared the chicken breasts at 10:30 AM. Whole eggs 48 F Baked potatoes 57; dated prepared 7/17/23. Sliced cooked peppers and onions 48 F; dated prepared 7/17/23. Pureed rice 49 F; dated prepared 7/17/23. A review of the "Cadbury Refrigerator/Freezer Temperature Log" for July 2023, indicated that the meat walk-in refrigerator was observed at 38 F that morning. A further review of the log indicated all the temperatures were within normal range for the month.	F 812	and ice accumulation to prevent bacterial growth. #2 The facility immediately discarded the chicken soup from the walk-in refrigerator. The dietary staff were immediately counseled and re-educated about storing potentially hazardous food. #3 The facility immediately discarded and replace all pitted and discolored cutting boards within the kitchen. The facility immediately defrosted and cleaned the ice cream reach-in freezer to assure no frost buildup. The dietary staff were immediately counseled and re-educated regarding possible cross-contamination and or bacterial growth due to the condition of the cutting boards and the ice build-up in the ice cream reach-in freezer. #4 The facility immediately discarded the sliced apples. The dietary staff were immediately counseled and re-educated regarding proper storage of opened canned food. #5 The facility immediatley discarded all meal trays exhibiting any cracks or chips. The dietary staff were immediately conuseled and re-educated regarding damaged meal trays. Element Two Identification of at Risk	

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F 812	Continued From page 75 On 7/18/23 at 11:30 AM, the surveyor interviewed Cook #1 who stated he marinated the chicken at 9:00 AM that morning. On 7/18/23 at 1:38 PM, the surveyor with the FSD conducted a follow-up inspection of the meat walk-in refrigerator and observed the ambient temperature of the walk-in refrigerator was 50 F. At this time, the FSD calibrated two thin probed digital thermometers in an ice bath to 32 F, and the surveyor observed the FSD obtain the following temperatures: Hot dogs 50 F Chopped chicken 42 F Whole eggs 49 F The FSD stated she had placed the marinated chicken in the walk-in freezer to cool down. On 7/19/23 at 10:03 AM, the surveyor interviewed the Regional FSD who stated Maintenance was in the kitchen yesterday repairing the meat walk-in refrigerator, and discovered an ice accumulation on the condenser unit that was at least an inch thick. The Regional FSD stated there should be no ice accumulation on the condenser because it could interfere with the refrigerator becoming the appropriate temperature of 41 F. The Regional FSD stated the facility removed all food from the walk-in refrigerator yesterday. The surveyor observed the walk-in refrigerator was emptied, and the ambient temperature was 38 F. 2. During initial kitchen tour on 7/18/23 at 11:03 AM, the surveyor in the presence of the FSD observed the meat walk-in refrigerator's door was	F 812	Residents #1 All Residents that are at risk for receiving items from the walk-in refrigerator have the potential to be affected by this practice. No residents were effected as items were discarded. #2 All Residents that are at risk for receiving improperly cooled down food items have the potential to be affected by this practice. No residents were effected as item were discarded. #3 All Residents that are at risk for receiving food items that were cut on a pitted or grooved cutting board have the potential to be affected by this practice. All Residents that are at risk fro receiving ice cream items from the reach-in freezer have the potential to be affected by this practice. No residents were effected as item were discarded. #4 All Residents that are at risk for receiving the apple cobbler have the potential to be affected by this practice. No residents were effected as item were discarded. #5 All Residents that are at risk for receiving cracked or damanged meal trays have the potential to be affected by this practice. No residents were effected as item were discarded.	

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	315183	A. BUILDING _____ B. WING _____	C 07/28/2023

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F 812	Continued From page 76 open, and the ambient temperature was 55 F. At this time, the surveyor observed a full deep hotel pan filled to just below the rim of chicken soup labeled as prepared 7/18/23. On 7/18/23 at 1:38 PM, the surveyor with the FSD conducted a follow-up kitchen inspection of the meat walk-in refrigerator. The surveyor observed the ambient temperature at 50 F. At this time, the FSD calibrated two thin probed digital thermometers to 32 F in an ice bath. The surveyor observed the same full hotel pain of chicken soup labeled prepared 7/18/23, on a shelf that was observed earlier that morning at 11:03 AM. The surveyor requested the FSD obtain a temperature of the chicken soup which was 99 F. On 7/18/23 at 1:45 PM, the surveyor interviewed the Lead Cook in the presence of the FSD who stated she made the chicken soup that morning at 7:30 AM, and it was done cooking at 9:00 AM. The Lead Cook stated she transferred the chicken soup into a full deep hotel pan at 9:15 AM, covered and labeled it, and placed it in the meat walk-in refrigerator by 9:30 AM. The Lead Cook stated the soup was at 190 F when cooked, but she did not monitor the temperature when she placed the soup in the walk-in refrigerator or during the cooling process. The Lead Cook stated the facility did not take temperatures or document the temperatures during the cooling process. The FSD confirmed this, that the only temperature logs the kitchen maintained was for food on the tray line. On 7/18/23 at 1:50 PM, the surveyor asked the FSD and the Regional FSD if the kitchen had a	F 812	Element Three Systemic Change #1 The facility "Cold Food" policy was reviewed which addresses appropriate temperature for serving or storing cold food 41 degrees or below. The facility "Reporting Equipment/Maintenance Needs" policy was reviewed which addresses identifying equipment or maintenance needs daily or as needed within the kitchen. Dietary staff were re-educated regarding these policies. Dietary staff were re-educated about the proper temperature for food storage to assure no bacterial growth and addressing maintenance needs immediately upon discovery. #2 The facility created a "HACCP" policy which addresses the appropriate way to cool down food items which include utilizing a ice bath to bring down the food temperature over two hours to 70 degrees F and then an additional four hours to bring the temperature down from 70 degrees to 41 degrees F. The policy also addresses food safety plan to help identify potential hazards in the food preparation process through monitoring and controlling each step to prevent "critical control points" (CCP). Dietary staff were educated regarding the policy. Dietary staff were re-educated on the process and safety of cooling down food items to prevent bacterial growth. #3 The facility "Cutting Board Safety and	

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F 812	Continued From page 77 hazard analysis and critical control points (HACCP) plan (management system in which food is safely addressed through the analysis and control of biological, chemical, and physical hazards from raw material production, procurement and handling, to manufacturing, distribution and consumption of the final product). The FSD was unaware of a HACCP plan the Regional FSD also stated he was unsure if the facility used a HACCP plan; that the facility did not record time and temperatures of cooked foods, that the chicken soup should never have been saved. The Regional FSD stated the facility had two hours to bring the temperature of the food down to 70 F and an additional four hours to bring the temperature down from 70 F to 41 F. The Regional FSD stated this could be accomplished with the use of ice baths. The FSD and Regional FSD acknowledged that from the Lead Cook's interview that the soup was in the meat walk-in refrigerator for about four and a half hours, was observed in the walk-in refrigerator at 11:03 AM, and the temperature did not reach 70 F which according to the Regional FSD should occur in two hours. On 7/19/23 at 10:03 AM, the Regional FSD informed the surveyor that the facility was now utilizing a HACCP plan, which they were not prior to surveyor inquiry. The Regional FSD provided the surveyor with a "HACCP Food Chill Time and Temperature Log" which indicated to place all food in a shallow three (3) inch or less depth pan and label with the expiration date of three days from production. Food may be uncovered during the cooling process however once temperature is reached must be covered. Ice paddles should be used to cool liquids. Chill food from 140 F to 70 F within two hours or less and chill food from 70 F	F 812	Usage" policy was reviewed which addresses any cutting boards that display deep grooves, cracks, sevre discoloring or fading must be discarded immediately and not used. The facility "Reporting Equipment/Maintenance Needs" policy was reviewed which addresses the Food Service Director or Designee will identify equipment or maintenance needs daily. Dietary staff were re-educated regarding these policies. Dietary staff were re-educated that while we dispose of cutting boards every three months however if one displays deep grooves, cracks, sevre discoloring or fading it is to be discarded immediately. Dietary staff were re-educated that while we have the ice cream reach-in freezer defrosted and cleaned weekly if it displays signs of ice build up it is to be cleaned and defrosted immediatley. #4 The facility created a "Food Preparation" policy that addresses proper storage of opened canned foods. The dietary staff were educated that anytime a canned food itme is opened it must be refrigerated for storage. #5 The facility "Reporting Equipment/Maintenance Needs" policy was reviewed which addresses notifying maintenance for any and all equipment that is exhibiting signs of wear. The dietary staff were educated that anytime they see a meal tray that is showing signs of wear to discard the item and make	

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F 812	Continued From page 78 to 41 F in an additional four hours or less. If food is not chilled within limits rapidly reheat to 165 F and begin chill process again; if second attempt fails discard food and document. 3. On 7/19/23 at 10:10 AM, the surveyor in the presence of the FSD conducted a follow-up kitchen tour and observed the following: On a storage rack eight large yellow, five large white, ten large blue, six large red, six large brown, and five large green cutting boards all deeply pitted and discolored black and brown. The FSD stated cutting boards were changed every three months or sooner if needed because food could become stuck in the pits and grooves and cross-contamination and bacterial growth could occur. The FSD confirmed these cutting boards should not be in use. The ice cream reach-in freezer contained an accumulation of ice build-up and discoloration. The FSD and Regional FSD confirmed there should be no accumulation of ice. The FSD stated that the ice cream reach-in freezer was cleaned weekly, but was unable to provide any documentation to verify. 4. On 7/19/23 at 10:35 AM, the surveyor in the presence of the FSD observed on a cooling rack three deep full hotel pans covered in foil labeled 7/18/23 and use by 7/21/23. The FSD stated they were sliced apple that were from a can that Cook #1 used to prepare apple cobbler. At this time, the surveyor in the presence of the FSD interviewed Cook #1 who stated he opened the cans of sliced apples yesterday, poured the apples into the pans, added sugar and cinnamon	F 812	maintenance aware. Element Four Quality Assurance #1 The Dietary Director will conduct daily rounds and audit the temperatures for all refridgerators and freezers within the kitchen along with any possible ice build up for one week and then weekly for three months to assure 100 percent compliance. Results will be provided to the Licensed Nursing Home Administrator (LNHA) who will review the findings and provide direction as appropriate. The Licensed Nursing Home Administrator (LNHA) will report the findings in aggregate at the monthly QAPI meeting for further action as required. Facility Educator will be responsible for maintaining education for staff on proper food storage and the Licensed Nursing Home Administrator (LNHA) for the correction of deficiency #2 The Dietary Director will conduct daily rounds and audit all HACCP food items within the kitchen for one week and then weekly for three months to assure to assure 100 percent compliance of proper cool down timeframes and measures are being met. Results will be provided to the Licensed Nursing Home Administrator (LNHA) who will review the findings and provide direction as appropriate. The Licensed Nursing Home Administrator (LNHA) will report the findings in aggregate at the monthly QAPI meeting	

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F 812	Continued From page 79 to them, covered the pans and dated, and left on the cooling racks to make today. Cook #1 stated he did not refrigerate the canned apples after opening; he was unaware that the canned apples needed to be refrigerated after opening. The FSD at this time stated she was unsure if the canned apples needed to be refrigerated after opening. On 7/19/23 at 10:40 AM, the surveyor in the presence of the FSD interviewed the Regional FSD who stated canned food needed to be refrigerated after being opened. The FSD stated the apples were supposed to be for apple cobbler today, and she could not speak to why they were not refrigerated. At this time, the FSD used a digital thin probed thermometer calibrated to 32 F in an ice bath to obtain a temperature of the sliced apples, which was 81 F. On 7/19/23 at 10:51 AM, the surveyor re-interviewed the Regional FSD who stated he was usually in the facility once a week to offer support to the FSD. The Regional FSD stated once canned food items were opened, they needed to be refrigerated for food safety because of bacterial growth in the temperature danger zone. The Regional FSD stated he noticed the apple on the cooling rack this morning and informed Cook #1 to discard, but the cook did not. On 7/19/23 at 10:56 AM, the surveyor interviewed Cook #1 who stated yesterday afternoon at some time, opened the canned apples to prepare apple cobbler for Friday's dessert that he was planning on finishing preparing today (Wednesday). Cook	F 812	for further action as required. Facility Educator will be responsible for maintaining education for staff on proper cooling methods and the Licensed Nursing Home Administrator (LNHA) for the correction of deficiency #3 The Dietary Director will conduct daily rounds and audit all cutting boards and ice cream reach-in freezer for one week and then weekly for three months to assure all cutting boards display no signs of deep pitting, cracks, sevre discoloring or fading and the ice cream reach-in freezer has no ice build up. Results will be provided to the Licensed Nursing Home Administrator (LNHA) who will review the findings and provide direction as appropriate. The Licensed Nursing Home Administrator (LNHA) will report the findings in aggregate at the monthly QAPI meeting for further action as required. Facility Educator will be responsible for maintaining education for staff on proper cooling methods and the Licensed Nursing Home Administrator (LNHA) for the correction of deficiency #4 The Dietary Director will conduct daily rounds and audit all opened canned food items that are storage wihtin the kitchen for one week and then weekly for three months to assure all items are properly storaged and refrigerated. Results will be provided to the Licensed Nursing Home	

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F 812	Continued From page 80 #1 stated he makes a cake that goes on top of the apples that he bakes, and these apples were never baked yesterday; just removed from the cans and cinnamon and sugar was added. Cook #1 stated no one told him to start preparing the apple cobbler yesterday, that he was getting some of the baking done yesterday for the menu. A review of this week's menu reflected that apple cobbler was the dessert for Friday's dinner. On 7/20/23 at 9:24 AM, the surveyor interviewed the Vice President of Dining Corporation who stated the facility did not have a preparation policy or procedure, that the facility used the meal tracker production sheets that indicated what was needed for each meal, but there was no policy or procedure for when to start preparing a menu item. 5. On 7/25/23 at 7:44 AM, the surveyor observed the breakfast meal tray line. The surveyor observed the residents' meal trays stacked on the tray line, and observed thirty-two meal trays with the plastic finish chipped off exposing metal and other tray fibers. At this time, the FSD had the Dietary Aide remove the chipped resident meal trays and discarded all thirty-two trays. The FSD acknowledged that the trays were not safe to use because the chipped plastic could get in a resident's meal and bacterial growth. On 7/25/23 at 7:49 AM, the surveyor observed the FSD using a digital thin probed thermometer calibrated to 32 F in an ice bath obtained the following temperatures of cold food items on the tray line:	F 812	Administrator (LNHA) who will review the findings and provide direction as appropriate. The Licensed Nursing Home Administrator (LNHA) will report the findings in aggregate at the monthly QAPI meeting for further action as required. Facility Educator will be responsible for maintaining education for staff on proper open can storage and the Licensed Nursing Home Administrator (LNHA) for the correction of deficiency #5 The Dietary Director will conduct daily rounds and audit the condition of the meal trays for one week and then weekly for three months to assure all meal trays show no signs of cracking or wear. Results will be provided to the Licensed Nursing Home Administrator (LNHA) who will review the findings and provide direction as appropriate. The Licensed Nursing Home Administrator (LNHA) will report the findings in aggregate at the monthly QAPI meeting for further action as required. Facility Educator will be responsible for maintaining education for staff on proper cooling methods and the Licensed Nursing Home Administrator (LNHA) for the correction of deficiency The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 09/07/2023 to ensure the deficient Tag 0812 will not reoccur.	

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F 812	Continued From page 81 Fat free milk 53 F Fat free lactose milk 54 F Yogurt 60 F The FSD acknowledged that cold food should be at 41 F or below. On 7/25/23 at 8:40 AM, the surveyor and the FSD conducted an inspection of the milk walk-in refrigerator and observed the ambient temperature was 35 F. At this time, the FSD used a calibrated digital thin probed thermometer and obtained the temperature of a fat free milk which was 41 F. On 7/27/23 at 9:32 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Acting Director or Nursing (ADON), Executive Director, Staff Educator, and Regional Registered Nurse acknowledged that cold food should be stored and maintained at temperatures 41 F or below, refrigerators should be maintained at 41 F or below, the facility should be cooling foods according to the HACCP plan that was not in place prior to surveyor inquiry, kitchen refrigeration and freezer equipment should be maintained without ice accumulation, discolored and pitted cutting boards should not be used as well as chipped resident meal trays, and canned food needed to refrigerated after opening. A review of the facility provided "Cold Foods Policy" dated revised 5/8/22, included..potentially hazardous foods must be held and served off tray line or dining room service at 41 degrees Fahrenheit or below...food that is cooked then chilled to 41 degrees Fahrenheit must be tracked through our Corporate HACCP Logging	F 812		

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F 812	Continued From page 82 Tool...HACCP Memo hot foods must be cooled down within two hours to 70 degrees Fahrenheit and the cooled to 41 degrees Fahrenheit within the next four hours for a total of six-hour process. A review of the facility provided "Food Temperatures" policy dated revised 6/2022, included all hot food items must be cooked to the appropriate internal temperatures, held and served at a temperature of at least 135..all cold food items must be maintained and served at a temperature of 41 F or below... A review of the facility provided "Reporting Equipment/Maintenance Needs Policy" dated 3/2020, included FSD or Designee will identify equipment or maintenance needs daily or as needed... A review of the facility provided "Cutting Board Safety and Usage Policy" dated revised 3/2022, included...if any deep grooves, cracks, severe discoloring, or fading occurs, they must be discarded and not used. NJAC 8:39-17.2(g)	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		9/7/23

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F 880	Continued From page 83	F 880		

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 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

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F 880	Continued From page 84 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, interviews, and review of pertinent facility documents, it was determined that the facility failed to a.) follow appropriate infection control practices and perform hand hygiene as indicated during dining observation, b.) ensure Ex.Order 26.4(b)(1) kept in a clean and sanitary condition and stored properly to reduce the risk of infection, and c.) follow appropriate infection control practices and perform hand hygiene as indicated during a medication pass. This deficient practice was identified on 1 of 2 nursing units (Nelson-6) for 1 of 3 residents reviewed for Ex.Order 26.4(b)(1) (Resident #62) and for 2 of 4 residents reviewed for medication pass (Residents #13 and #78.) This deficient practice was evidenced by the following: 1. On 7/19/23 at 12:06 PM, the surveyor observed Certified Nursing Aide (CNA #1) who	F 880	Tag 0880 Element One Corrective Actions #1 Resident #62 The Certified Nurse Aide (CNA) that did not properly exhibit proper infection control were immediately counseled and re-educated about properly performing hand hygiene before and after contact with each resident. #2 Resident #13 The Ex.Order 26.4(b)(1) were immediately discarded. The Registered Nurse (RN) that did not properly exhibit proper infections control were immediatley counseled and re-educated about proper cleaning and storage of a Ex.Order 26.4(b)(1) #3 Resident #78	

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F 880	Continued From page 85 approached the covered food cart, removed a tray and entered Resident Room [redacted]. CNA #1 placed the food tray on the bed side table (BST) of the resident in bed A; removed the plate cover and placed it on the bed; removed the lid from the coffee cup; unwrapped a straw and placed it into the foil cover of the apple juice; and moved the BST closer to the resident. CNA #1 then went directly with no observed hand hygiene to the resident in bed B bed, and assisted the resident with position in bed by using the bed remote to elevate the head of the bed, and moved the BST in front of the resident. CNA #1 then performed hand hygiene using alcohol based hand rub (ABHR) when she exited the room. CNA #1 returned to the food cart, and removed a tray and entered Resident Room [redacted] CNA #1 placed the food tray on the BST of the resident in bed B; removed the plate cover and placed it on the bed; removed the lid from the coffee cup; opened the napkin and tucked it into the resident's neckline; and moved the BST closer to the resident. CNA #1 then went directly with no observed hand hygiene to the resident in bed A, and grasped the white foam cup and the clear plastic cup on the BST and moved them closer to the resident; then moved the BST closer to the resident. The resident then picked up his/her white foam cup. CNA #1 then performed hand hygiene using ABHR when she exited the room. CNA #1 returned to the food cart, removed a tray and entered Resident Room [redacted]; and placed the tray on the BST of the resident in bed A. No hand hygiene was observed after serving the resident their tray. CNA #1 again returned to the food cart, removed a tray and placed it on the BST of the resident in room [redacted] bed A. CNA #1 then moved the BST closer to the resident; removed the food cover and placed it on the bed; reached down to	F 880	The Agency Licensed Practical Nurse (LPN) that did not exhibit proper infection control between residents was immediatley removed from her assignment and sent home. This nurse no longer works at the facility. Element Two Identification of at Risk Residents #1 Resident #62 All Residents that are on this Certified Nurse Aide (CNA) assignment have the potential to be affected by this practice. The Certified Nurse Aide was re-educated and then observed completing passing out the meal trays and no improper infection control practices were noted. #2 Resident #13 All Residents that receive [redacted] have the potential to be affected by this practice. All [redacted] was spot check throughout the facility to ensure proper storage and infection contorl. No improper storage were noted. #3 Resident #78 All Residents that are on this Agency Licensed Practical Nurse (LPN) assignment have the potential to be affected by this practice. All staff were re-educated regarding washing hands between caring for each resident to prevent infection. Element Three Systemic Change #1 Resident #62 The facility "Food and Nutritional	

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	315183	A. BUILDING _____ B. WING _____	C 07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 CHERRY HILL, NJ 08002

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F 880	Continued From page 86 the floor to pick up a black folded item and placed it on the bed; moved the resident's shoes away from the resident's feet; and moved the BST closer to the resident. CNA #1 then went directly with no observed hand hygiene to the resident in room Ex.Order 7 bed B, and moved the BST closer to the resident. CNA #1 then performed hand hygiene using ABHR when she exited the room. When CNA #1 entered the hallway, she retrieved a yellow wet floor sign and placed it over a spill in the hallway. CNA #1 then went directly with no observed hand hygiene to the food cart; removed a tray and placed it on the BST of the resident in room Ex.Order 7 bed B. On 7/19/23 at 12:32 PM, the surveyor interviewed CNA #1 who stated that when the food cart arrived on the unit, that the staff checked the meal ticket to ensure the tray was correct; they poured coffee if requested; they delivered the tray to each resident; cleaned the resident's hands; and then returned to the cart to retrieve the next tray. CNA #1 acknowledged that she did not perform hand hygiene correctly and stated, "I was moving fast." CNA #1 acknowledged that she should have performed hand hygiene between each resident; when she touched the items on the floor; and when she touched the wet floor sign. CNA #1 stated that it was important to perform hand hygiene correctly to prevent cross contamination. On 7/19/23 at 12:42 PM, the surveyor interviewed Licensed Practical Nurse (LPN #1) who stated that before the trays were served, that the resident's hands were sanitized with wipes and that when the food cart arrived on the unit, the staff ensured that the food matched the ticket; staff served coffee or tea; and they set up or fed	F 880	Services" policy was reviewed which addresses appropriate measures of hand hygiene for infection control. Certified Nurse Adie staff were re-educated regarding the policy. Certified Nurse Aide (CNA) staff were re-educated about the proper washing their hands before and after contact with each resident, even if gloves are worn before eating, drinking and or handling food. #2 Resident #13 The facility "Hand Held Ex.Order 26.4(b)(1) r" policy was reviewed which addresses proper storage of Ex.Order 26.4(b)(1). The nursing staff were re-educated on this policy regarding storing Ex.Order 26.4(b)(1) in a storage bag after proper cleaning. #3 Resident #78 The facility "Hand Hygiene" policy was reviwed which addresses proper infection control between caring for residents. The staff were re-educated regarding this policy on utilizing hand hygiene before and after direct contact with residents, before preparing and or handling medications, immediatley after glove removal, after contact with a resident's intact skin and finally after contact with objects in the immediate vicinity of the resident. Element Four Quality Assurance #1 Resident #62 The Infection Preventionist (IP) or Designee will conduct daily rounds per shift and audit Certified Nurse Aide	

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F 880	Continued From page 87 the resident their meal if needed. LPN #1 stated that during meal pass, hand hygiene was performed before the trays were passed out, and ABHR was used before leaving the resident's room. The surveyor informed LPN #1 of CNA #1's tray pass observation, and LPN #1 acknowledged that CNA #1 did not perform hand hygiene correctly; that she should have used ABHR before caring for each resident and after she touched anything on the floor. LPN #1 stated it was important to perform hand hygiene correctly to prevent cross contamination of germs, fluids, or dirt. On 7/19/23 at 1:02 PM, the surveyor interviewed Unit Manager/LPN (UM/LPN) who stated that during meal time, staff used hand wipes on the residents and then washed their own hands prior to serving the food trays. She then stated that ABHR should have been used with each tray that was touched, between each resident, and when staff exited the resident's room. The surveyor informed the UM/LPN of CNA #1's tray pass observation, and the UM/LPN acknowledged that CNA #1 did not perform hand hygiene correctly, and stated that it was important for infection control that she used hand sanitizer between each resident and after touching the wet floor sign. On 7/20/23 at 11:10 AM, the surveyor interviewed the Acting Director of Nursing (ADON) who stated that when the food cart was delivered to the unit, the CNA removed a tray; reviewed the meal ticket and delivered the tray; helped the resident with set up if needed; then sanitized their hands when they exited the room. The ADON stated during meal pass, hand hygiene should have been done before a tray was removed from the cart and	F 880	passing meal trays for one week and then weekly for three months to assure proper infection control. Results will be provided to the Director of Nursing (DON) who will review the findings and provide direction as appropriate. The Director of Nursing (DON) will report the findings in aggregate at the monthly QAPI meeting for further action as required. Infection Preventionist (IP) will be responsible for maintaining education for staff on infection control and the Director of Nursing (DON) for the correction of deficiency #2 Resident #13 The Infection Preventionist (IP) or Designee will conduct daily rounds per shift and audit all Ex.Order 26.4(b)(1) for one week and then weekly for three months to assure proper storage. Results will be provided to the Director of Nursing (DON) who will review the findings and provide direction as appropriate. The Director of Nursing (DON) will report the findings in aggregate at the monthly QAPI meeting for further action as required. Infection Preventionist (IP) will be responsible for maintaining education for staff on infection control and the Director of Nursing (DON) for the correction of deficiency #3 Resident #78 The Infection Preventionist (IP) or Designee will conduct daily rounds per shift and spot check resident care for one	

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F 880	Continued From page 88 before exiting the resident's room. The surveyor informed the ADON of CNA #1's tray pass observation, and the ADON acknowledged that CNA #1 did not perform hand hygiene correctly, and stated that she should have performed hand hygiene prior to touching the resident's tray, in between residents, when retrieving items from the floor, and after touching the wet floor sign. The ADON stated that it was important to perform hand hygiene correctly to prevent passing germs and for infection control. On 7/25/23 at 1:45 PM, the Licensed Nursing Home Administrator (LNHA) met with the survey team, and was made aware of the tray pass observation on the Nelson-6 nursing unit on 7/19/23. On 7/26/23 at 1:29 PM, the Regional Registered Nurse (RRN) met with the surveyors, and was made aware of the tray pass observation on Nelson-6 nursing unit on 7/19/23. RRN confirmed that hand hygiene should have been performed between caring for each resident in the room, when touching inanimate objects, and prior to passing the food trays. A review of the facility document "Summary Report of Meeting/In-Service" dated 7/10/23, 7/11/23, 7/12/23, 7/13/23, and 7/18/23, included Subjects covered: Employees must wash their hands: before and after contact with each resident, even if gloves are worn. Before eating, drinking, or handling food...CNA #1 signed and dated the in-service on 7/11/23. 2. On 7/20/23 at 10:08 AM, the surveyor observed Resident #62 in bed with covers over	F 880	week and then weekly for three months to assure proper storage. Results will be provided to the Director of Nursing (DON) who will review the findings and provide direction as appropriate. The Director of Nursing (DON) will report the findings in aggregate at the monthly QAPI meeting for further action as required. Infection Preventionist (IP) will be responsible for maintaining education for staff on infection control and the Director of Nursing (DON) for the correction of deficiency The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 09/07/2023 to ensure the deficient Tag 0880 will not reoccur.	

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F 880	Continued From page 89 his/her head. There was a Ex.Order 26.4(b)(1) (a Ex.Order 26.4(b)(1) the side table with Ex.Order 26.4(b)(1) that was dated 7/18/23. The t Ex.Order 26.4 was connected to Ex.Order 26 cup that was resting on the side table. There was a cell phone resting next to the Ex.Order 26.4(b)(1) sitting near the Ex.Order 26.4(b)(1), a cup of applesauce resting near Ex.Order 26.4(b)(1) cup, and a brown paper bag resting near the Ex.Order 26.4(b)(1) cup. On 7/20/23 at 10:42 AM, the surveyor heard humming sounds from the resident's room. Upon entering, the surveyor observed the Ex.Order 26.4(b)(1) running with the connected Ex.Order 26.4(b) under the sheet that was covering the resident's head. On 7/20/23 at 11:27 AM, the surveyor observed the Ex.Order 26.4(b)(1) on the resident's side table. The Ex.Order 26.4(b) was connected to Ex.Order 26.4 cup that was resting on the table and touching the wall. The surveyor reviewed the medical record for Resident #62. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility in Ex.Order 26.4(b)(1) with diagnoses which included Ex.Order 26.4(b)(1)	F 880		

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F 880	Continued From page 90 A review of the July 2023 Order Summary Report revealed a physician's order dated 6/23/2023, for Ex.Order 26.4(b)(1) [redacted] times a day for shortness of breath (SOB). A review of the corresponding July 2023 Medication Administration Record (MAR) reflected the above physician's order and was documented as administered. On 7/21/23 at 09:19 AM, the resident was observed lying in bed, alert, watching television. The surveyor interviewed the resident who acknowledged that the Ex.Order 26.4(b)(1) was theirs, and that it was used each day. The resident stated, "The nurse sets it up, she puts the stuff in it, and she Ex.Order 26.4(b)(1) The resident stated that when the medication was finished, that the nurse Ex.Order 26.4(b)(1) and that sometimes he/she would have turned the Ex.Order 26.4(b)(1) The surveyor inquired as to who put the Ex.Order 26.4 on the table, and the resident stated, "I guess she does. I don't, she does all that." The surveyor inquired as to who Ex.Order 26.4(b)(1), and the resident stated, "They don't clean it. It don't really need to be cleaned, Ex.Order 26.4(b)(1) [redacted]." On 7/21/23 at 9:50 AM, the surveyor interviewed the Registered Nurse (RN) that was caring for Resident #62, who stated that the resident received a Ex.Order 26.4(b)(1) on her shift. The RN stated that each resident had their own Ex.Order 26.4(b)(1) and that prior to the Ex.Order 26.4(b)(1) n being administered, she washed the Ex.Order 26.4(b)(1) put the	F 880		

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F 880	Continued From page 91 Ex.Order 26.4(b)(1) for administration. The RN stated that when the Ex.Order 26.4(b)(1) was completed, she Ex.Order 26.4(b)(1) t 9:54 AM, the surveyor accompanied the RN to the resident's room and observed the Ex.Order 26.4(b)(1) on the side table. The RN acknowledged that it was the resident's Ex.Order 26.4(b)(1) that was used, and it was not stored correctly. The RN stated that the Ex.Order 26.4(b)(1) needed to be stored in a plastic bag, and then she picked up a plastic bag from the floor. The RN stated that she would get a new plastic bag and a Ex.Order 26.4(b)(1) ecause it was not properly covered which was important for sanitary reasons. The RN removed the Ex.Order 26.4(b)(1) from the resident's room. On 7/21/23 at 10:01 AM, the surveyor interviewed the UM/LPN who stated that it was the nurse's responsibility to obtain the resident's Ex.Order 26.4(b)(1) and to Ex.Order 26.4(b)(1) The UM/LPN stated that when the Ex.Order 26.4(b)(1) was completed, that the Ex.Order 26.4(b)(1) The surveyor discussed with the UM/LPN the Ex.Order 26.4(b)(1) observations, and reviewed photographs of the resident's Ex.Order 26.4(b)(1) taken on 7/20/23 and 7/21/23. The UM/LPN acknowledged that the Ex.Order 26.4(b)(1) was not stored correctly, and stated that it was important after the Ex.Order 26.4(b)(1) that it should have been stored in a bag to prevent infection.	F 880		

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F 880	Continued From page 92 On 7/21/23 at 10:14 AM, the surveyor interviewed the ADON who stated that the nurse was responsible for obtaining the Ex.Order 26.4(b)(1) [redacted] ensuring the Ex.Order 26.4(b)(1) was Ex.Order 26.4(b)(1) [redacted]. The ADON stated the Ex.Order 26.4(b)(1) was cleaned after a Ex.Order 26.4(b)(1) [redacted] d stored in a plastic bag. The surveyor discussed with the ADON the Ex.Order 26.4(b)(1) observations and reviewed photographs of the resident's Ex.Order 26.4(b)(1) taken on 7/20/23 and 7/21/23. The ADON stated the Ex.Order 26.4(b)(1) was not stored correctly and that it should have been cleaned and placed in a labeled and dated plastic bag. The ADON stated, "I wouldn't have left it on the table, I would put it in a bag and store it in the drawer." The ADON stated it was important to clean and store the Ex.Order 26.4(b)(1) [redacted] correctly for infection control. On 7/21/23 at 10:43 AM, the surveyor interviewed the Staff Educator/LPN (SE/LPN) who stated that the nurses were responsible for obtaining the Ex.Order 26.4(b)(1) [redacted] with the resident's room number and name. The SE/LPN stated that once a Ex.Order 26.4(b)(1) was administered, the nurse removed Ex.Order 26.4(b)(1) [redacted]. The SE/LPN stated that if the Ex.Order 26.4 was not soiled, it would have been reconnected to the Ex.Order 26.4 and stored in a plastic bag. The surveyor discussed with the SE/LPN the Ex.Order 26.4(b)(1) observations and reviewed photographs of the resident's Ex.Order 26.4(b)(1) r taken on 7/20/23 and 7/21/23. The SE/LPN confirmed that	F 880		

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F 880	Continued From page 93 the Ex.Order 26.4(b)(1) was not stored correctly and that it was important for infection control to make sure that the Ex.Order 26.4(b)(1) were stored in a plastic bag after they were cleaned. 3. On 7/21/23 from 8:39 AM through 8:57 AM, the surveyor during Medication Pass observation of LPN #2 made the following observations: LPN #2 prepared medication for Resident #13 wearing a pair of gloves, and observed the resident in bed eating breakfast. LPN #2 administered the resident's oral medications wearing the same pair of gloves, but placed the resident's Ex.Order 26.4(b)(1) in the resident's bedside table to administer after the resident finished eating. LPN #2 then removed her gloves and without performing hand hygiene, proceeded to her medication cart to prepare medications for Resident #13's roommate (Resident #78). LPN #2 donned (put on) a new pair of gloves without performing hand hygiene, and removed Resident #78's medication from her cart and placed it into a medication cup. LPN #2 then proceeded into the resident's room wearing the same gloves, and administered the medication to Resident #78. LPN #2 then proceeded back to Resident #13's bedside table wearing the same gloves, and retrieved the Ex.Order 26.4(b)(1) the drawer and applied it to Resident #13's Ex.Order 26 LPN #2 then proceeded out of the resident's room wearing the same gloves, and removed the gloves at the medication cart and did not perform hand hygiene. On 7/21/23 at 8:57 AM, the surveyor interviewed LPN #2 who acknowledged she should have	F 880		

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F 880	Continued From page 94	F 880		

changed her gloves and performed hand hygiene between caring for Resident #13 and Resident #78, and confirmed not doing so was an infection control issue.

On 7/21/23 at 9:01 AM, the surveyor interviewed the Staff Educator/LPN who stated nurses must perform hand hygiene between caring for each resident to prevent infection.

On 7/26/23 at 12:21 PM, the surveyor interviewed the facility's Infection Preventionist/LPN (IP/LPN) who stated LPN #2 should have removed her gloves and sanitized her hands, before proceeding to care for another resident.

On 7/27/23 at 9:39 AM, the survey team met with the facility Administration which included the ADON who confirmed that hand hygiene must be performed between caring for each resident to prevent infection.

A review of the facility provided "Hand Hygiene" policy revised 10/27/22, included... alcohol-based hand rub is the preferred method for routine hand hygiene. Use alcohol-based hand rub...for the following situations:...before and after direct contact with residents; before preparing or handling medications; immediately after removing gloves; after contact with a resident's intact skin; after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident...

A review of the facility provided "Food and Nutritional Services" policy dated last date revised of 7/18/23, included...staff must wash hands prior to delivering the next tray if they have handled room items or Resident clothing...

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F 880	Continued From page 95 A review of the facility provided "Hand Held Ex.Order 26.4(b)(1) " policy dated revised date 3/2020, included...store Ex.Order 26.4(b)(1) in a storage bag... NJAC 8:39 - 19.4(a)(m)(n); 27.1 (a)	F 880		

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S 000	Initial Comments Complaint NJ #:165322; 165640 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny 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: Complaint NJ#: 165322; 165640 Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. This was evident for 12 out of 42 shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated)	S 560	Tag 0560 Element One Corrective Actions A staffing analysis was completed to identify by shift the minimum amount of direct care staff and licensed nursing staff required by regulatory requirements to meet the care needs of the residents based on the daily census. The staffing schedule was reviewed by the DON with the staffing coordinator to identify by shift the required numbers of staff. Immediately when facility noted that staffing requirements where not met for 12 of the 42 shifts the facility reached out to	9/7/23

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

Electronically Signed | 08/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060409	A. BUILDING: _____ B. WING _____	C 07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 CHERRY HILL, NJ 08002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/1/2021: 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. During entrance conference on 7/18/23 at 10:45 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Acting Director of Nursing (ADON) stated that the facility's staffing consisted of a high number of Agency staff which the facility tried to keep continuity with Agency staff, but the number of staff per shift was good. At this time, the surveyor requested the facility to complete the "Nurse Staffing Report" for the past two weeks. A review of the "Nurse Staffing Report" completed by the facility for the weeks of 7/2/23 to 7/8/23 and 7/9/23 to 7/15/23, which revealed the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift; 1 CNA to 14 residents for the evening shift;	S 560	agencies to fill vacant direct care positions. Facility staff were offered bonuses for picking up extra shifts. Agencies are contacted to fill vacant direct care certified nurse aide and licensed nurse positions while the facility advertised for new staff. Facility nursing staff are offered bonuses for picking up extra shifts when needed. The Facility continues to run Online Ads, offers sign on bonus and generous referral bonuses to attract new staff. Interviews are being conducted daily as applicants apply both scheduled or walk-ins. The staffing coordinator reviews the daily, weekly, and monthly staff schedules with the DON to assure staffing levels meet regulatory requirements and to offer extra shifts to cover vacation and days off in advance. Element Two Identification of at Risk Residents All residents have the potential to be affected by this practice. Element Three Systemic Change DON/ADON review staffing daily and weekly to ensure all resources have been used to staff the facility as per state mandates on an ongoing basis. Agencies are sent all staffing needs in advance and additional staff requested to cover in the event of callouts. The Facility continues to work with a recruiter and use digital and social media	

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	060409	A. BUILDING: _____ B. WING _____	C 07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 CHERRY HILL, NJ 08002

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S 560	Continued From page 2 and total number of staff to residents on the evening shift as documented below: 7/2/23 had 11 CNAs for 106 residents on the day shift, required 13 CNAs. 7/3/23 had 10 CNAs for 106 residents on the day shift, required 13 CNAs. 7/5/23 had 11 CNAs for 103 residents on the day shift, required 13 CNAs. 7/6/23 had 11 CNAs for 101 residents on the day shift, required 13 CNAs. 7/7/23 had 11 CNAs for 101 residents on the day shift, required 13 CNAs. 7/8/23 had 11 CNAs for 101 residents on the day shift, required 13 CNAs. 7/9/23 had 10 CNAs for 101 residents on the day shift, required 13 CNAs. 7/10/23 had 12 CNAs for 101 residents on the day shift, required 13 CNAs. 7/11/23 had 10 CNAs for 101 residents on the day shift, required 13 CNAs. 7/12/23 had 10 CNAs for 101 residents on the day shift, required 13 CNAs. 7/13/23 had 6 total staff for 101 residents on the evening shift, required 10 total staff. 7/13/23 had 2 CNAs to 6 total staff on the evening shift, required 3 CNAs. On 7/24/23 at 10:37 AM, the surveyor interviewed the Staffing Coordinator who stated if the facility was short on staff for a shift, it was the responsibility of the Nursing Supervisors and herself to call the facility's CNAs at home to see if they could cover the shift, and if not, the facility used Agency staff for coverage. If the facility was short staffed, the Nursing Supervisors and the nurses assisted the CNAs with care of the residents. The facility used state requirements for staffing ratios, which was a challenge at times to meet.	S 560	to staff the facility in compliance with regulations. Administration has formed a staffing committee and has conducted salary analyses and implemented creative strategies for attracting new employees to minimize the use of agency personnel. The staffing committee includes frontline staff and managers to identify ways the facility can improve the work environment to retain and attract new employees. The committee recommendations are shared with regional and corporate staff for review and implementation. Bonuses and incentive programs have been implemented to attract and to retain current staff. The facility is utilizing all types of digital media as well as headhunters to identify and hire new staff. Element Four Quality Assurance Daily staffing levels are reported to administrator and if there are any shortages additional incentives are provided to employees to work an extra shift. The success of bonuses and incentives is being analyzed by the facility Administrator and DON who make recommendations to the ownership regarding what incentives or bonuses are working. Staffing is discussed at daily morning operations meetings and recommendations solicited from the management team about ways to attract new hires to fill vacant positions. HR and staffing coordinator/designee will track	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060409	A. BUILDING: _____ B. WING _____	C 07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 CHERRY HILL, NJ 08002

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S 560	Continued From page 3 NJAC 8:39-5.1(a)	S 560	efforts and success of initiatives above and report findings to the administrator weekly for four months or until minimum staffing levels have been met on a consistent basis. The administrator will communicate findings to corporate staff for assistance and further direction as appropriate. Days and shifts where facility did not meet staffing requirement along with incentives used to attract staff for the days and shifts will be brought to QAPI on a monthly basis by DON x3 months. Also, recruitment efforts for the month x3 months will be submitted to the Administrator to evaluate progress of recruitment and retention efforts. Findings will be reported to the QAPI committee monthly and recommendations will be made based upon outcomes. The HR Director tracks monthly hiring and retention efforts which are reviewed at the monthly QAPI meeting and shared with Executive Director.	

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
315183 Y1	A. Building B. Wing Y2	9/19/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 CHERRY HILL, NJ 08002

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 F0583	Correction	ID Prefix F0656	Correction	ID Prefix F0657	Correction
Reg. # 483.10(h)(1)-(3)(i)(ii)	Completed	Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed
LSC	09/07/2023	LSC	09/07/2023	LSC	09/07/2023
ID Prefix F0658	Correction	ID Prefix F0684	Correction	ID Prefix F0755	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	09/07/2023	LSC	09/07/2023	LSC	09/07/2023
ID Prefix F0759	Correction	ID Prefix F0761	Correction	ID Prefix F0804	Correction
Reg. # 483.45(f)(1)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(d)(1)(2)	Completed
LSC	09/07/2023	LSC	09/07/2023	LSC	09/07/2023
ID Prefix F0809	Correction	ID Prefix F0812	Correction	ID Prefix F0880	Correction
Reg. # 483.60(f)(1)-(3)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	09/19/2023	LSC	09/07/2023	LSC	09/07/2023
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	
7/28/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060409	A. Building B. Wing	9/19/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 CHERRY HILL, NJ 08002

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 09/07/2023	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	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
7/28/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING **01** B. WING _____	**07/28/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	**2150 ROUTE 38** **CHERRY HILL, NJ 08002**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The nursing home building was stated to be constructed in the 1980's with no current major renovations or noted additions. It was a one story building Type II (111) construction and is fully sprinklered. The facility is identified as 2-wings: Nelson #5 501 to 532 Nelson #6 601 to 632 The facility was divided into 4-smoke zones and the 300 KW exterior diesel generator does approximately 90% of the facility. There was supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility was stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life. The facility has 118 certified beds. At the time of the survey the census was 101. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
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,	K 324		8/17/23

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

Electronically Signed | 08/14/2023

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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING **01** B. WING _____	**07/28/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	**2150 ROUTE 38** **CHERRY HILL, NJ 08002**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 1 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 observation and interview on 7/21/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure that cooking equipment was protected in accordance with NFPA (National Fire Protection Association) 96. This deficient practice was evidenced for 1 of 1 electric stoves and was evidenced by the following: On 7/21/23 at 10:10 AM, the surveyor observed in the occupied Physical Therapy room located in the Nelson-6 nursing unit, that the electric (not energized) training stove oven was observed to be storing 7-reams of combustible paper on 2-shelves. An interview was conducted with the MD and	K 324	Tag 0583 Element One Corrective Actions All combustible items were immediatley removed from the ADL oven. Element Two Identification of at Risk Residents All Residents receiving therapy have the potential to be at risk if the oven was to ever be plugged in. Immediatley rounds were performed to assure no other combustible items were being improperly stored throughout the facility. No other deficienes noted. Element Three Systemic Change The facility reviewed proper storage of items within the therapy gym. Therapy	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING **01** B. WING _____	**07/28/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	**2150 ROUTE 38** **CHERRY HILL, NJ 08002**

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K 324	Continued From page 2 RPOD at the time of the observation, and they stated that nothing combustible should have been stored in the electric training stove oven at any time. The Licensed Nursing Home Administrator was informed of the observation at the Life Safety Code exit conference on 7/21/23. NFPA 96 NJAC 8:39-31.2(e) NFPA 101-2012 : 19.3.2.5	K 324	staff were re-educated regarding the policy by the Facili. Nursing staff were re-educated that no combustible items can or are to be stored in any devices (whether plugged in or not) that have a heating element to them. Element Four Quality Assurance The Therapy Director or Designee will conduct rounds 1 time per shift to ensure no combustible items are being improperly stored within the therapy gym for one week and then weekly for three months. Results will be provided to the Licensed Nursing Home Administrator (LNHA) who will review the findings and provide direction as appropriate to assure 100 percent compliance. If findings are not 100 percent compliant further education and or discipline will be provided. The DON will report the findings in aggregate at the monthly QAPI meeting x 3 months. Facility Educator will be responsible for maintaining education for staff on proper storage. The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 08/17/2023 to ensure the deficient Tag 0583 will not reoccur.	

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
315183 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/19/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 CHERRY HILL, NJ 08002

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0324	Correction Completed 08/17/2023	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
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/28/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO