STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315038	A. BUILDING _____ B. WING _____	C 04/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SUMMIT RIDGE	**20 SUMMIT STREET WEST ORANGE, NJ 07052**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 #'s NJ00152736, NJ00154046, NJ00154073, NJ00154662, NJ00156473 Survey Date: 4/03/23 Census: 147 Sample: 29 + 3 closed records + 27 = 59 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 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint # NJ00154046 Based on observation, interview, record review, and review of the facility provided pertinent documents, it was determined that the facility	F 658	1-Residents #80 assessed by NP, no order received, Resident #24 was assessed, and order was discontinued. Resident # 295 no longer resides at the facility.	4/19/23

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

Electronically Signed | 04/14/2023

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F 658	Continued From page 1 failed to: a) follow through with [NJ Exec. Order 26] recommendation for a total of eleven (11) months for one (1) of four (4)residents, (Resident#80) reviewed for [NJ Exec. Order 26:] concerns; b) follow the physician's order with regard to [NJ Exec. Order 26:4.b.1] medications with parameters for one (1) of twenty nine (29) residents, (Resident#24) reviewed for medications; and, c) ensure that resident's [NJ Exec. Order 26] was obtained and recorded according to the facility's procedure for one (1) of six (6), (Resident#295) reviewed for [NJ Exec. Order 26:4.b.] according to the standards of clinical practice. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health	F 658	2-All residents have potential to be affected. 3-DON/Designee educated all nurses regarding the following facility policies. A-Ensure that all consults are discussed w1th residents attending doctor and appropriate documentation is in place B-Ensure residents weights are correctly entered into the residents medical records. C-Ensure orders that require a hold parameter be transcribed correctly 4-DON/designee will audit physician orders, resident weights, and prn orders for 4 residents weekly x 4 weeks then Monthly x 2. Results of these findings will be reported to the Administrator at the monthly QAPI meeting	

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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 3/22/23 at 9:45 AM, the surveyor observed Resident #80 seated in a regular chair in the room where the resident resided, watching TV (television). The resident stated to the surveyor that at times, he/she felt EX Order 26.4B1.

The surveyor reviewed Resident #80's hybrid medical records and showed the following:

The Admission Record (AR; or face sheet; an admission summary) was admitted to the facility with diagnosis that included EX Order 26.4B1 [redacted].

The Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care, dated EX Order 26.4B1 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of EX Order 26.4B1, indicating EX Order 26.4B1.

A review of the form titled, [name redacted] dated EX Order 26.4B1 revealed that the NJ Exec. Order 26:4 had seen and examined Resident #80 who also documented under the Treatment Notes, " .....Recommend EX Order 26.4B1 bottle for NJ Exec. Order 26:4.b.1 (EX Order 26.4B1) for EX Order 26.4B1 EX Order 26.4B1

On 3/22/23 at 9:50 AM, the surveyor interviewed

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the Registered Nurse/Unit Manager (RN/UM) who stated that if the dentist had any recommendations after assessing any resident, the dental form will be handed to the nurses on the unit who will then be responsible to call the resident's physician for recommendation approval. The RN/UM further stated that the nurse who called the physician will be expected to document in progress notes.

On 3/22/23 at 10:00 AM, the surveyor notified the RN/UM that there were no progress notes found in the electronic medical records regarding the [NJ Exec. Order 26:4.b.1] recommendation.

On 3/24/23 at 9:30 AM, the RN/UM showed the surveyor a progress notes documented by the Nurse Practitioner (NP) dated [NJ Exec. Order 26:4.b.1] at 19:54 (7:54 PM) which revealed, "General Note [NJ Exec. Order 26:4.b.1] 19:54 Late Entry: Note text: Received a call from nurse on unit, Pt (patient) refused [NJ Exec. Order 26:4.b.1] [redacted]. Pt was educated on the importance of compliance with prescribed medications. Pt acknowledged understanding."

On 3/24/23 at 9:35 AM, the surveyor interviewed Resident #80 who stated to the surveyor that they could not recall any medical practitioner who discussed about a [NJ Exec. Order 26:4.b.1]. The resident further stated that he/she used the same regular [NJ Exec. Order 26:4.b.1] since residing in the facility.

On 3/24/23 at 10:40 AM, the surveyor informed the facility's Licensed Nursing Home Administrator (LNHA), Regional LNHA, Director of Nursing (DON), and Regional Clinical Supervisor (RCS). The DON stated that any medical practitioner were expected to document

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the progress notes as soon as possible. The DON further stated that the recommendation from the EX Order 26.4B1 was missed. The Regional LNHA added regarding the NP note which was documented 11 months later as unacceptable.

2. On 3/10/23 at 12:01 PM, the surveyor observed Resident#24 laying on the bed with the head of the bed elevated while EX Order 26.4B1 was infusing via [redacted].

The surveyor reviewed the medical records of Resident#24 and showed the following:

The resident's AR reflected that the resident was admitted to the facility with diagnoses that included unspecified EX Order 26.4B1 [redacted]

The [redacted] Comprehensive Minimum Data Set (CMDS), revealed EX Order 26.4B1 for daily decision making were EX Order 26.4B1.

The March 2023 Order Summary Report (OSR) revealed an order date of EX Order 26.4B1 for EX Order 26.4B1 [redacted]

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EX Order 26.4B1 [redacted] or the top number, is the amount of pressure experienced by the EX Order 26.4B1 while the EX Order 26.4B1 EX Order 26.4B1.

The above physician's order for EX Order 26.4B1 was transcribed to the electronic Medication Administration Record (eMAR). A review of the March 2023 eMAR showed that the physician's order to administer the EX Order 26.4B1 was not followed for the following dates when the NJ Exec. Orde was NJ Exec. Order 26:4.b.1

EX Order 26.4B1 [redacted]

On 3/16/23 at 11:23 AM, the surveyor interviewed and notified the Licensed Practical Nurse (LPN) of the above findings. The LPN acknowledged that she was the assigned nurse on EX Order 26.4B 3 that documented the 8EX Order 26.4B1 The LPN stated that she should have followed the physician's order to administer the EX Order 26 [redacted]. She further stated that the EX Order 26 order for EX Order 26.4B1 should be clarified because "how can a nurse remember that there was an order for EX Order 26.4B1 if the NJ Exec. Orde is above EX Order ?" She indicated that the order should be changed to a standing order.

On 3/16/23 at 12:53 PM, the surveyor asked the DON for a copy of the facility's policy about physician's orders and medication with parameters, and the DON stated that she will get back to the surveyor.

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F 658	Continued From page 6 On 3/20/23 at 8:33 AM, the surveyor followed up with the DON about the medication with parameters policy, and the DON stated that she will get back to the surveyor. On 3/21/23 at 01:03 PM, the survey team met with the LNHA, DON, and the RCS and were made aware of the above findings. On 3/22/23 at 11:04 AM, the survey team met with the RCS and the DON. The DON stated, "for me, the order should have been put in differently, which should have been clarified." A review of the facility's Physician Services Policy with an updated date of 12/2022 that was provided by the DON included that the medical care of each resident is under the supervision of a Licensed Physician and that the physician will perform pertinent, timely medical assessments; prescribe an appropriate medical regimen; provide adequate, timely information about the resident's condition and medical needs; visit the resident at appropriate intervals; and ensure adequate alternative coverage. There was no facility policy that was provided with regard to medication with parameters that were provided to the surveyor. 3. On 3/20/23, the surveyor reviewed the hybrid closed record for Resident #295 and revealed the following:	F 658		

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F 658	Continued From page 7 The AR documented that the resident was admitted on [EX Order 26.4B1] with diagnosis that included but were not limited to EX Order 26.4B1 [redacted] The MDS dated [EX Order 26.4B1], section C of the MDS, revealed a BIMS score of EX Order 26.4B1, suggesting a EX Order 26.4B1. The personalized Care Plan (CP) documented a focus of, "Resident #295 presents with [EX Order 26.4B1] due to EX Order 26.4B1 [redacted] The CP documented interventions which included, "Monitor NJ Exec. Order 26:4.b.1) as available." This portion of the CP was initiated on [NJ Exec. Order 26:4.b.1] Review of the Admission/Readmission Height and [EX Order 26.4B1] Worksheet found in the resident's paper chart documented the resident's [NJ Exec. Order 26:4] on [EX Order 26.4B1] showed a documentation of [redacted] lbs. via EX Order 26.4B1 [redacted] Entries are required and were found blank for Day 2, Day 3, Week 1, Week 2, Week 3, and Week 4. The computerized information located in the Progress Notes and [NJ Exec. Order 26:4.b] section for the time period Resident #295 was admitted to the facility provided no further information documenting	F 658		

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F 658	Continued From page 8 [redacted] or attempts to [redacted] this resident. On 3/21/23 at 10:04 AM, the surveyor interviewed the Registered Dietician (RD) who explained that new admission residents are weighed initially then weekly for 4 weeks and then monthly. The RD added, "Dieticians are responsible for acquiring the weights for residents admitted to the facility." The RD explained that she was not working at the facility at the time. No further documentation was submitted to show that the resident was weighed weekly. On 3/23/23 at 11:54 AM , the surveyor interviewed the DON who clarified that the facility is responsible for weighing new admission residents on Day 1, Day 2 and possibly Day 3. Weights are then obtained weekly for 4 weeks thereafter. The DON indicated that the weight information is conveyed to the dietician and the dietician documents and evaluates if there's any modification that needs to be made. No further information was provided. NJAC 8:39-11.2 (b); 29.2 (d)	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		4/19/23

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F 689	Continued From page 9 by: Based on observation, interview, review of the medical record, and review of other pertinent facility documentation, it was determined that the facility failed to follow and maintain NJ Exec. Order 26:4.b.1 [redacted] as ordered by the physician and as written on the resident's plan of care for one (1) of three (3) residents (Resident #94) reviewed for accidents. This deficient practice was evidenced by the following: On 3/10/23 at 10:36 AM, the surveyor observed Resident #94 lying in a low to the floor bed. The surveyor observed a blue floor mat that was upright on its side leaning against the right side of the bed. The surveyor did not observe a floor mat on the left side of the bed or anywhere else in the room. Resident #94 NJ Exec. Order 26:4.b.1 to the surveyor. On 3/16/23 at 10:50 AM, the surveyor observed Resident #94, with the bed sheet over the resident's head, lying in a low to the floor bed. The surveyor observed a blue floor mat that was upright on its side leaning against the right side of the bed. The surveyor did not observe a floor mat on the left side of the bed or anywhere else in the room. On 3/16/23 at 11:37 AM, the surveyor, in the presence of another surveyor, observed Resident #94, lying in a low to the floor bed. The surveyors observed a blue floor mat that was upright on its side leaning against the right side of the bed. The surveyors did not observe a floor mat on the left side of the bed or anywhere else in the room.	F 689	EX Order 26.4B1 were provided to Resident #94 Residents second floor mat was placed. Nursing assistant, Nurse and Unit Manger was in-serviced regarding the need of lowering the mat to the floor after care. 2-All residents have the potential to be affected by this deficient practice. 3-All residents with floor mats orders were assessed to ensure that the interventions and care plans were appropriate and being implemented. DON/Designee educated all nurses and certified nurse aides regarding falls interventions. 4-The DON/Designee will audit 5 residents with floor mats orders or care plans weekly x 4, monthly x 2. Results of these findings will be reported to the Administrator at the monthly QAPI meeting.	

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F 689	Continued From page 10 The surveyor reviewed Resident #94's medical record and revealed the following: The Admission Record (or face sheet; an admission summary) indicated that the resident had diagnoses which included but were not limited to unspecified EX Order 26.4B1 [redacted]. The admission Minimum Data Set, an assessment tool used to facilitate the management of care, dated EX Order 26.4B1 reflected a Brief Interview of Mental Status (BIMS) score of EX EX Order 26.4B1 which indicated EX Order 26.4B1 EX Order 26.4B1. The active Order Summary Report dated 3/22/23, reflected a physician's order dated NJ Exec. Order 26:4.b, for NJ Exec. Order 26:4.b.1 [redacted]. A review of the resident's individualized care plan reflected a focused area dated EX Order 26.4B1, that the resident had an EX Order 26.4B1 with EX Order 26.4B1 r/t (related to) EX Order 26.4B1 EX Order 26.4B1 Interventions included but were not limited to, EX Order 26.4B1 when in bed with an initiated date of EX Order 26.4B1. On 3/16/23 at 11:54 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) regarding Resident #94. The CNA stated that the resident	F 689		

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was at risk for [redacted] and that she checked on the resident often. The surveyor asked the CNA what the purpose was for floor mats. The CNA stated that floor mats were used to prevent injury.

On 3/16/23 at 11:58 AM, the surveyor asked the Licensed Practical Nurse (LPN) and the CNA to enter Resident #94's room to observe how the one floor mat was placed on its side and not flat on the floor. The LPN and CNA confirmed that the placement of the one floor mat was not correct. The surveyor asked the LPN how an order for EX Order 26.4B1 should be placed. The LPN stated that the floor mats should be placed on both sides of the bed on the floor. She added that the reason was in case the resident fell out of bed the mats would protect them. The CNA added that the staff on 3-11 shift usually put them down.

On 3/16/23 at 12:02 PM, the surveyor asked the A wing Unit Manager (UM) what the expectation of floor mats were. The UM stated that floor mats should be in place at the resident's bedside, flat on the floor.

On 3/16/23 at 12:04 PM, the surveyor and the UM went to Resident #94's room. The surveyor asked the UM if the floor mat that was observed was supposed to be upright. The UM stated that the floor mat was not supposed to be upright and that it should be flat on the floor. The surveyor asked the UM if there was a second floor mat in the resident's room. The UM confirmed that there was only one floor mat. She then proceeded to place the one floor mat flat on the floor on the right side of the resident's bed.

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F 689	Continued From page 12 On 3/21/23 at 01:09 PM, the surveyor, in the presence of the survey team, notified the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON) and Regional Clinical Supervisor (RCS) the above findings that Resident #94's floor mats were not appropriately placed according to a physician's order during multiple observations. On 3/22/23 at 11:25 AM, in the presence of the survey team and the RCS, the DON stated that she looked into Resident #94's floor mats and that the resident had the floor mats but that when the CNA provides care they sometimes forgot to put them down. She added that the CNA does not want to step on them [floor mats]. At that same time, the surveyor notified the DON that there was only one floor mat in the room during all observations and that the staff had confirmed that there was only one floor mat. The surveyor then asked the DON if there should have been two floor mats in the room and placed flat on the floor. The DON stated that there should have been two floor mats and that they should have been down on the floor. A review of the facility provided policy titled, "Falls and Fall Risk, Managing" with an updated date of 10/2022, included the following: Policy Statement Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling .... Resident-Centered Approaches to Managing Falls and Fall Risk	F 689		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SUMMIT RIDGE	**20 SUMMIT STREET WEST ORANGE, NJ 07052**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. 2. If a systematic evaluation of a resident's fall risk identifies several potential interventions, the staff may choose to prioritize interventions (i.e., to try one or a few at a time, rather than many at once) ... 7. In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling. N.J.A.C. 8:39-27.1 (a)	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills	F 693		4/19/23

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F 693	Continued From page 14 and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to: a) administer EX Order 26.4B1 [redacted] per the physician's order, b) document the NJ Exec. Order 26:4.b.1 according to physician's order, and c) properly NJ Exec. Order 26:4.b.1 according to the standard of clinical practice. This deficient practice was identified for one (1) of two (2) residents, (Resident #24) reviewed for receiving NJ Exec. Order 26:4.b.1 and was evidenced by the following: On 3/10/23 at 11:52 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM). The LPN/UM informed the surveyor that Resident #24 was on [redacted] On 3/10/23 at 12:01 PM, the surveyor observed the resident laying on the bed with the head of the bed elevated, and NJ Exec. Order 26:4.b.1. The surveyor observed that the resident had a NJ Exec. Order 26:4.b.1 hanging on a pole, attached to a NJ Exec. Order 26:4.b.1, and infusing at a rate of NJ Exec. Order 26:4.b.1). The resident's Admission Record (or face sheet, an admission summary) reflected that the resident was admitted to the facility with diagnoses that included NJ Exec. Order 26:4.b.1 [redacted]	F 693	1-Resident #24 was assessed, no adverse effects were noted. The physician was notified and orders were clarified with the dietician. The correct rate was confirmed and proper labeling affixed to the [redacted] bottle. 2-All residents who receive tube feeding have the potential to be affected by this deficient practice. 3-DON/ Designee will conduct a facility wide in-service for all licensed nurses for the proper procedure of TF hanging and labeling. 4-The DON/Designee will conduct audits for all TF residents to ensure proper labeling and rate of flow is accurate weekly x 1 month, then biweekly x 2 month, then monthly x3 and discussed at the monthly QAPI meeting	

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F 693	Continued From page 15	F 693		

NJ Exec. Order 26:4.b.1 [redacted]

The NJ Exec. Order 26:4.b.1 Comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate care management, revealed NJ Exec. Order 26:4.b.1 [redacted]

The NJ Exec. Order 26:4.b.1 3 CMDS revealed that the resident had a NJ Exec. O[redacted]

The March 2023 Order Summary Report (OSR) revealed a physician's orders as follows:

Order date 02/23/23 7:44 AM and d/c (discontinue) date EX Order 26.4B1 5:21 PM for EX Order 26.4B1 one time a day EX Order 26.4B1 EX Order 26.4B1 [redacted] continuous up at EX Order 26.4B1) PM and down once TV (total volume): NJ Exec. Order 26:4.b.1 [redacted]

Order date EX Order 26.4B1 PM EX Order 26.4B1 order one time a day EX Order 26.4B1 at EX Order 26.4B1 hr continuous up at EX Order 26[redacted] and down once TV: NJ Exec. Order [redacted] ml/day is infused, providing EX Order 26.4B1 of EX Order 26[redacted].

The above order for EX Order 26.4B1 was

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F 693	Continued From page 16 transcribed into an electronic Medication Administration Record (eMAR) and signed as administered daily in the March 2023 eMAR. The [EX Order 26.4B1] order total volume [EX Order 26.4B1] in 24 hrs amount was documented from 3/11/23 through 3/19/23 for a [NJ Exec. Order 26:4.b.1] by nurses. Further review of the medical records showed that the physician's order on [NJ Exec. Order 26:4.b] for EX Order 26.4B1 was not followed as shown on the [EX Order 26.4B1] eMAR signed by nurses from [EEX Order 26.4B1] through [EX Order 26.4B1] as [EX Order 26.4B1] TV. On 3/23/23 at 8:32 AM, the surveyor observed the resident laying on the bed with the head of the bed elevated with eyes closed. The [NJ Exec. O] was infused via a pump hung on a pole at [EX Order 26.4B1] with a [NJ Exec. Order 26:4.b.1]) at [EX Order 26.4B1] registered on the pump machine. At that same date and time, the surveyor immediately looked for the assigned nurse and went to the [EX D] unit nursing station. The Unit Clerk (UC) informed the surveyor that the nurse was "probably" in another resident's room. Then, the surveyor asked for the LPN/UM, and the UC responded that she will get back to the surveyor. On 3/23/23 at 8:37 AM, the surveyor interviewed the LPN/UM, and later on, Licensed Practical Nurse#1 (LPN#1) came. The surveyor asked the LPN/UM and LPN#1 regarding the resident's order for [NJ Exec. Ord] LPN#1 informed the surveyor that she was not the one who hung [NJ Exec. Order 26:4] because it was ordered to start and hung at [NJ Exec. Order 26:4.b.1], and was not the nurse who set up the [NJ Exec.], it was the 3-11 PM shift nurse from yesterday (3/22/23).	F 693		

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F 693	Continued From page 17	F 693		

The LPN further stated that she had to check first the eMAR for the actual order.

On that same date and time, both the surveyor, LPN/UM, and LPN#1 went inside the resident's room and observed that the resident's [NJ Exec. O] was infusing at a rate of [EX Order 26.4B1]. The resident's [NJ Exec. O] bag that was hung on the pole had the resident's name, date and time started (3/22/23 at four (4) PM). The [NJ Exec. Order 26:4.b.1] had incomplete information because the [NJ Exec. Order 26:4.b.1] ml/hr rate) was left blank.

Afterward, the surveyor followed the LPN/UM in the [EX O] unit nursing station to check the resident's order for [NJ Exec]. LPN#1 left and continued her medication administration to other residents. The LPN/UM stated that the resident's order for [NJ Exec. O] was [EX Order 26.4B1] at [EX Order 26.4B1] continuous up at four (4) PM and down once [EX Order 26.4B1] is infused.

Furthermore, the LPN/UM stated that LPN#2 was the one who worked on 3/22/23 and hung the [NJ Exec. O] of the resident. The LPN/UM indicated that she will get back to the surveyor for LPN#2's phone number. The surveyor asked the LPN/UM why the order was not followed for [NJ Exec. O] and the LPN/UM stated that "I do not know these nurses, they are not checking."

On 3/23/23 at 8:43 AM, the surveyor observed the resident in their room with [NJ Exec] infusing at [NJ Exec] [EX Order 26.4B1] with [EX Order 26.4B1] remaining to be infused according to the [NJ Exec. Order 26:4.b.1] machine monitor.

On 3/23/23 at 8:50 AM, the surveyor observed the Director of Nursing (DON) inside the

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F 693	Continued From page 18	F 693		

resident's room and checked the [NJ Exec. Order] machine that was [EX Order 26.4B1] at [EX Order 26.4B1] at that time. The surveyor observed the DON wrote [EX Order 26.4B1] at the [NJ Exec. Order 26:4.b.1] where the blank information for the [NJ Exec. Order] order was previously seen by the surveyor and the LPN/UM.

On that same date and time, the surveyor interviewed the DON after the DON left the resident's room. The DON stated that she did not know who changed the [NJ Exec. Order] because she left around 4:30 PM yesterday (3/22/23) and had checked the resident to make sure that the [NJ Exec. Order] was on the right [NJ Exec. Order] according to the physician's order. The DON further stated that she had to make sure that the nurses are documenting and following the [NJ Exec. Order] after the surveyor's inquiry on why the [NJ Exec. Order] of [EX Order 26.4B1] was not followed as seen on the [EX Order 26.4B1] eMAR that nurses were documenting TV of [EX Order 26] ml/day. The surveyor asked the DON why she wrote [EX Order 26.4B1] and the DON did not respond.

Furthermore, the DON informed the surveyor that when she checked the [NJ Exec. Order] yesterday (3/22/23) before leaving the facility, the [NJ Exec. Order 26:4.b.1] was wrong and that she had to correct it, that was why she did not know who changed the rate again to [EX Order 26] [EX Order 26]. She further stated that the nurses who signed [EX Order 26.4B1] were "just not checking."

On 3/23/23 at 9:19 AM, the surveyor interviewed LPN#1. LPN#1 showed the surveyor how to operate the [NJ Exec. Order 26:4.b.1] machine and explained that the [NJ Exec. Order 26:4.b.1] shows the rate (ml/hr), [NJ Exec. Order 26:4.b.1], and the lower rate was the remaining [NJ Exec. Order] to be infused. LPN#1 showed also that the nurse who

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F 693	Continued From page 19 initiated the four (4) PM [NJ Exec. O] will set up also the [NJ Exec. O] in the machine. LPN#1 acknowledged that the rate should have been at [EX Order 26.4B1] and the [NJ Exec.] was [EX Order 26.4B1] LPN#1 stated that the physician's order for [EX Order 26.4B1] and [EX Order 26.4B1] should have been followed. On that same date and time, the LPN/UM came and checked the [NJ Exec. Order 26:4] and stated that the [EX Orde] [EX Order 26] was not written earlier when both the surveyor and LPN/UM checked the resident. The LPN/UM further stated that she did not know who wrote that rate on the [NJ Exec] bag. The surveyor notified the LPN/UM that it was the DON who was inside the resident's room earlier. On 3/23/23 at 9:52 AM, the surveyor called LPN#2 for an interview, and LPN#2 did not respond to the call. On 3/23/23 at 01:29 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Associate Regional Director (ARD), DON, and Regional Clinical Supervisor (RCS), and were made aware of the above findings. The DON stated that the facility recognized an oversight for [NJ Exec.] for not following the [EX Order 26.4B1] and not documenting [EX Order 26.4B1] in the March 2023 eMAR, "I'm lost for words." On 3/24/23 at 10:36 AM, the survey team met with the LNHA, DON, Regional Administrator (RA), and Regional Dietician. At that same time, the Regional Dietician stated that when Resident #24 was admitted to the facility, it was the Regional Dietician who did the resident's [NJ Exec. Order 26:4.b.1]. She further	F 693		

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F 693	Continued From page 20 stated that the resident came in with EX Order 26.4B1 [redacted] EX Order 26.4B1 [redacted] e EX Order 26.4B1 [redacted]), later, was noted with EX Order 26.4B1 [redacted] EX Order 26.4B1 [redacted], then was transferred back to the hospital. The Regional Dietician informed the survey team that when the resident came back from hospitalization, the resident was reassessed, and NJ Exec. [redacted] was adjusted to keep the resident NJ Exec. Order 26.4 [redacted] Furthermore, the Regional Dietician stated that the resident was on EX Order 26.4B1 [redacted] with a total of EX Order 26.4B1 [redacted] The Regional Dietician acknowledged that the physician's order for NJ Exec. [redacted] should have been followed. The Regional Dietician further stated that there was no negative effect on the resident. A review of the undated facility's Basic Guidelines for Enteral Feeding Policy that was provided by the DON included that TF should be delivered by nursing as ordered by a physician, and all changes in TF should be accompanied by a physician's order. On 3/28/23 at 12:03 PM, the survey team met with the LNHA, RA, and DON, and there was no additional information provided by the facility team.	F 693		
F 695 SS=D	NJAC 8:39-27.1(a) Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy	F 695		4/19/23

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F 695	Continued From page 21 care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility provided documents, it was determined that the facility failed to maintain the necessary NJ Exec. Order 26:4.b.1 and services for a resident who was receiving EX Order 26.4B1 treatment according to standards of practice. This deficient practice was identified for one (1) of one (1) resident (Resident #24) reviewed for NJ Exec. Order 26:4.b.1. This deficient practice was evidenced by the following: On 3/10/23 at 12:01 PM, the surveyor observed Resident#24 laying on the bed with the head of the bed elevated, and NJ Exec. Order 26:4.b.1. The surveyor observed that the resident had EX Order 26.4B1 in use at EX Order 26.4B1 EX Order 26.4B1 attached to a EX Order 26.4B1 EX Order 26.4B1 (EX Order 26.4B1 EX Order 26.4B1 The resident's Admission Record (or face sheet, an admission summary) reflected that the resident was admitted to the facility with EX Order 26.4B1 , type EX Order 26.4B1 EX Order 26.4B1	F 695	1-Resident # 24 was assessed by primary nurse. The physician order for NJ Exec. Order 26:4 was received and the care plan was updated. 2-All residents on oxygen have the potential to be affected by the deficient practice. 3-DON/Designee educated all nurses regarding physician orders and updating care plans. 4-DON/Designee will audit physician orders and care plans for 5 residents with oxygen orders weekly x 4 weeks and monthly x 2. Results of these findings will be reported to the Administrator at the monthly QAPI meeting.	

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EX Order 26.4B1 [redacted]

The NJ Exec. Order 26:4.b.1 Comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate care management, revealed EX Order 26.4B1 for daily decision-making were NJ Exec. Order 26:4.b.1. The CMDS did not reflect that the resident was on NJ Exec. Order 26:4.b

A review of the EX Order 26.4B1 Order Summary Report revealed that there was no order for EX Order 26.4B1

The personalized care plan did not reflect that the resident was on EX Order 26.4B1 and there were no interventions for EX Order 26.4B1.

The Progress Notes (PN) for Skilled Charting dated EX Order 26.4B1 electronically signed by the Licensed Practical Nurse (LPN) revealed that the resident was on EX Order 26.4B1).

The PN with an effective date of 3/13/23 at 10:26 PM showed that the Registered Nurse (RN) documented that Resident #24 was in bed, head of the bed elevated, and with EX Order 26.4B1.

On 3/16/23 at 10:40 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) regarding the care plan and NJ Exec use. The LPN/UM informed the surveyor that

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F 695	Continued From page 23 the resident on [EX Order 26.4B1] should have an order and care plan. The LPN/UM stated that the care plan and physician order for [EX Orde] should be initiated on admission and when the resident started to use the [EX Orde] On that same date and time, the surveyor notified the LPN/UM of the above findings. The surveyor asked the LPN/UM why the resident had no order and care plan for [EX Orde] when the surveyor observed the resident with [EX Orde] in use on 3/10/23 and nurses documented on [EX Order 26.4B1] and [EX Order 26.4B1] the resident with [EX Orde] use, and the LPN/UM stated: "I do not know." The LPN/UM acknowledged that the resident had been using the [EX Orde] and was unable to state when the resident started to use the [EEX Orde] Furthermore, the LPN/UM stated that it was the nurse's responsibility, "specifically" the UM and the DON to initiate the care plan for the resident. On 3/21/23 at 01:03 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, and Regional Clinical Supervisor (RCS) and were made aware of the above findings. On 3/22/23 at 11:04 AM, the survey team met with the RCS and the DON. The DON discussed the resident's other concerns except for the [EX Orde] findings. The surveyor followed up with the facility team about what happened and why the resident was seen with [EX Orde] in use with no order and no care plan. The DON stated, "can I get back to you with that?" A review of the facility's Care Plans,	F 695		

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F 695	Continued From page 24 Comprehensive Person-Centered Policy with an updated date of 10/2022 that was provided by the DON included that the resident population in the long-term and sub-acute care plans need to be initiated on admission, after significant clinical changes and updated as needed. UM will be responsible to oversee the care plans that are being reviewed periodically by nursing staff. Care plan problems are to be identified on admission, through interdisciplinary, and after significant clinical areas arise. Standardized care plans are to be modified on the computer to meet the clinical needs of the resident. A review of the facility's Respiratory Management Policy updated 2023 that was provided by the DON included that patients will be assessed for the need for respiratory services as part of the nursing assessment process. On 3/28/23 at 12:03 PM, the survey team met with the LNHA, Regional Administrator, and DON, and there was no additional information provided by the facility team.	F 695		
F 755 SS=F	NJAC 8:39-11.2 (e)(1)(2) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755		4/19/23

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F 755	Continued From page 25 §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, record review, and review of facility provided documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure, a) dispensed and administered NJ Exec. Order 26:4.b.1 medication was accurately accounted for (Resident #2, #12, #31, #78, and #120), b) discontinued medications were removed from active inventory (Resident #122 and #46), which was identified separately in two (2) of six (6) medication carts, c) medications were not pre-poured for more than one medication pass,	F 755	1-The nurse who failed to provide pharmaceutical services in accordance with professional standards for resident #2, #12, #31, #78, #120 was immediately educated and a medication pass evaluation was given. Residents #122 and #46 orders were reviewed. Discontinued medications were removed from the medication cart. Nurses were educated on removing discontinued medications from the medication carts. All expired medication was immediately	

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F 755	Continued From page 26 medications were secured within the medication cart (Resident #78 and #12), d) medications were destroyed after resident refusal (Resident #12) e) accurate accounting of Resident #12's dispensed EX Order 26.4B1 which was identified in one (1) of four (4) nurses observed during medication administration f) expired narcotic medications were removed from the electronic back-up machine, identified for one (1) of one (1) of the electronic emergency backup machine observed during medication storage inspection. The deficient practice was evidence by the following: 1) On 3/16/23 at 10:39 AM, the surveyor and the Licensed Practical Nurse/Unit Manager#1 (LPN/UM #1) began the narcotic medication inspection, which was stored in a mounted, double locked portion of the medication cart (narcotic box), located in the low side of unit EX Orde On 3/16/23 at 10:44 AM, in the presence of the LPN/UM #1, the surveyor observed Resident #2's EX Order 26.4B1 bingo card (a multidose card containing individually packaged medications) that contained EX Orde tablets. A review of the Individual Patient Controlled Substance Administration Record (declining inventory log) for Resident #2's EX Order 26.4B1 / EX Order 26.4B1 indicated a count of EX Ord tablets and was not signed dispensed on EX Order 26.4B1.	F 755	removed from the electronic back up for controlled medication and request submitted for destruction. 2-All residents have the potential to be affected by this deficient practice. 3-DON/designee will monitor and educate all nurses on the process of documenting and administering narcotics. DON/designee will ensure all carts are audited nightly by the 11-7 supervisor. The DON/Designee educated the RN supervisors to ensure the earliest expiration date is entered in the electronic back up for controlled medication. 4-DON/Designees will conduct 2 medication pass evaluation weekly x 4 weeks then 2 medication pass evaluations bimonthly x 2 months. Results of these findings will be reported to the Administrator at the monthly QAPI meeting. DON/designee will audit 5 resident charts weekly x4 weeks then bimonthly x 2 months. Results of these findings will be reported to the Administrator at the quarterly QAPI meeting DON/designee will conduct a weekly audit with the corresponding electronic back up for controlled medication accountability report to check for any expired medications in the electronic back up for controlled medication. The findings will be reported to the administrator during the quarterly QAPI.	

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F 755	Continued From page 27 At that time, LPN/UM #1 informed the surveyor that the declining inventory log must be signed once a medication was dispensed from the bingo card. At that time, in the presence of the surveyor and LPN/UM#1, the Registered Nurse#1 (RN #1) assigned to the low side medication cart [redacted] stated he administered the EX Order 26.4B1 [redacted] to Resident #2 on that day. RN #1 stated he should have signed the declining inventory log immediately after he dispensed the medication. At that time, the LPN/UM #1 stated she would provide an in-service (education) to RN #1 and inform the Director of Nursing (DON) about the discrepancy on the accuracy of the inventory against the declining inventory log. The surveyor reviewed the medical records for Resident #2. The resident's electronic Medication Administration Record (eMAR) for Resident #2 reflected a signed administration of EX Order 26.4B1 [redacted] on On 3/16/23 at 10:53 AM, in the presence of the LPN/UM #1, the surveyor observed Resident #12's EX Order 26.4B1 [redacted] was missing. A review of the declining inventory log for Resident #12's EX Order 26.4B1 indicated a count of one tablet and was last signed dispensed on EX Order 26.4B1.	F 755		

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F 755	Continued From page 28 The surveyor reviewed the medical records for Resident #12. The resident's eMAR for Resident #12 reflected a signed administration of EX Order 26.4B1 on EX Order 26.4B1. On 3/16/23 at 10:57 AM, in the presence of the LPN/UM #1, the surveyor observed Resident #31's EX Order 26.4B1 EX Order 26.4B1 bingo card that contained EX Order tablets. A review of the declining inventory log for Resident #31's EX Order 26.4B1 indicated a count of EX Order tablets and was last signed dispensed on EX Order 26.4B1. The surveyor reviewed the medical records for Resident #31. The resident's eMAR for Resident #31 reflected a signed administration of EX Order 26.4B1 on EX Order 26.4B1 On 3/16/23 at 11:02 AM, in the presence of the LPN/UM #1, the surveyor observed Resident #78's NJ Exec. Order 26:4.b.1 bingo card that contained EX Order tablets. A review of the declining inventory log for Resident #78's EX Order 26.4B1) mg indicated a count of EX Order tablets and was last signed dispensed on EX Order 26.4B1. The surveyor reviewed the medical records for Resident #78.	F 755		

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F 755	Continued From page 29 The resident's eMAR for Resident #31 reflected a signed administration of EX Order 26.4B1 on EX Order 26.4B1. On 3/16/23 at 11:04 AM, in the presence of the LPN/UM #1, the surveyor observed Resident #120's EX Order 26.4B1 bingo card that contained EX Ord tablets. A review of the declining inventory log for Resident #120's EX Order 26.4B1 indicated a count of EX Ord tablets and was last dispensed on EX Order 26.4B1 The surveyor reviewed the medical records for Resident #120. The resident's eMAR for Resident #120 reflected a signed administration of EX Order 26.4B1 on EX Order 26.4B1 On 3/16/23 at 11:34 AM, during an interview with the surveyor the LPN/UM #1 stated all narcotic medications should have been signed immediately once dispensed and removed from the narcotic box. On 3/16/23 at 11:39 AM, during an interview with the surveyor, RN #1 stated he signed the administration on the eMAR. He also stated he had not signed the declining inventory logs because his shift has not ended that day. RN #1 confirmed that he should have signed the declining inventory log immediately after dispensing the narcotic medications to the residents.	F 755		

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On 3/16/23 at 11:43 AM, the LPN/UM #1 stated she would provide an in-service to the nurses. The LPN/UM #1 stated it was important to ensure the inventory count was correct and to ensure the medication was in fact dispensed and administered to the corresponding resident; "that's our policy".

2) On 3/16/23 at 01:10 PM, the surveyor and the LPN began non-narcotic inspection of the medication cart located in the high side of unit [redacted]

At that time, the surveyor observed two (2) plastic ampules of EX Order 26.4B1 ([redacted] with a handwritten open date of 01/13/23. The box was labeled by the provider pharmacy for Resident #122. The LPN informed the surveyor that she had not dispensed or administered the [redacted] to the resident during her shift and it must have been discontinued.

The surveyor reviewed the medical records for Resident #122.

A review of the Order Audit Report (OAR) for Resident #120 reflected the [redacted] was ordered on [redacted] and was discontinued on [redacted]

At that time, the surveyor observed a box of [redacted] labeled by the provider pharmacy dated [redacted] for Resident #46. The LPN informed the surveyor that she had not dispensed or administered the [redacted] to the

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F 755	Continued From page 31 resident during her shift and it must have been discontinued. The surveyor reviewed the medical records for Resident #46. A review of the OAR for Resident #46 reflected the EX Order 26.4B1 was ordered on EX Order 26.4B1 and was discontinued on EX Order 26.4B1 On 3/16/23 at 01:15 PM, during an interview with the surveyor the LPN/UM #1 stated the 11 to 7 shift nurse was supposed to check the cart for expired and discontinued medications. They will inform us nurses on the 7 to 3 shift for follow up. On 3/16/23 at 01:16 PM, LPN/UM #1 stated there was a log for accountability but could not locate the corresponding accountability log at that time. The surveyor requested for LPN/UM #1 to provide further information as soon as she was able to locate the log. No further information was provided. On 3/16/23 at 01:20 PM, LPN/UM #1 stated she would remove the discontinued medications, separated from the active inventory and place with the other expired and discontinued medications in a locked medication room. 3) On 3/20/23 at 10:00 AM, on the [redacted] wing, the surveyor arrived and observed RN #2 attending to Resident #47 who was facing the side of the medication cart. The surveyor observed RN #2 administer medications to Resident #47 who left after medication administration.	F 755		

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F 755	Continued From page 32 At that time, the surveyor observed pills in a medication cup. There were no markings on the medication cup to identify the intended resident. At that time, RN #2 stated the medications were already prepared (pre-poured) for Resident #78 prior to the arrival of Resident #13. RN #2 stated, Resident #13 arrived, requested for his medications and she proceeded to prepare and administer Resident #13's medications. At that time, the surveyor observed RN #2 crush Resident #78's pre poured medications, leave the medication cart and enter Resident #78's room with the crushed medications in hand. On 3/20/23 at 10:09 AM, the surveyor walked over to the other side of the same medication cart and observed an unlabeled packet that contained crushed medication(s) on top of the medication cart. On 3/20/23 at 10:13 AM, RN#2 returned to the medication cart after exiting Resident #78's room. RN#2 confirmed with the surveyor that the unlabeled packet contained crushed medications and that it was prepared for Resident #12. At that time, RN#2 stated she was an agency nurse, it was her first day, and she was not aware of the facility policy regarding unlabeled, unattended medications on her medication cart. 4) On 3/20/23 at 10:14 AM, in the presence of the surveyors, RN #2 stated she prepared Resident #12's medication but the resident was asleep.	F 755		

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At that time, RN #2 stated she should not have left the unlabeled crushed medications on the cart because someone could have eaten it, pocketed it, or taken it physically and orally. RN #2 stated ingestion of unprescribed medications could result in unwanted adverse effects such as anaphylactic reaction (medical emergency and a life-threatening hypersensitivity reaction), hypotension (low blood pressure) and/or gastrointestinal issues (any condition that occurs from the mouth to the anus).

On 3/20/23 at 10:20 AM, during an interview with the surveyors, RN #2 stated she should have disposed the unlabeled packet of medications for Resident #12 as soon as she received the refusal. RN #2 stated the packet contained the following:

-EX Order 26.4B1
EX Order 26.4B1)
EX Order 26.4B1)
-EX Order 26.4B1
EX Order 26.4B1

At that time, RN #2 informed the surveyors that she kept the unlabeled crushed medications in a packet on the cart because it contained EX Order 26.4B1.

At that time, RN #2 stated she was unsure of the policy regarding the disposal of EX Order 26.4B1.

On 3/20/23 at 10:26 AM, RN#2 left with the unlabeled packet of medications to speak with LPN/UM #1.

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On 3/20/23 at 10:28 AM, RN #2 and LPN/UM #1 returned to the medication cart. In the presence of the surveyors and LPN/UM #1, RN #2 stated "yes, I did leave the crushed medications on the cart".

5) At that time, in the presence of LPN/UM #2 and RN #1, the surveyors observed the Resident #12's EX Order 26.4B1 bingo card that contained EX Order 26.4B1 tablets.

A review of the declining inventory log for Resident #12's EX Order 26.4B1 g indicated a count of EX Order 26.4B1 tablets and was last signed dispensed on EX Order 26.4B1.

On 3/20/23 at 10:52 AM, during an interview with the surveyor, LPN/UM #1 stated when a narcotic medication is removed from the bingo card, the declining inventory log is signed immediately.

On 3/20/23 at 11:22 AM, the surveyors observed LPN/UM #1 and RN #2 signed the declining inventory sheet and indicated that the EX Order 26.4B1 was wasted on EX Order 26.4B1 and included the time. The surveyors observed LPN/UM #1 and RN #2 pour the unlabeled packet of medications for Resident #12 into the drug buster (drug disposal system).

The surveyor reviewed the medical records for Resident #12.

A review of the admission record reflected the resident was admitted EX Order 26.4B1 with diagnoses that included EX Order 26.4B1

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F 755	Continued From page 35 EX Order 26.4B1 r, and NJ Exec. Order 26:4.b.1 The quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated EX Order 26.4B1 reflected the resident had a brief interview for mental status (BIMS) score of EX Orde out of EX Order which indicated EX Order 26.4B1. Section K0100 indicated "none" for signs and symptoms of possible EX Order 26.4B1. A review of the physician order included an enteral feed order. The eMAR included the following medication that were scheduled to be administered at 9:00 AM: EX Order 26.4B1 6) On 3/20/23 at 01:23 PM, during the observation of the cycle count for the controlled substance (narcotic) medications stored in the electronic back-up box conducted by the DON and LPN/UM#2, the surveyor observed EX Order 26.4B1 of the EX Ord tablets of EX Order 26.4B1 EX Order 26.4B1) EX Order 26.4B1 that expired on EX Order 26.4B1. At that time, the DON confirmed she also observed EX Order 26 tablets of EX Order 26.4B1 EX Order 26.4B1 tablets that expired on EX Order 26.4B1. On 3/20/23 at 01:26 PM, LPN/UM #2 also confirmed she also observed EX Order 26.4B1 tablets of	F 755		

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F 755	Continued From page 36 EX Order 26.4B1 tablets that expired on EX Order 26.4B1 At that time, the DON stated the 11-7 shift nurse and the 7-3 shift nurse should have reconciled the count and checked for the expiration date of the narcotic medications. The DON stated she would remove the expired EX Order 26.4B1 tablets file the necessary forms with the Drug Enforcement Agency (DEA) prior to the destruction of the expired EX Order 26.4B1 tablets. She stated she would store expired narcotic in her office in a double locked area. On 3/20/23 at 01:36 PM, the DON stated no expired medications should have been present in the electronic back-up machine and the nurses during the shift-to-shift change were responsible. On 3/21/23 at 01:16 PM, in the presence of the survey team, the Regional Clinical Supervisor (RCS), the Licensed Nursing Home Administrator (LNHA) and the DON, the surveyor discussed the concerns involving medication storage and administration observations. On 3/22/23 at 11:14 AM, in the presence of the survey team, RCS, LNHA, the DON, stated she attempted to provide education to RN #2 regarding the missed dose during medication pass, not signing the declining inventory log, and the crushed medications left unattended but RN #2 refused to sign. At that time, the DON stated the declining inventory log should have been signed by the nurse for accountability and that was the expectation.	F 755		

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F 755	Continued From page 37 At that time, the DON stated an in-service was provided to the 11-7 shift nurses to check for expired medications. The DON stated expired medications would have loss of efficacy for the residents. The DON acknowledged the importance of the back-up medications be in-date which would ensure medications were available for residents when needed. No further information was provided. A review of the facility provided policy "Controlled Substance" revised April 2022 included under Policy Statement: The facility shall comply with laws, regulations, and other requirements related to handling, storage, disposal and documentation of Schedule II and other controlled substances. Section 3. indicated, This record must contain: d. number on hand, j. signature of nurse administering medication. A review of the facility policy provided, "Medication Storage" revised on 11/22, included under Policy: The facility shall store all medications and biologicals in a safe, secure, and orderly manner. Under section 1. Medications and biologicals shall be stored in the packaging, containers, or other dispensing systems in which they are received. Section 3. All medications will be stored in a locked cabinet, cart or medication room that is accessible only to authorized personnel. Section 5. Expired, discontinued and/or contaminated medications will be removed from the medication storage areas and dispose as per State guideline. A review of the facility provided policy	F 755		

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F 755	Continued From page 38 "Medication Administration" updated 10/2022 included under Policy Interpretation and Implementation section 9. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication will document in medication administration record.	F 755		
F 759 SS=D	NJAC 8:39-27.1(a), 29.4 (a)(c)(g)(h)(k), 29.7(c) 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, record review, and review of facility provided documents, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication observation conducted on 3/20/23, the surveyor observed four (4) nurses administer medications to four (4) residents. There were 29 opportunities, and two (2) errors were observed which resulted in a medication error rate of 6.9%. This deficient practice was identified for two (2) of four (4) nurses that administered medications to two (2) of four (4) residents (Resident #344 and Resident #31) and was evidenced by the following: 1) On 3/20/23 at 8:48 AM, the surveyor observed the Licensed Practical Nurse (LPN) take	F 759	1-Licensed practice nurse and Registered nurse both received on the spot education regarding overall medication administration/rights of medication administration provided by DON. No resident was harmed by the deficient practice. 2.All residents have the potential to be affected by this deficient practice. 3.DON/designee educated all licensed nurses on medication administration, administering medication safely and timely. Education provided as in regards to resident #344 including following physician orders/site of administration and administering meds timely with meals. As it pertained to resident #31 the	4/19/23

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F 759	Continued From page 39 Resident #344's vitals, exited the room and cleaned the blood pressure cuff. On 3/20/23 at 8:53 AM, the surveyor observed the LPN prepare medications for Resident #344. The medications included the following: -EX Order 26.4B1 [redacted] one time a day for HTN (hypertension EX Order 26.4B1 [redacted] At that time, the LPN stated she would hold the administration of EX Order 26.4B1 since breakfast had not arrived to be served to the residents in the unit. On 3/20/23 at 9:03 AM, the surveyor observed the LPN was about to administer the EX Order 26.4B1 into Resident #344's EX Order 2 EX Order. The surveyor stopped the LPN from continuing the medication administration of the EX Order 26.4B1 and asked the LPN to review the physician order (PO) for that	F 759	education to all nurses included medication administration of seizure medication and the potential harm that comes from not following the prescribed dose. In addition all licensed nurses will have a competency on medication administration upon hire, annually and on a as needed basis. 4.DON/designee will conduct two medication pass competencies for nurses weekly x 4 then 2 medication pass competencies monthly x 2. Results of these findings will be reported to the Administrator at the quarterly QAPI meeting.	

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F 759	Continued From page 40	F 759		

medication.

On 3/20/23 at 9:07 AM, the surveyor and the LPN reviewed the electronic medication administration record (eMAR) for the EX Order 26.4B1. The LPN confirmed the eMAR indicated to administer the EX Order 26.4B1 into the EX Order 26.4B1 only.

At that time, during an interview with the surveyor, the LPN stated it was important for medications to be administered as ordered because it could have caused side effects and, in this case, antibiotic resistance.

The surveyor reviewed the medical records for Resident #344.

The Admission Record (face sheet, an admission summary) reflected, Resident #344 was admitted to the facility with diagnoses that included, NJ Exec. Order 26:4.b.1

The admission Minimum Data Set (aMDS), an assessment tool used to facilitate the management of care, dated EX Order 26.4B1, reflected that the resident had a Brief Interview of Mental Status (BIMS) score of EX Order 26.4B1 which indicated that the resident was EX Order 26.4B1

The resident's electronic Medication Administration Record (eMAR) reflected a PO dated EX Order 26.4B1

2) On 3/20/23 at 10:45 AM, the surveyor

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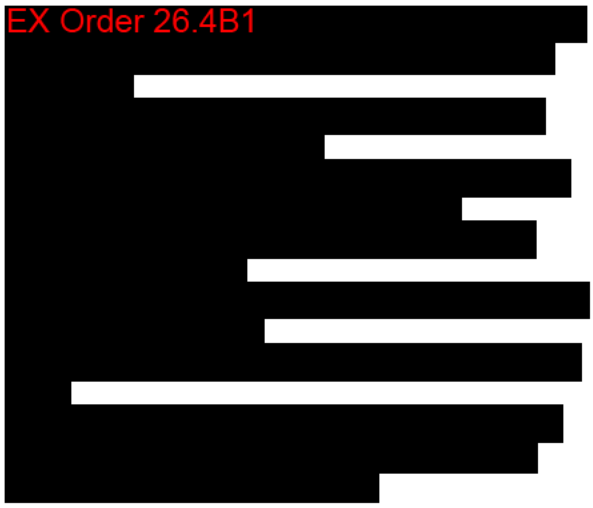
F 759	Continued From page 41 observed the Registered Nurse (RN) prepare medications for Resident #31. The medications included the following: EX Order 26.4B1  On 3/20/23 at 11:00 AM, the RN stated she had 7 (seven) pills in the medication dose cup and the EX Order 26.4B1 drop container. On 3/20/23 at 11:05 AM, the RN confirmed with the surveyor that she was ready to administer medications to Resident #31. On 3/20/23 at 11:07 AM, the RN and the surveyor entered Resident #31's room. The surveyor stopped the RN from continuing the medication administration and asked the RN to review the PO. On 3/20/23 at 11:08 AM, the surveyor and the RN reviewed the eMAR for the EX Order 26.4B1. The RN stated she should have prepared to	F 759		

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F 759	Continued From page 42 administer two (2) tablets instead of one (1) tablet. At that time, the RN stated it was important to administer the medication as ordered and in this case the resident had a history of EX Order 26.4B1 [redacted]. The surveyor reviewed the medical records for Resident #31. A review of the admission record reflected, Resident # 31 was admitted to the facility on EX Order 26.4B1 with diagnosis that included, other seizures, unspecified EX Order 26.4B1 [redacted]. According to the aMDS, dated EX Order 26.4B1, reflected that the resident had a BIMS score of EX Order 26.4B1 EX Order 26 which indicated that the resident had a EX Order 26.4B1. The resident's Clinical Physician Orders reflected a PO dated EX Order 26.4B1 for EX Order 26.4B1 [redacted]. A review of the resident's eMAR reflected EX Order 26.4B1 [redacted] On 3/21/23 at 01:16 PM, in the presence of the survey team, the Regional Clinical Supervisor (RCS), the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), the surveyor discussed the concerns involving the	F 759		

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F 759	Continued From page 43 medication administration observation. On 3/22/23 at 11:14 AM, in the presence of the survey team, the RCS, and the LNHA, the DON stated she attempted to provide education to the RN who refused to sign. No further information was provided. A review of the facility provided policy "Medication Administration" updated 10/2022 included under Policy Statement, Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation included the following: 2. Medications must be administered in accordance with the orders, including any required time frame. 3. Medications must be administered within one (1) hour of their prescribed time frame unless otherwise specified (for example, before and after meal orders). 5. The individual administering the medication must check the label against the Physician's orders to verify the right resident, right medication, right dosage, right time, right method (route) of administration before giving the medication. 12. New personnel authorized to administer medications will not be permitted to prepare or administer medication until they have been oriented to the medication administration system used by the facility. NJAC 8:39-11.2(b), 29.2(d)	F 759		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)	F 804		4/19/23

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F 804	Continued From page 44 §483.60(d) Food and drink 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 # NJ00152736 Complaint # NJ00154046 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure the safe and appetizing temperatures of hot food, cold food and drinks served to the residents. This deficient practice was identified for 2 (two) of 2 (two) residents, (Residents #80 and #27) confirmed during the lunchtime meal service on 3/22/23 for 2 (two) of 2 (two) nursing units tested for food temperatures by two surveyors and was evidenced by the following: On 3/22/23 at 11:52 AM, the surveyors and the Food Service Director (FSD) were on the [redacted]-Wing unit observing lunch tray distribution. At 11:57 PM, surveyor #1 pulled a tray from the food truck (Cart 1) in the [redacted] Wing unit. The surveyor observed that Certified Nursing Assistants (CNA) began to deliver meal trays to residents at 11:55 AM. After the last meal tray was delivered to a resident at 12:13 PM, the surveyors took the temperatures of the following items (regular consistency) in the presence of	F 804	1.CNAs and nurses were immediately educated on the importance of prompt delivery of food trays to the residents when delivered to the units. The trays for residents #80 and 27 were checked and found to be acceptable There was no harm to done. 2.All residents have the potential to be affected by this deficient practice. 3.Kitchen staff will announce when meal trays are arriving to all units. DON/designee will conduct an in service for all kitchen staff, CNAs and nurses on the process of announcing when meal trays are being delivered to the units. 4.DON/designee will perform biweekly audits on delivery of meal trays to residents x 4 weeks, then weekly x 4 then monthly. AS it pertains to resident #80 and 27 their meal temperatures will always be included in biweekly audit. Results of these findings will be reported to the Administrator at the quarterly QAPI meeting.	

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F 804	Continued From page 45	F 804		

FSD with calibrated thermometers:

Coffee	142.2 degrees F
Mashed Potato	124 degrees F
Open Faced Roast Pork Sandwich	122.4 degrees F
Herbed Green Beans	109.9 degrees F
Lemon Cake	71.6 degrees F
Cranberry Juice	59 degrees F

On 3/22/23 at 12:34 PM, surveyor #1 pulled a tray from the food truck (Cart 1) on the [redacted]-Wing Unit. The surveyors observed the CNA began to deliver meal trays to residents at 12:35 PM. After the last meal tray was delivered to a resident at 12:45 PM, the surveyors took the temperatures of the following items (regular consistency):

Coffee	151.1 degrees F
Mashed Potato	136.6 degrees F
Open Faced Roast Pork Sandwich	124.6 degrees F
Herbed Green Beans	114 degrees F
Tossed Salad	66 degrees F
Lemon Cake	73 degrees F

On 3/22/23 01:10 PM, the surveyor interviewed the FSD who agreed that the temperatures of the food were not maintained at an appetizing temperature to the residents but thinks the time

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F 804	Continued From page 46 from when the trays arrive on the unit and when the CNA start passing out the trays takes too long which in turn makes the temperature of the foods drop. NJAC 8:39-17.4(e)	F 804		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record and review of pertinent facility documentation, it was determined that the facility failed to provide the correct consistency of diet according to physician's order. This deficient practice was identified for one (1) of twenty-nine (29) sampled residents (Resident #81) during dining observation. The deficient practice was evidenced by the following: On 3/16/23 at 12:37 PM, the surveyor observed Resident #81 seated in a wheelchair in the main dining room with their lunch meal on the table in front of him/her. The surveyor observed Resident #81's lunch plate had two whole chicken thighs on it. The surveyor then reviewed Resident #81's lunch meal ticket which included the following: CHOPPED MEATS ONLY. The meat served to Resident #81 was not chopped and was not the	F 805	1.Resident #81 was immediately evaluated by [redacted]. Nursing and recreation staff were immediately educated. 2.All residents have the potential to be affected by this deficient practice. 3.A nurse is present in the dining room at the steam table during meals to verify meal tickets to ensure all residents receive the correct meal consistency. DON/designee conducted an in-service for all licensed nurses on the process of meal consistency verification during meal times in the dining room. 4.FSD/Designee will audit 10 resident meal tickets daily x 2 weeks, then weekly x 1 then monthly x 2. Results of these findings will be reported to the Administrator at the quarterly QAPI	4/19/23

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F 805	Continued From page 47 correct consistency of diet ordered. On 3/16/23 at 12:38 PM, the surveyor interviewed the Dietary Aide (DA) who had plated Resident #81's lunch from the steam table. The surveyor asked the DA what the process was for plating and serving the correct consistency of diet for residents. The DA stated that the staff would come up to the steam table with the meal ticket and the staff would read the meal ticket to her and that she would plate what was read to her. On 3/16/23 at 12:39 PM, the surveyor asked the DA to look at the meal ticket and lunch plate of Resident #81. The DA confirmed that the consistency of the meat on the plate was not correct and it was not the consistency that was listed on the meal ticket. The DA stated that Resident #81's diet must have changed yesterday. She added that the staff would tell me what was on the resident's meal ticket and then I would plate it. The DA then removed the incorrect plated meal from Resident #81. The DA then plated chopped chicken and then brought it over to Resident #81. On 3/16/23 at 12:41 PM, the surveyor asked Resident #81 which staff member brought over the original lunch plate. Resident #81 could not tell the surveyor which staff member it was. On 3/16/23 at 12:42 PM, the surveyor asked a Certified Nursing Assistant (CNA) that was in the main dining room what the process was for serving the resident's meal. The CNA stated that the staff place the meal tickets on the table in front of the resident. The staff then take the meal ticket to the steam table and the staff show the	F 805	meeting.	

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F 805	Continued From page 48 DA the meal ticket. The staff then bring the meal to the resident. On 3/20/23 at 12:23 PM, the surveyor observed the plating and serving of meals in the main dining room. The surveyor observed several staff members take the meal ticket from the table and read what the diet on the meal ticket was to the DA. The DA then would plate what the staff told her and give the plate to the staff member to bring to the resident. On 3/20/23 at 12:34 PM, the surveyor observed a Recreation Aide (RA) get the meal ticket that was in front of Resident #81 and brought it to the steam table. The RA told the DA the name (Resident #81) that was on the meal ticket. The RA did not tell the DA what the diet consistency was. The DA plated chopped chicken pot pie. The RA then brought the plate to Resident #81. On 3/20/23 at 12:38 PM, the surveyor interviewed the RA who stated that it was her first day and she was being trained. The surveyor asked why she did not tell the DA what the diet consistency was. The RA stated that she took the meal ticket to the DA and told the DA who the meal ticket was for. She added that she had not been trained yet and that it was her first time to do it. The surveyor then reviewed Resident #81's medical record. A review of the Admission Record (AR; or face sheet; an admission summary) indicated that the resident had diagnoses which included but were not limited to[redacted]	F 805		

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EX Order 26.4B1 [redacted].

A review of the quarterly Minimum Data Set, an assessment tool, dated EX Order 26.4B1 reflected a Brief Interview of Mental Status (BIMS) score of EX Order 26.4B1 which indicated EX Order 26.4B1.

A review of the active Order Summary Report dated EX Order 26.4B1, reflected a physician's order dated EX Order 26.4B1, for NJ Exec. Order 26:4.b.1 consistency, Provide [redacted] milk, NJ Exec. Order 26:4.b.1 for EX Order 26.4B1.

A review of the resident's individualized care plan reflected a focused area dated EX Order 26.4B1, that the resident has EX Order 26.4B1 problems r/t (related to) EX Order 26.4B1. Interventions included but were not limited to, Diet as Ordered: Regular diet, double portions with 2 (two) PM and H.S. (at bedtime) snack. Consult with dietitian and change if chewing/swallowing problems are noted.

A review of the EX Order 26.4B1 Evaluation and Plan of Treatment for Certification Period of EX Order 26.4B1 included the following: Factors Supporting Medical Necessity Current Referral-Reason for Referral: Patient referred to NJ Exec. Order 26:4.b.1 [redacted] Precautions- ...diet: regular, NJ Exec. Order 26:4.b.1 only,

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NJ Exec. Order 26:4.b.1
EX Order 26.4B1 [redacted]

A review of the EX Order 26.4B1 Discharge Summary with dates of services EX Order 26.4B1 to EX Order 26.4B1 included the following:
Objective Progress/Functional Comparison with Goals
Comments: pt w/ NJ Exec. Order 26:4.b.1 [redacted] ...
Discharge Status and Recommendations
Diet Recs (recommendations)-Solids=Regular textures, Mechanical Soft/Chopped textures

A review of the [redacted] Consultation dated [redacted] included the following:
Treatment notes: ...patient has NJ Exec. Order 26:4.b.1 [redacted] ...

A review of the [redacted] Consultation dated [redacted] included the following:
Treatment notes: ...Pt has generalized NJ Exec. Order 26:4.b.1 ...

A review of the Resident Profile Details provided by the facility included the following:
Diet: Regular NJ Exec. Order 26:4.b.1

On 3/21/23 at 9:33 AM, the surveyor interviewed the Dietician regarding Resident #81. The Dietician stated that she typically recommends the diet for the residents. She stated that Resident #81 was recently downgraded to a NJ Exec. Order 26:4.b.1 because the resident complained that it hurt to chew. She added that the resident needed to see a [redacted] but that the resident did

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F 805	Continued From page 51 not want to. The Dietician stated that the EX Order 26.4B1 EX Order 26.4B1 did an evaluation and recommended a downgrade to NJ Exec. Order 26:4.b.1 in the beginning of February. The surveyor then asked the Dietician what would happen if Resident #81 received meat that was NJ Exec. Order 26:4.b.1 consistency. The Dietician stated that the resident would not have swallowing or choking issues but that the resident might not be able to NJ Exec. Order 26:4.b.1]. She added that the resident's issue was with NJ Exec. Order 26:4.b.1 On 3/21/23 at 9:39 AM, the surveyor interviewed the Food Service Director (FSD) regarding the process of plating and serving food in the main dining room. The FSD stated that the meal ticket goes to the table where the resident is seated first. The Recreation Aides and the CNA's takes the meal ticket to the Dietary staff member that is plating the food from the steam table and then shows the Dietary staff member the meal ticket. She added that the plater takes responsibility to ensure the consistency given is correct. On 3/21/23 at 9:45 AM, during surveyor interview, the Regional Director of Operations for Dietary stated that it was a team effort between nursing and dietary and that the person that serves the resident at the end is responsible. On 3/21/23 at 11:16 AM, the surveyor interviewed the Director of Recreation (DR) regarding the process of serving meals in the main dining room. The DR stated that the recreation department staff help with serving food to the residents. The DR stated that Dietary staff place the meal tickets on the tables. She added that recreation staff and CNA's take the ticket to the steam table and tell the resident's name and diet	F 805		

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F 805	Continued From page 52	F 805		

to the person plating the food. The staff then bring the food and the meal ticket to the resident. The surveyor asked the DR what the importance of the correct diet being served was. The DR stated that it was for safety reasons. The surveyor then told the DR the observation the surveyor had of the RA not telling the plater the diet consistency of Resident #81. The DR stated that the plater knew Resident #81.

On 3/21/23 at 01:09 PM, in the presence of the survey team, the surveyor told the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON) and the Regional Clinical Supervisor of the concern that Resident #81 was provided an incorrect consistency of meat, the meat was [redacted] according to the physician's order. The surveyor also told the concern that there was not a consistent process among the staff observed and interviewed to ensure residents received the correct consistency of diet that was ordered by a physician.

On 3/22/23 at 10:39 AM, in the presence of the survey team and the Regional Licensed Nursing Home Administrator (RLNHA), the Director of Rehab (DoR) stated that Resident #81 verbalized that he/she had a [redacted] and was assessed by the [redacted]. She stated that the appropriate diet was [redacted] and smaller consistency. She added it was only for meat and not all protein. She stated that the resident was safe with any consistency, that it was a preference and not for aspiration [issues]. The DoR stated that chicken was not a meat and that it was considered a poultry. The DoR stated that the resident had a [redacted]

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EX Order 26.4B1 issue and that the resident was able to chew it [chicken] but that the resident liked it smaller to chew.

On that same date and time, the surveyor then asked if a resident's meal ticket had regular diet on it, should the resident receive a regular diet. The RLNHA stated that he assumed so. He added that staff are supposed to follow the diet order. The RLNHA then stated that the process "needs to be tweaked" and that the facility educated the dining room staff, not that there was noncompliance. The surveyor then asked what the process for serving the meal should be to ensure the correct consistency is served to the resident. The RLNHA stated that whoever the "runner" was would say what the diet is. He added that he would have to check what the process was at this facility.

On 3/22/23 at 10:57 AM, the surveyor reviewed the definition of meat. According to The American Meat Science Association meat is defined as red meat (beef, pork, and lamb), poultry, fish/seafood, and meat from other managed species (AMSA, 2017). According to U.S. Department of Agriculture meat is defined as the flesh of animals (including fishes and birds) used as food, that can be part of a healthful diet.

On 3/22/23 at 11:48 AM, the surveyor interviewed Resident #81 regarding the consistency of the resident's diet. Resident #81 stated that he/she was not sure when the NJ Exec. Order 26:4.b.1 consistency was started. Resident #81 stated "it's easier for me to chew." Resident #81 then stated that it was hard for him/her to cut food because

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F 805	Continued From page 54 his/her [redacted] and could not use his/her [redacted] On 3/22/23 at 12:04 PM, the surveyor interviewed the DoR. The DoR stated Resident #81 could use [redacted]. She added that Resident #81 had [redacted] issues and that the resident complained that it was hard to chew and that was why the resident was on [redacted] She then stated that the resident could not cut it [meat] small enough. She added that she believed chewing hurt the resident. On 3/23/23 at 01:32 PM, in the presence of the survey team, the LNHA, and the DON, the RLNHA stated that they redefined the process and that the nurse stands at the steam table and makes sure the meal ticket matches the food plated. The RLNHA then stated that the staff were in-serviced but that they maintain that chicken and meat is different. He added that it was a personal preference and not a swallowing related manner. The surveyor then asked what the importance of the correct consistency of diet was. The RLNHA stated "basic level is to follow the order." A review of the facility provided policy titled, "Meal Distribution" with a revised date of 9/2017, included the following: Procedures 1. All meals will be assembled in accordance with the individualized diet order, plan of care, and preferences ... 4. The nursing staff will be responsible for verifying meal accuracy and the timely delivery of meals to residents/patients. 5. For point-of-service dining, the Dining Services	F 805		

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F 805	Continued From page 55 department staff, under the supervision of the licensed nurse, will assemble the meal in accordance with the individual meal card and present it to the care staff for delivery to the resident/patient. A review of the facility provided policy titled, "Meal Distribution: Infection Control Considerations" with a revised date of 9/2017, included the following: 1. All meals will be assembled in accordance with the individualized diet order, plan of care, and preferences ... 4. The nursing staff shall be responsible for verifying meal accuracy and delivery of meals to resident/patients. N.J.A.C. 8:39-17.4(a)(1,2); 27.1	F 805		
F 812 SS=E	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.	F 812		4/12/23

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F 812	Continued From page 56 §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) consistently monitor refrigerator and freezer temperatures and document them in the facility logs and b) maintain the kitchen environment and equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development a foodborne illness. This deficient practice was evidenced by the following: On 3/10/22 at 9:59 AM, in the presence of the Food Service Director (FSD), the surveyor observed the following: 1. In walk-in refrigerator#1, the surveyor observed one of five pitchers of iced tea with a use-by date of 3/05. The pitcher was half full. The FSD stated that it should have been discarded on the use-by date. 2. In the food preparation (prep) area, near the oven, the surveyor observed five knives stocked in between the crease of the prep table and oven, two out of five knives with dried brown and white substances. The FSD asked the Dietary Cook (DC) why the five knives were not properly stored, then, the DC immediately placed the five knives in the knife rack without cleaning it first. 3. The ice scooper was stored with a missing cover attached to the wall near the kitchen office. Above the ice scooper, a ceiling tile with dried	F 812	1. Corrective actions accomplished for residents found to have been affected by the deficient practice: A. Iced tea with expired use by date was immediately discarded. All dietary staff were educated/in-serviced on proper labeling and dating policy/processes. B. Dirty knives by the cook station were immediately washed and stored properly. All dietary staff were educated/in-serviced on proper execution of cleaning standards and equipment storage. C. Hot dog buns with no open/expiration date were immediately discarded. All dietary staff were educated/in-serviced on proper dry food storage policy/processes. D. New ice scoop and container with lid were ordered and installed as soon as received on 3/24/2023. E. All dietary staff were educated/in-serviced on cold food storage policy/processes- specifically accurate recording of temperatures in the logs. 2. A. All dietary staff were educated/in-serviced on proper labeling and dating policy/processes. B. All dietary staff were educated/in-serviced on proper execution of cleaning standards and equipment storage.	

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F 812	Continued From page 57 black and brown substances. The FSD stated that it was "okay" for the ice scooper to have no cover. The FSD further stated that the black and brown substances from the ceiling tile were from the accumulated water dripping. On 3/13/23 at 10:25 AM, in the presence of the FSD, the surveyor observed the following: 1. In walk-in refrigerator#2, the surveyor observed the Refrigerator Temperature (temp) Log for March 2023 had two dates with missing temperature and initials for dates 3/12/23 and 3/13/23 for AM (morning) temp. 2. In freezer#1, 3, and 4, the surveyor observed the Freezer Temperature Log for March 2023 had two dates missing temp and initials for dates 3/12/23 and 3/13/23 for AM temp. 3. In freezer#2, the surveyor observed the Freezer Temperature Log for March 2023 had two dates missing temp and initials for dates 3/12/23 and 3/13/23 for AM temp. 4. In the dry storage room, the surveyor observed eight (8) pieces of hotdog buns in a plastic bag with no date. The hotdog buns had no molds. The FSD stated that the hotdog buns should have a use by date. The FSD was unable to state the delivery date of the hotdog buns. The surveyor reviewed the delivery receipts that were provided by the Regional Dining Services (RDS) dated 3/13/23 and showed that there was no delivery for hotdog buns for that day. On 3/21/23 at 9:00 AM, the surveyor interviewed	F 812	C. All dietary staff were educated/in-serviced on proper dry food storage policy/processes. D. All dietary staff were educated/in-serviced on cold food storage policy/processes- specifically accurate recording of temperatures in the logs. E. Manager□s daily audit form put in place to monitor proper execution of corrective actions. 3. A. The monitoring of Labeling and Dating will be completed by the FSD/Designee using Daily Audit form for 4 weeks or until concerns are corrected. 1. Label and dating audits findings will be reported to the Administrator weekly. B. The monitoring of accurate recording of temperatures in the logs will be completed by the FSD/Designee using Daily Audit form for 4 weeks or until concerns are corrected. 1. Temperature recording audits findings will be reported to the Administrator weekly. C. The monitoring of execution of cleaning standards and equipment storage will be completed by the FSD/Designee using Daily Audit form for 4 weeks or until concerns are corrected. 1. Cleanliness audits findings will be reported to the Administrator weekly. D. The monitoring of execution of proper dry food storage policy/processes will be completed by the FSD/Designee using	

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F 812	Continued From page 58 the DC. The DC informed the surveyor that the cook was responsible for checking and logging refrigerator and freezer temperatures when he comes at five (5) AM. The DC stated that the ice scooper should have a cover. He acknowledged that he worked on 3/10/23, 3/12/23, and 3/13/23, and he should have logged the temps for the refrigerator and freezers. He further stated that on 3/12/23 and 3/13/23 (Sunday and Monday) for AM shift he was not able to log temps because of short staff. On that same date and time, the DC stated that on 3/10/23, "I was hurrying up," because he heard that the surveyors entered the facility and stocked the unclean knives in between the crease of the oven and prep table. He further stated that he should not store the unclean knives back in the rack and should have washed them first. On 3/21/23 at 01:03 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Regional Clinical Supervisor (RCS) and were made aware of the above findings. On 3/22/23 at 11:04 AM, the survey team met with the RCS and the DON and the surveyor followed up on responses from yesterday's (3/21/23) findings from the kitchen. The DON stated that she was not the right person to respond to kitchen concerns. On 3/23/23 at 01:29 PM, the survey team met with the Associate Regional Director (ARD), LNHA, DON, and the RCS. The surveyor asked and followed up regarding the kitchen findings,	F 812	Daily Audit form for 4 weeks or until concerns are corrected. 4. Dry food storage policy/processes audits findings will be reported to the Administrator weekly and reviewed by the quarterly QAPI meeting	

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F 812	Continued From page 59	F 812		

and if the facility had a response. The ARD stated that he will get back to the surveyor.

A review of the undated Ice Policy that was provided by the RDS included that Ice will be prepared and distributed in a safe and sanitary manner, and ice scoops will be cleaned and stored in a separate container.

A review of the undated Manual Warewashing Policy that was provided by the RDS included that all serviceware and cookware will be air-dried prior to storage.

The surveyor reviewed the undated Warewashing Policy that was provided by the RDS and showed that all dishware, serviceware, and utensils will be cleaned and sanitized after each use.

A review of the facility's Food Storage: Cold Foods Policy with a revised date of 4/2018 that was provided by the RDS revealed that the freezer temperatures will be maintained at a temperature of 0 degrees Fahrenheit or below, an accurate thermometer will be kept in each refrigerator and freezer. A written record of daily temperatures will be recorded. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross-contamination.

On 3/24/23 at 10:36 AM, the survey team met with the LNHA, Regional Administrator, DON, and the Regional Dietician. There was no additional information provided by the facility team regarding kitchen concerns.

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F 812	Continued From page 60 NJAC 8:39-17.2(g)	F 812		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. 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 properly dispose of and maintain the waste in garbage dumpster areas. This deficient practice was identified for one (1) of two (2) garbage dumpsters in the garbage disposal area. This deficient practice was evidenced by the following: During an observation on 3/13/23 at 11:14 AM by two surveyors and the Food Service Director (FSD), the outside dumpster area revealed two dumpsters next to each other. Dumpster #1 had a lid open with garbage bags in it. Dumpster #1 with trash around the surrounding area on the floor that included plastics, papers, and other garbage. There was a puddle of water near Dumpster #1. In addition, there was garbage soaked in the puddle of water. The FSD stated that she was not able to determine how long the garbage was on the floor. She acknowledged that the puddle of water and garbage was there for more than a week because it was hard to identify what kind of garbage was on the floor. The FSD stated that Dumpster #1 lid should be closed at all times when not in use, and no trash should be within the surrounding area of the dumpsters to prevent rodent infestation.	F 814	1- No residents were harmed by the deficient practice, Dumpster lid was closed immediately, the area around dumpster was cleaned up immediately. 2- All residents have the potential to be harmed by the deficient practice 3- a. All dietary staff were educated/in-serviced on proper trash disposal. b. The dietary department coordinated with Maintenance department and put in place dumpster cleaning schedule and log. c. Dietary Manager's daily audit form put in place to monitor proper execution of corrective actions. 4- The monitoring of proper garbage disposal and dumpster area cleanliness will be completed by the FSD/Designee using Daily Audit form for 4 weeks or until concerns are corrected. Dumpster area audits findings will be reported to the Administrator weekly and reviewed by the Quarterly Qapi meeting.	4/12/23

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F 814	Continued From page 61 On that same date and time, the surveyors and the FSD observed Dumpster #2 with surrounding folded boxes outside the dumpster, on the floor. The FSD informed the surveyors that it was the kitchen staff's responsibility to keep the area clean and notify the housekeeping department if needed to be cleaned. She acknowledged that there should be no folded boxes and garbage of any kind on the floor, or outside the dumpster. At the same time, the surveyors and the FSD observed upon re-entering the facility multiple trash in the surrounding area that included papers, plastics, used disposable masks, and cigarette butts. On 3/21/23 at 9:00 AM, the surveyor interviewed the Dietary Cook (DC). The DC stated that "I really feel bad," about the garbage area outside the facility and that he was made aware of what had happened on 3/13/23 observations of the two surveyors and the FSD, and "honestly, I see that too, garbage all over the floor." The DC acknowledged that there should be no garbage outside the dumpsters, and the lids should be closed at all times to prevent rodents. He further stated that the FSD and facility management were aware of the dumpsters and garbage disposal area cleanliness concerns. On 3/21/23 at 01:03 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and the Regional Clinical Supervisor (RCS) and were made aware of the above findings. A review of the undated facility's Dispose of	F 814		

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F 814	Continued From page 62 Garbage and Refuse Policy that was provided by the Regional Dining Services included that the Dining Services Director coordinates with the Director of Maintenance to ensure that the area surrounding the exterior dumpster area is maintained in a manner free of rubbish or other debris. On 3/24/23 at 10:36 AM, the survey team met with the LNHA, Regional Administrator, DON, and the Regional Dietician. There was no additional information provided by the facility team. NJAC 8:39-19.3(a); 19.7(a)(b)	F 814		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the	F 880		4/19/23

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F 880	Continued From page 63 facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880		

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F 880	Continued From page 64 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility provided documents, it was determined that the facility failed to: a) perform hand hygiene appropriately for two (2) (Certified Nursing Aide and Housekeeper) of eight (8) staff and b) properly use PPE (personal protective equipment) for two (2) (Certified Nursing Aide and Housekeeper) of four (4) observed in accordance with the Centers for Disease Control and Prevention (CDC) guidelines and facility policy. This deficient practice was evidenced by the following: According to the U.S. CDC guidelines Hand Hygiene Recommendations, Guidance for Healthcare Providers (HCP) for Hand Hygiene and COVID-19, page last reviewed 1/8/2021 included that the HCP should perform hand hygiene before and after direct contact with the residents, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids or contaminated surfaces, and immediately after glove removal. In addition, wear gloves, according to Standard Precautions, when it can be anticipated that contact with blood	F 880	F880 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: The CNA and housekeeper who failed to perform hand hygiene appropriately were immediately in-serviced on proper hand hygiene practices. The CNA and housekeeper who failed to don and doff PPE properly were immediately in-serviced on proper donning and doffing PPE. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents have the potential to be affected by this deficient practice. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: DON/designee conducted facility wide in service on infection control practices including hand hygiene and the donning and doffing of PPE.	

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F 880	Continued From page 65 or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin, or contaminated equipment could occur; gloves are not a substitute for hand hygiene; if your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment, and after removing gloves. 1. On 3/10/23 at 9:32 AM, the Director of Nursing (DON) informed the surveyor that the COVID-19 outbreak concluded on 2/24/23 and the positive staff who was the [NJ Exec. Order 26:4.b.1] reported on 3/07/23 tested [NJ Exec. Order 26:4.b] for COVID-19 (tested outside the facility) and did not return to the facility after tested for COVID-19 to self isolate. The DON further stated that the [NJ Exec. Order 26:4.b.1] worked on 3/06/23 in the facility, then was off on 3/07/23. During an Entrance conference on 3/10/23 at 10:30 AM of the surveyor with the DON, Regional Clinical Supervisor (RCS), and the Regional Administrator (RA), the DON informed the surveyor that the facility census (total number of residents) was 147. The facility management indicated that there were no residents on TBP (transmission-based precaution; used in addition to standard precautions for residents with known or suspected infection). On 3/10/23 at 11:52 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM). The LPN/UM informed the surveyor that Resident #133 was on contact precaution (involves contact of a susceptible person with a contaminated intermediate object such as needles, dressings, gloves, or contaminated (unwashed) hands) for EX Order 26.4B1	F 880	4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: DON/designee will conduct audits for infection control practices, hand hygiene and donning and doffing competencies weekly x 1 month, then biweekly x 1 month then monthly. The results of these findings will be reported to the administrator during the QAPI meeting.	

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F 880		F 880		

Continued From page 66

EX Order 26.4B1 [redacted] he LPN/UM stated that staff and visitors were expected to follow the instructions outside the resident door to perform hand hygiene and wear PPE that included an N95 mask, gown, gloves, and eye protection.

On 3/16/23 at 10:33 AM, the surveyor observed the Certified Nursing Aide (CNA) remove her used surgical mask, and took a new surgical mask from the PPE box outside Resident #133's room without performing hand hygiene. Three posted signs outside the resident's room showed that staff must perform hand hygiene before entering the resident's room in the Enhanced Barrier Precautions (an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission of MDRO's (or MultiDrug Resistant Organism; Bacteria that resist treatment with more than one antibiotic) that included [redacted], sequence of PPE use, and Contact Precautions.

At the same time, the surveyor observed the CNA donned (put on) an isolation gown, a new pair of gloves, and eye protection without performing hand hygiene. The surveyor observed the CNA take the new pair of gloves inside the CNAs uniform pocket. Prior to entering the resident's room, the surveyor asked the CNA for an interview.

During an interview of the surveyor with the CNA, the CNA informed the surveyor that she recently started to work at the facility a week ago. The

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F 880	Continued From page 67 CNA stated that it was the Staffing coordinator (SC) who provided in-service and education about infection control during her orientation that included hand hygiene and PPE use. The CNA further stated that she will go to the resident's room to check on the resident and provide direct care. At that same time, the CNA stated that she should have performed hand hygiene, before entering the resident's room, after removing her used surgical mask, and before donning PPE. She indicated that she should not store gloves in her uniform pocket due to infection control. Furthermore, the CNA was not aware that the resident was on contact precautions due to an infection. The CNA further stated that she knew that the resident was on Enhanced Barrier Precautions (EBP) due to the resident having a EX Order 26.4B1 but not aware of "any" EX Order 26.4B1. The surveyor then asked the CNA why there was a posted sign outside the resident's room for Contact Precautions, the CNA had no answer. The CNA acknowledged that she will have to talk to the Unit Manager and verify the information about Contact Precautions. On 3/16/23 at 10:40 AM, the surveyor notified the RCS of the above concerns. The RCS informed the surveyor that she will talk to the CNA immediately. On that same date and time, the surveyor notified the LPN/UM about the above findings. The LPN/UM informed the surveyor that Resident #133 was also on EBP. She further stated that residents with a break on their NJ Exec. Order 26:4.b.1 like	F 880		

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F 880	Continued From page 68 EX Order 26.4B1 and the presence of EX Order 26.4B1, EX Order 26.4B1 will be placed on EBP wherein the staff who will provide direct care were required to wear complete PPE that included mask, gown, gloves, and eye protection. The LPN/UM stated that the CNA should be aware of the precautions, followed the instructions outside the resident's door to perform hand hygiene, and not store gloves in her uniform pocket for infection control. 2. On 3/21/23 at 10:48 AM, the surveyor observed the Housekeeper (HK) wearing a surgical mask and gloves while standing in front of room EX Order 2. There was a posted sign outside the room for EBP which indicated that everyone must clean their hands, including before entering and when leaving the room. The HK did not perform hand hygiene after removing the used gloves and threw the used gloves in the garbage in the cleaning cart parked in front of the EX Order 2 room. On that same date and time, the HK walked around the cleaning cart outside the resident's room, placed the dustpan into the rack of the cleaning cart, took the mop, took a new pair of gloves, and then re-entered room EX Order 2 without performing hand hygiene. Inside the room, the surveyor observed the HK before entering the bathroom donned a new pair of gloves that was taken from the cleaning cart without performing hand hygiene. At that same time, the surveyor asked the HK for an interview outside the room. During an interview, the HK informed the surveyor that she's been working at the facility for two (2)	F 880		

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F 880	Continued From page 69 weeks now. The HK stated that she was provided an education about infection control, hand hygiene, and PPE use during her orientation but was unable to remember who provided that education. The HK further stated that she did not know what the posted sign for EBP was all about and that she had to perform hand hygiene before entering and after exiting the room. In addition, the HK was not aware that she had to perform hand hygiene in between the use of gloves, and the HK stated that she was not told at orientation about it. On 3/21/23 at 10:15 AM, the surveyor interviewed and notified the LPN/UM regarding the above findings for the HK. The LPN/UM stated that room [EX Order 26] was on EBP because Resident #195 had a EX Order 26.4B1 [redacted] access [EX Order 26.4B1] that required everyone to perform hand hygiene before entering and exiting the room and to use complete PPE when providing direct care. At that same time, the LPN/UM stated that the HK should have followed the posted sign outside the room and performed hand hygiene. The LPN/UM further stated that she will talk to the HK's Supervisor about the incident because it was the HK Supervisor who provides education about hand hygiene and infection control to the housekeeping staff. On 3/21/23 at 10:59 AM, the surveyor interviewed the Infection Preventionist Nurse (IPN). The IPN informed the surveyor that she was responsible for providing education to all staff which includes new employees,	F 880		

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F 880	Continued From page 70 housekeepers, and CNAs with regard to infection control which included hand hygiene and PPE use. On that same date and time, the surveyor notified the IPN of the above findings with CNA and the HK. The IPN stated that both the CNA and HK should have followed the posted signs outside the residents' door for EBP and Contact Precautions for hand hygiene and PPE use because both staff received education during their orientation. On 3/21/23 at 01:03 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, and RCS and were made aware of the above findings. A review of the facility's Handwashing/Hand Hygiene Policy with a revised date of 01/2023 that was provided by the DON included that the facility considers hand hygiene the primary means to prevent the spread of infections. After contact with objects in the immediate vicinity of the resident; after removing gloves; before and after entering isolation precaution settings; hand hygiene is the final step after removing and disposing of personal protective equipment. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. A review of the facility's EBP Policy and Procedure with an adapted date of 11/21/22 that was provided by the RCS included that EBP will be implemented (when Contact Precautions do	F 880		

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F 880	Continued From page 71 not otherwise apply) for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status and infection or colonization with an MDRO. Definitions: 1. Standard Precautions are a group of infection prevention practices that apply to the care of all residents, regardless of suspected or confirmed infection or colonization status. They are based on the principle that all blood, body fluids, secretions, and excretions may contain transmissible infectious agents. Proper selection and use of PPE, such as gowns and gloves, is one component of Standard Precautions, along with hand hygiene, environmental cleaning and disinfection, and reprocessing of reusable medical equipment; 2. Contact Precautions are one type of TBP that is used when pathogen transmission is not completely interrupted by Standard Precautions alone. Contact Precautions are intended to prevent transmission of infectious agents like MDROs, that are spread by direct or indirect contact with the resident or the resident's environment. On 3/22/23 at 11:04 AM, the survey team met with the RCS and the DON. The DON stated that the HK and the CNA should have sanitized their hands and followed the EBP and Contact Precautions with regard to hand hygiene and PPE use. NJAC 8:39-19.4 (a)(1)	F 880		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement	F 886		4/19/23

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F 886	Continued From page 72 and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.	F 886		

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F 886	Continued From page 73 §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on the interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to conduct COVID-19 testing for two (2) of two (2) residents (Residents#132 and #39) and 16 of 16 staff identified as close contacts following a staff member testing positive for COVID-19 in accordance with the facility's policies and Centers for Disease Control and Prevention (CDC) guidelines for infection control and to mitigate the spread of COVID-19 (a deadly, highly transmissible infectious disease). The deficient practice was evidence by the following: Reference: According to the CDC guidance titled "Interim Infection Prevention and Control	F 886	1-All residents and staff in close contact with the dietician were tested, surveillance was conducted for all residents and staff. 2-All residents who are exposed to COVID have the potential to be affected by this deficient practice. 3-IP/ Designee will conduct COVID testing based on Contact tracing. Testing will be performed Day 1, Day 3 and Day 5 for all exposed residents and staff. DON was educated regarding testing plan by Regional Clinical supervisor. 4-IP/ Designee will audit testing logs weekly x 4, Monthly x 2 and findings will be reported to quarterly QAPI meeting.	

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F 886	Continued From page 74 Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic" with an updated date of Sept. 23, 2022, included the following: Perform SARS-CoV-2 Viral Testing Asymptomatic patients with close contact with someone with SARS-CoV-2 infection should have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5 ... Nursing Homes ... Responding to a newly identified SARS-CoV-2-infected HCP [Healthcare Personnel] or resident When performing an outbreak response to a known case, facilities should always defer to the recommendations of the jurisdiction's public health authority. A single new case of SARS-CoV-2 infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed. The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. Perform testing for all residents and HCP [Healthcare Personnel] identified as close contacts or on the affected unit(s) if using a	F 886		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 75 broad-based approach, regardless of vaccination status. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5... On 3/13/23 at 8:45 AM, the Director of Nursing (DON) provided the contact tracing for a staff member, Dietician #1, who tested positive for COVID-19 on 3/07/23. The document was titled "COVID-19 Contact Tracing" [a facility assessment tool], dated 3/08/23, which included the following information: the staff member who tested positive, the last day the staff member worked, the day they tested positive, if the staff member had symptoms, if the staff member was vaccinated, and questions about potential exposure to COVID-19 prior to testing positive. The document indicated the staff member last worked at the facility on 3/06/23. On 3/20/23 at 11:21 AM, the surveyor interviewed the Infection Control Preventionist Nurse (ICPN), who stated that the DON conducted the contact tracing follow up for Dietician #1 and that she was not at work during the time to complete the contact tracing. The ICPN stated there was a binder where COVID-19 test results were kept and that residents' test results could be found in their medical records. On 03/20/23 at 11:55 AM, the surveyor interviewed the DON, in the presence of the Regional Director of Clinical Services (RDCS)	F 886		

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	315038	A. BUILDING _____ B. WING _____	C 04/04/2023

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F 886	Continued From page 76 about contact tracing and COVID-19 testing protocols. The DON stated when there was a known positive COVID-19 staff or resident, contact tracing was done to determine residents or staff who have been exposed to the positive COVID-19 individual. The DON further stated if they were unable to determine the individuals exposed from contact tracing, facility wide testing would be conducted. At that same time, the DON confirmed for the positive COVID-19 staff member on 3/07/23, contact tracing was conducted, exposed staff and residents identified were tested. The surveyor asked the DON the frequency of testing for exposed staff and residents identified as close contacts. The RDCS replied to the surveyor testing was to be conducted day 1 (one), 3 (three), and 5 (five) after an individual tested positive for COVID-19. The DON was asked to provide testing documentation for the identified close contacts from the contact tracing conducted. On 3/21/23 at 11:05 AM, the DON provided the surveyor with staff COVID-19 testing results for staff and residents tested after contact tracing was conducted for the COVID-19 positive staff member. A review of provided documents revealed a form titled, "COVID-19 POC Antigen Test" for each person identified through contact tracing, which included the resident/staff member's name, test kit information, date of the test, and the test results. The provided COVID-19 test results for the residents and staff members were dated 3/08/23 and then for the following week on 3/14/23 and 3/15/23.	F 886		

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F 886	Continued From page 77 On 3/23/23 at 9:50 AM, the surveyor interviewed Dietician #1 who tested [NJ Exec. Order 26:4.b.1] for [NJ Exec. Order 26:4.b.1] on [NJ Exec. Order 26:4.b.1]. Dietician #1 confirmed she last worked on 3/06/23 in the building. She stated on [NJ Exec. Order 26:4.b.1] she had NJ Exec. Order 26:4.b.1, did not come to the facility, and worked from home. Dietician #1 stated she went to the doctor on the same day and was tested for [NJ Exec. Order 26:4.b.1], which came back [NJ Exec. Order 26:4.b.1]. Dietician #1 stated she notified the DON who asked questions about which residents she had contact with, staff she had meetings with, when the symptoms started, and her potential source of exposure to [NJ Exec. Order 26:4.b.1]. Dietician #1 stated from [NJ Exec. Order 26:4.b.1] to [NJ Exec. Order 26:4.b.1] she worked from home and returned to work on [NJ Exec. Order 26:4.b.1] when she no longer had symptoms for more than 3 (three) days. On 3/23/23 at 10:09 AM, the surveyor interviewed the DON about infection control protocols, including contact tracing and COVID-19 testing. The DON stated the facility's infection control practice was based on the facility policies, along with CDC, state, and local guidelines. On that same date and time, the DON stated the dietician notified her on 3/08/23 that she had tested NJ Exec. Order 26:4.b.1. The DON stated she asked Dietician #1 about her symptoms, when her symptoms started, where she may have been exposed to [NJ Exec. Order 26:4.b.1], and close contacts she had in the facility. The DON stated Dietician #1 reported two residents (Resident #132 and Resident #39) as close contacts, but all the residents on the unit were tested as a precaution. The DON further stated staff who were in close contact with Dietician #1 were	F 886		

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F 886	Continued From page 78	F 886		

tested.

At that time, the surveyor asked the DON when the identified residents and staff were tested. The DON replied on 3/08/23 and the following week on 3/15/23. The surveyor then asked the DON about the facility's policy for testing of identified close contacts after a staff or resident tested positive for COVID-19. The DON replied once a week. The surveyor asked the DON about CDC guidelines for testing. The DON did not provide a verbal response to the question.

Furthermore, the DON stated all residents and staff were asymptomatic. The surveyor reviewed with the DON the facility's outbreak plan provided to the survey team, which revealed testing after a positive staff/resident and identification of close contacts indicated testing should be completed on day 1, 3 and 5. The DON stated she would look into providing further information to the surveyor and that the policy might not be up to date.

On 3/23/23 at 01:29 PM, the surveyor notified the DON, the Licensed Nursing Home Administrator (LNHA), the Regional Clinical Supervisor (RCS), and the Associate Regional Director about the above findings. The RCS acknowledged that the facility's testing policy was to be conducted on Day 1 (one), 3 (three) and 5 (five). The facility stated they would provide further information.

On 3/24/23 at 10:43 AM, the DON provided the list COVID-19 testing for residents and staff for the COVID-19 positive staff on 3/07/23. A review of the documents revealed testing for residents and staff identified as close contacts occurred on

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F 886	Continued From page 79 3/08/23, 3/14/23, and 3/15/23. No further documentation was provided regarding COVID-19 testing. On 3/27/23 at 12:27 PM, the surveyor spoke with the DON, in presence of RCS, who acknowledged the facility policy was to test identified resident and staff after a positive COVID case on day 1 (one), day 3 (three) and day 5 (five). The surveyor asked the DON who was responsible for contact tracing and COVID-19 testing. The DON stated the ICPN was responsible. The surveyor asked who was responsible for overseeing and ensuring that the ICPN was carrying out her responsibilities. The DON replied "I am....and the Administrator". A review of the facility's policy titled "Policy for Emergent Infectious Diseases (COVID-19) (Outbreak Plan V10)", with an updated date of 11/21/22, included the following: Test Based Prevention Strategy ... Asymptomatic patients with close contact with someone with SARS-CoV-2 infection ... Testing is recommended immediately (but not earlier than 24 hours after the exposure) and if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. Day 1 (where day of exposure is day 0), day 3, and day 5 .... Testing of Residents and Staff as follows: 2. If there is a new identified COVID-19 positive staff or resident in a facility that can identify close contacts, then: Residents: regardless of vaccination status, who had close contact with a COVID-19 individual must be tested.	F 886		

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F 886	Continued From page 80 Staff: regardless of vaccination status, that had a higher-risk exposure with a COVID-19 positive individual must be tested. Testing is completed on Day 1-Day 3-Day 5 or in accordance with the recommendations by local health department (LHD). N.J.A.C. 8:39-5.1(a), 19.4 (a)	F 886		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility provided documents, it was determined that the facility failed to provide a safe, sanitary, and comfortable environment for residents and staff for two (2) of two (2) facility areas observed for an environmental tour (laundry area and resident rooms) according to facility and standard of clinical practice. This deficient practice was evidenced by the following: On 3/16/23 at 11:49 AM, the surveyor toured the laundry area in the presence of the Laundry Service Director (LSD). The surveyor observed a commercial size trash can in the middle of the laundry room dryer area. The depth of water collection in the commercial trash can was approximately 5 (five) inches deep. The leak is in the folding and preparing laundered personal	F 921	1. No individual resident was identified in this alleged deficiency. The toilet bowl located in rooms C1 and C2 shared bathroom was cleaned by housekeeping director The faucet and the interior of the tub to rooms C1 and C2 were also cleaned by the housekeeping Director when bought to the attention of the surveyor. Contracted plumber scheduled to complete the leak in the laundry room. Laundry room clean linen and laundered personal resident clothing was temporarily moved to another clean room when bought to attention of the administrator by the surveyor. 2. All residents (resident rooms) have the potential to be affected, thus, the Administrator and Environmental Services Director conducted an audit of all resident rooms to evaluate each resident room for	5/10/23

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F 921	Continued From page 81 resident clothing area. There was a rack of clean clothes of residents that were not covered near the open ceiling tile with a leak. On that same date and time, the LSD stated that the leak in the laundry dryer area had been there since he was hired "[redacted]." The LSD further stated, "the trash receptacle is being used to collect the water from the ceiling leak." The LSD was unable to answer if it was clean water or dirty water that was leaking. During an interview on 3/16/23 at 12:00 PM with the surveyor with Maintenance Personnel (MP), the MP stated, "the leak is being caused by a resident's room on the C-Wing above. It has a cracked pipe behind a tiled wall and that the plumber is aware of." In an interview on 3/16/23 at 12:30 PM with the Head of Maintenance (HOM), Licensed Nursing Home Administrator (LNHA), and Regional LNHA, all acknowledged the leak in the laundry dryer room area and that it has been there since 12/25/22. The LNHA stated, "there is numerous email correspondence with the plumber and facility management." The HOM stated, "that there is no scheduled date for it to be fixed, the leak is confirmed to be a crack in an interior pipe and the water line is clean water not dirty." On that same date and time, the surveyor notified the Regional LNHA, LNHA, and HOM of the above findings. The Regional LNHA stated that the tub on the C-wing should be white in color and clean. The Regional LNHA further stated that the toilet should not be actively running with water.	F 921	cleanliness. Rooms found to be insufficiently cleaned have been re-cleaned. 3. The facilitys policy for Resident Room Cleaning, daily has been reviewed, and no changes are indicated. The Environmental Services Director has been educated making sure the laundry room stays clean . The Environmental Services Director has in serviced each member of the housekeeping staff on the correct protocol to clean a resident room properly and then had the housekeeper do a return demonstration verifying compliance with the facilitys policy and procedure on Resident Room Cleaning, daily. 4. The Environmental Services Director or designee will conduct Resident Room Environmental Reviews to confirm that resident rooms are being cleaned per facility policy as follows: Weekly rounding of laundry area weekly x 4 weeks, then biweekly x 1 monthly, then monthly. At least four random resident room reviews for each housekeeper per week for 30 days; and then at least three resident room reviews for each housekeeper per week for 30 days; and then at least two resident room reviews for each housekeeper per week thereafter. Should a concern be found, immediate corrective action will occur. Results of the monitoring and any corrective action will be discussed during the facilitys Quarterly QAPI meetings for a minimum of six months and continued thereafter with the monitoring increased or decreased until	

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F 921	Continued From page 82 On 3/16/23 at 12:49 PM, the surveyor observed in the presence of the LNHA and Regional LNHA, a shared bathroom between two resident rooms C1 and C2, the toilet continuously ran with water, with brown decolorization watermarks on the inside of the bowl. On that same date and time, the surveyor observed in the presence of the LNHA and Regional LNHA, a shared bathroom between two resident rooms C1 and C2, the faucet continuously leaked in the tub. The faucet had black-colored sediment flaking off the rim of the spout and the interior of the tub was discolored with brown and black streaks down the side and around the drain. On 3/27/23 at 12:00 PM, the surveyor interviewed the LNHA in the presence of other surveyors. The LNHA stated that there was no set schedule "yet" to fix the leak in the laundry room. A review of the provided email chain by the LNHA revealed that the concern leak in the laundry room started on 12/25/22 and the HOM was notified. Further review of the provided email chain response by the LNHA showed that the succeeding email was sent on 02/26/23 at 12:17 PM with a notification to HOM questioning the progress of the leak as it was still an issue. A review of the Personal Property policy, updated on 10/2022, provided by the DON, did not reflect the environment in its verbiage.	F 921	100% compliance is achieved.	

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F 921	Continued From page 83 A review of the Laundry Operations policy, revised on 6/2016, provided by the LNHA, did not reflect the environment in its verbiage. N.J.A.C. 8:39 -31.2 (e)	F 921		

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	060739	A. BUILDING: _____ B. WING _____	C 04/04/2023

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S 000	Initial Comments Complaint #'s NJ00152736, NJ00154046, NJ00154073, NJ00154662, NJ00156473 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 #'s NJ00154046, NJ00154073, NJ00154662 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 14 out of 14 Day Shifts reviewed. Findings include: Reference: New Jersey Department of Health	S 560	1) a) Center staffing ratios as required by NJDOH were communicated to staffing coordinator and all Nurse managers and supervisors to match ratios of 1:8 on day shift; 1:10 on evening shift and 1:14 on night shift b) Center staffing schedule ratios are developed, reviewed and posted two weeks prior to utilization to comply with required staffing ratios. c) Administrator, DON and Staffing Coordinator meet every morning to go over daily staffing sheets and look ahead	4/14/23

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

Electronically Signed | 04/14/23

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S 560	Continued From page 1 (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 02/19/23 to 02/25/23 and 02/26/23 to 03/04/23, the staffing to resident ratios that did not meet the minimum requirement of one (1) CNA to eight (8) residents for the day shift as documented below: The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -02/19/23 had 15 CNAs for 147 residents on the day shift, required 18 CNAs. -02/20/23 had 16 CNAs for 147 residents on the day shift, required 18 CNAs.	S 560	at copies of projected schedule of the next two weeks to ensure required staffing ratios. d) DON, Administrator and staffing coordinator meet weekly to review the 4 week master schedule to ensure facility has staff that meets the needs. 2) All residents have potential to be affected by the same deficit practice. 3) a) If staffing deficits on master staffing schedule are identified, Center will communicate all unfilled shifts to in-house staff for coverage. b) Center will continue external recruitment efforts to fill open positions and review and revise as necessary c) Center will maintain multiple contacts with staffing agencies to meet required staffing ratios and review as necessary d) Center will continue to offer bonus structure to incentivize staff to fill shifts if needed and revise as necessary. e) Center will continue to make efforts to retain staff by way of employee engagement events. 4) a) Center Staffing Coordinator will review projected census and staffing ratio to assure staffing compliance. b) Administrator, DON, and Staffing Coordinator will continue to meet daily to go over projected staffing to assure required staff ratios. c) If ratios are projected to not be met, Center will post openings for in-house staff as well as contact contracted agencies to maintain staffing compliance.	

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S 560	Continued From page 2 -02/21/23 had 16 CNAs for 147 residents on the day shift, required 18 CNAs. -02/22/23 had 17 CNAs for 147 residents on the day shift, required 18 CNAs. -02/23/23 had 16 CNAs for 147 residents on the day shift, required 18 CNAs. -02/24/23 had 17 CNAs for 152 residents on the day shift, required 19 CNAs. -02/25/23 had 18 CNAs for 151 residents on the day shift, required 19 CNAs. -02/26/23 had 16 CNAs for 151 residents on the day shift, required 19 CNAs. -02/27/23 had 16 CNAs for 148 residents on the day shift, required 18 CNAs. -02/28/23 had 15 CNAs for 147 residents on the day shift, required 18 CNAs. -03/01/23 had 17 CNAs for 147 residents on the day shift, required 18 CNAs. -03/02/23 had 15 CNAs for 147 residents on the day shift, required 18 CNAs. -03/03/23 had 15 CNAs for 147 residents on the day shift, required 18 CNAs. -03/04/23 had 16 CNAs for 147 residents on the day shift, required 18 CNAs. On 3/24/23 at 12:52 PM, the surveyor interviewed the Staffing Coordinator (SC) regarding staffing. The SC acknowledged that the facility was aware of the number of CNAs required but did not always have the required number of CNAs. On 3/28/23 at 12:03 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Regional LNHA, and the Director of Nursing for an exit conference. There was no additional information provided by the facility team.	S 560	d) DON/Staffing Coordinator will conduct daily staffing audits for two weeks and bi-weekly for two months. e) Results of the audits will be presented to the quarterly QAPI meetings for review and revision as deemed appropriate. 5) Administrator to monitor staffing post to see what happened and pre via measures listed above for ongoing compliance.	

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
315038 Y1	A. Building B. Wing Y2	5/25/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SUMMIT RIDGE	20 SUMMIT STREET WEST ORANGE, NJ 07052

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 F0658	Correction	ID Prefix F0689	Correction	ID Prefix F0693	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(g)(4)(5)	Completed
LSC	04/19/2023	LSC	04/19/2023	LSC	04/19/2023
ID Prefix F0695	Correction	ID Prefix F0755	Correction	ID Prefix F0759	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(f)(1)	Completed
LSC	04/19/2023	LSC	04/19/2023	LSC	04/19/2023
ID Prefix F0804	Correction	ID Prefix F0805	Correction	ID Prefix F0812	Correction
Reg. # 483.60(d)(1)(2)	Completed	Reg. # 483.60(d)(3)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	04/19/2023	LSC	04/19/2023	LSC	04/12/2023
ID Prefix F0814	Correction	ID Prefix F0880	Correction	ID Prefix F0886	Correction
Reg. # 483.60(i)(4)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.80 (h)(1)-(6)	Completed
LSC	04/12/2023	LSC	04/19/2023	LSC	04/19/2023
ID Prefix F0921	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.90(i)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/10/2023	LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
4/4/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060739 Y1	A. Building B. Wing Y2	5/25/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SUMMIT RIDGE	20 SUMMIT STREET WEST ORANGE, NJ 07052

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 04/14/2023	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	
4/4/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315038	A. BUILDING **01** B. WING _____	**04/04/2023**

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COMPLETE CARE AT SUMMIT RIDGE	**20 SUMMIT STREET** **WEST ORANGE, NJ 07052**

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K 000	INITIAL COMMENTS The nursing home building construction was stated to be 1970s with no current major renovations or noted additions. It is a two story building Type I (222) construction and is fully sprinklered. The outside 450 KW diesel generator does 100 % of the building. The building has resident rooms on floor #1 and has Physical Therapy in the basement along with all facility utilities.The building has 2 elevator devices. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is 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 utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The building will be starting cosmetic renovations in the future and will have to notify DCA and Health Department, if the cosmetic renovations are beyond the meaning of cosmetic. The Maintenance Director indicated new and added electrical fixtures will be installed, which will	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/14/2023

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K 000	Continued From page 1 require notification. The facility has 152 certified beds. At the time of the survey the census was 142. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on interviews and documentation review on 04/03/23, in the presence of the Maintenance Director (MD), Regional Facilities Manager (RFM) and Administrator (ADM), it was determined that the facility failed to inspect fire doors annually in accordance with S&C 17-38-LSC. This deficient practice was identified for 7 of 7 fire doors observed and was evidenced by the following: On 04/03/23 at approximately 9:45 AM, the surveyor asked the MD, RFM and ADM, to provide the annual testing requirements for fire door assemblies in accordance with NFPA 80 and NFPA 105. The MD stated that currently the facility did inspect fire doors and the last inspection was completed on 03/15/23. The MD provided a facility fire and egress door check list.	K 211	1. No individual resident was identified in this alleged deficiency. 2. All residents have the potential of being affected by this deficient practice. 3. Maintenance Director properly inspected all seven identified fire doors utilizing an approved NFPA form. 4. The Maintenance Director or designee will perform quarterly audits for two quarters to ensure all fire doors are within compliance. The results of audits will be reported to the quarterly QAPI Committee meeting for review and analysis. The administrator is responsible for ongoing compliance	4/5/23

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K 211	Continued From page 2 The document indicated only a check next to the fire door and did not include the required annual testing for fire door assemblies in accordance with NFPA 80 and NFPA 105- Standard for Smoke Doors Assemblies and other Opening Protectives. The MD confirmed that currently this was the only document on fire doors he could provide. No other information was provided. The MD, RFM and ADM were informed of the finding's at the Life Safety Code Exit Conference on 04/04/23. NJAC 8:39-31.1(c), 31.2(e) NFPA 80 and 105: Standard for fire doors assemblies and other opening protectives NFPA 101 2012 edition Life Safety Code 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* to 7.2.1.15.8 S&C 17-38-LSC NFPA 101- 2012 edition Life Safety Code 19.7.3 Maintenance of Means of Egress 19.7.3.1	K 211		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on	K 222		4/10/23

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K 222	Continued From page 3 each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING	K 222		

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K 222	Continued From page 4 ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interviews from 04/03/23, in the presence of the Maintenance Director (MD), Regional Facilities Manager (RFM) and Administrator (ADM), it was determined that the facility failed to ensure that the 15-second delayed egress feature on 3 of 8 exit discharge doors (with this feature) were labeled and would activate properly when tested in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.6.1. This deficient practice was evidenced by the following: 1. At 11:15 AM, the surveyor observed 2-sets of exit/egress doors by the Physical Therapy room. The inside set of glass doors were equipped with a delayed 15-second egress feature, The door was not labeled indicating this feature was installed with a sign "Push Until Alarm Sounds, Door Can Be Opened in 15-seconds". The outside set of doors were labeled with a sign. 2. At 12:45 PM, the surveyor observed that exit/egress door by Resident Room A-9 was equipped with a delayed 15-second egress feature, The door was not labeled indicating this	K 222	1. No individual residents were identified in this alleged deficiency. On 4/4/23, a temporary sign was put in place to read "Push Until Alarm Sounds, Door Can Be Opened in 15 seconds" on the two identified exit/egress doors until the permanent sign is received. The permanent sign for the egress door near the physical therapy room and resident room A-9 was ordered on 4/10/23. No further exit/egress door was identified to not alarm as stated on the label. The vendor was called in and activated /corrected the alarm for the egress doors near resident room B-4 for failure to alarm. 2. All residents have the potential of being affected by this deficient practice. All egress doors were inspected to ensure a 15 second delayed egress sign was in place on 4/4/23. All egress doors were inspected to ensure the proper alarm sounded upon exiting on 4/4/23. 3. Maintenance Staff were re-educated on ensuring that egress doors have the 15 second delayed egress sign on them and alarm upon exiting as per the label on 4/4/23.	

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K 222	Continued From page 5 feature was installed with a sign "Push Until Alarm Sounds, Door Can Be Opened in 15-seconds". 3. At 01:06 PM, the surveyor observed that the exit/egress door by resident room B-4 was equipped with a delayed 15-second egress feature, The door was labeled indicating this feature was installed with a sign "Push Until Alarm Sounds, Door Can Be Opened in 15-seconds". The MD activated this feature but the alarm did not sound as stated on the door label, the door did open in 15-seconds. An interview was conducted with the MD during the observations, where he confirmed the findings above. The MD, RFM and ADM were notified of the findings at the Life Safety Code exit conference on 04/04/23. NJAC 8:39-31.2(e) NFPA 101:2012 - 7.2.1.6.1.1(3)C	K 222	4. The QAPI Committee has directed the Maintenance Director or his designee to perform quarterly audits for two quarters to ensure 15-second egress signs are on the doors and they each properly alarm as per the label. The results of the audits will be reported to the QAPI team quarterly. Administrator is responsible for ongoing compliance.	
K 281 SS=F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview from 04/03/23 to 04/04/23, in the presence of facility	K 281	1. No individual resident was identified in this alleged deficiency.	5/2/23

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K 281	Continued From page 6 Maintenance Director (MD), Regional Facilities Manager (RFM) and Administrator (ADM), it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. The deficient practice affected 4 of 10 occupied/unoccupied access areas observed and was evidenced by the following: 1. On 04/03/23 at 12:12 PM, the surveyor in the presence of the MD, RFM and ADM, observed at the floor #1 entrance foyer by the receptionist desk, that 5-wall light switches shutoff all the fixtures.The area was not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention. 2. On 04/03/23 at 12:19 PM, the surveyor in the presence of the MD, RFM and ADM, observed at the floor #1 B-wing dining room, that the wall light switch shutoff all the lighting fixtures in the occupied room. The area was not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention. 3. On 04/03/23 at 12:40 PM, the surveyor in the presence of the MD, RFM and ADM, observed at the floor #1 Alcore-wing occupied dining/day room, that (1) one wall light switch shutoff all (8) eight lighting fixtures in the occupied room. The area was not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention.	K 281	2. All residents have the potential of being affected by this deficient practice. No further occupied/unoccupied access areas showed non-compliance with this practice. 3. Electrician was called and assessed the identified areas for installing emergency illumination that would operate along the means of egress on 4/13/23. Maintenance director was educated on all emergency lighting requirements. 4. The Maintenance Director or designee will perform quarterly audits for two quarters to ensure all occupied/unoccupied areas have proper working order emergency illumination. The results of audits will be reported to the quarterly QAPI Committee meeting for review and analysis. The administrator is responsible for ongoing compliance.	

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K 281	Continued From page 7 4. On 04/04/23 at 10:30 AM, the surveyor in the presence of the MD, RFM and ADM, observed in the main exit/egress stairwell that (1) one wall light switch in the basement shutoff all lighting fixtures in that area, leaving the stairwell dark. The stairwell was not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention. The MD, RFM and ADM, all confirmed the finding's at the time of observations. The MD, RFM and ADM were informed of these findings at the Life Safety Code survey exit conference on 04/04/23. NFPA 101-2012 edition Life Safety Code: 7.8 Illumination of Means of Egress: 7.8.1.3* (2) NJAC 8:39-31.2(e)	K 281		
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 04/04/23, in the presence of the Maintenance Director (MD), Regional Facilities Manager	K 293	1. No individual resident was identified in this alleged deficiency. The two (2) illuminated exit signs were posted to	4/13/23

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K 293	Continued From page 8 (RFM) and Administrator (ADM) it was determined that the facility failed to provide exit signs showing the direction of travel, in every location where the direction of travel to reach the nearest exit was not apparent in accordance with NFPA 101, 2012 Edition, Section 19.2.10, 19.2.10.1, 7.10.1.2, 7.10.2, 7.10.2.1. The deficient practice was identified for 4 of 20 exit signs observed and was evidenced by the following: 1). At 12:50 PM, the surveyor in the presence of the MD, RFM and ADM observed that the set of smoke doors by resident room A20 and A26 were not provided with any illuminated exit signs. 2). At 01:18 PM, the surveyor in the presence of the MD, RFM and ADM observed that the set of smoke doors by resident room's B5 and B16 were not provided with any illuminated exit signs. An interview was conducted with the MD during the observations and he stated and confirmed the findings above. The MD, RFM and ADM were informed of the findings at the Life Safety Code exit conference on 04/04/23. NFPA 101, 2012 Edition, Section 19.2.10, 19.2.10.1, 7.10.1.2, 7.10.2, 7.10.2.1. NJAC 8:39-31.2(e)	K 293	identify the exit path near the smoke doors by the resident□s room A20/A26 and B5/B16. 2. All residents have the potential of being affected by this deficient practice. All exit signs within the facility were checked to ensure compliance. 3. The Maintenance Director or designee will perform monthly audits on all illuminated exit signs to ensure proper compliance. 4. The corrective action will be monitored by the QAPI committee x 3 months. The maintenance director or designee will complete monthly checks. The results of audits will be reported to the quarterly QAPI Committee meeting for review and analysis. The administrator is responsible for ongoing compliance	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour	K 321		4/11/23

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K 321	Continued From page 9 fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 04/03/23, in the presence of the Maintenance Director (MD), Regional Facilities Manager (RFM) and Administrator (ADM), it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, labeled and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3,	K 321	1. No individual resident was identified in this alleged deficiency. On 4/11/23, an auto-closing device was installed by our MD to the four basements rooms labeled classroom, staffing service, recruiting and regional offices. The MD installed a fill plate to the basement laundry set of doors on 4/6/23. Maintenance director shaved down the top of the door so it no longer hit the frame. Basement kitchen	

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	315038	A. BUILDING **01** B. WING _____	**04/04/2023**

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COMPLETE CARE AT SUMMIT RIDGE	**20 SUMMIT STREET** **WEST ORANGE, NJ 07052**

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K 321	Continued From page 10 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was identified in 7 of 15 hazardous storage room doors observed and was evidenced by the following: 1). At 09:50 AM, the surveyor observed in the basement that the room identified as a classroom was now being used to store hazardous combustible cardboard boxes and the door was not provided with an auto-closing device. 2). At 10:10 AM. the surveyor observed in the basement that the room identified as staffing service was now being used to store hazardous combustible cardboard boxes and the door was not provided with an auto-closing device. 3). At 10:15 AM. the surveyor observed in the basement that the room identified as recruiting office was now being used to store hazardous combustible cardboard boxes and the door was not provided with an auto-closing device. 4). At 10:20 AM. the surveyor observed in the basement that the room identified as regional office was now being used to store hazardous combustible cardboard boxes and the door was not provided with an auto-closing device. 5). At 10:25 AM. the surveyor observed that the basement laundry set of doors (right-side) was missing hardware. The approximately 3" hole in the door was covered with clear tape. 6). At 10:30 AM. the surveyor observed that the basement storage room will not latch due to the door hitting	K 321	door was adjusted so in closes properly 2. All residents have the potential of being affected by this deficient practice. 3. The Maintenance Director or designee will perform weekly rounding of self-closure doors to ensure compliance. The maintenance director/designee through routine facility rounding weekly will identify those areas that require attention/repair. Identified areas will be addressed per priority and reviewed during regular scheduled stand-up meetings. 4. The Maintenance Director or designee will perform quarterly audits for two quarters to ensure all storage doors are within compliance. The results of audits will be reported to the quarterly QAPI Committee meeting for review and analysis. The administrator is responsible for ongoing compliance	

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K 321	Continued From page 11 the top of the frame. 7). At 10:45 AM. the surveyor observed that the basement kitchen dietary door will not latch and close properly leaving an approximately 1/2" opening The MD, RFM and ADM confirmed the finding's during the observations. The MD, RFM and ADM were informed of the finding's at the Life Safety exit conference on 04/04/23. NJAC 8:39-31.2 (e) Life Safety Code 101-2012 edition	K 321		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review on 04/03/23, in the presence of the Maintenance Director (MD) and Regional Facilities Manager (RFM), it was determined that the facility failed to ensure a). smoke detection sensitivity testing was completed of the facility smoke detectors in accordance with NFPA 72 (2010 edition) section 14.4.5.3.2. and .b) to	K 345	1. No individual resident was identified in this alleged deficiency. The facility□s fire alarm system semi-annual inspection was completed on March 10, 2023. The facility□s smoke detector sensitivity testing was scheduled. 2. All residents have the potential of being affected by this deficient practice.	4/10/23

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K 345	Continued From page 12 provide an updated fire alarm system & testing inspection report as per NFPA 70 & 72. The deficient practice was identified for 2 of 2 inspection reports and was evidenced by the following: 1). At 11:10 AM, the surveyor reviewed all related fire alarm documentation provided by the MD from the fire alarm vendor to determine if the sensitivity test was performed. The reports were dated 03/10/23 and 03/09/22. The reports provided did not indicate any information on the testing of the smoke detector's for sensitivity. An interview was conducted with the MD and RFM during document review who both indicated they were not sure if the required sensitivity test for the facility smoke detectors were performed. The MD and RFM contacted the facility fire alarm vendor to see if sensitivity report was performed, and no further documentation was provided. 2). At 11:40 AM, during document review the surveyor reviewed all fire alarm documentation from the fire alarm vendor. The inspection reports were dated 03/10/23 and 03/09/22. The fire alarm system utilizes sealed lead acid batteries as a backup and requires a semi-annual inspection as per NFPA 70 & 72. An interview was conducted with the MD during document review, and he stated that he was not sure why the new facility fire alarm vendor was conducting its inspections annually. He stated the previous fire alarm vendor was conducting its inspections on a semi-annual basis.	K 345	3. Maintenance Director/Designee was educated on ensuring all life safety inspections and certifications are completed as per federal guidelines Maintenance Director/Designee will review reports from vendors biweekly for appropriate approvals and repairs needed. 4. The corrective action will be monitored by the QAPI committee x 6 months. The findings of the audits will be reported to the quarterly QAPI Committee meeting for review and analysis. The administrator is responsible for ongoing compliance.	

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K 345	Continued From page 13 The MD, RFM and ADM were informed of the findings at the Life Safety Code Exit conference on 04/04/23. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 70, 72	K 345		
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 04/04/23, in the presence of the Maintenance Director (MD), Regional facilities Manager (RFM) and Administrator (ADM), it was determined that the facility failed to a.) provide complete sprinkler coverage as required by	K 351	1. No individual resident was identified in this alleged deficiency. An outside fire sprinkler contractor was contacted to install complete sprinkler coverage in the identified elevator and men□s restroom. Contracted with company to assess and	4/25/23

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K 351	Continued From page 14 Centers for Medicare/Medicaid Services regulation § 483.90(a) physical environment and b.) install the sprinkler system in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.3.5, 4.6.12 and 9.7, NFPA 13, 2012 Edition, Section 6.2.7.1, 8.1, 8.1.1, 8.5.2.1, 8.5.5, 8.5.5.2 8.15.7, 8.15.7.1 and 8.15.7.5. The lack of sprinkler coverage could delay or prevent the extinguishment of a fire in this area. This deficient practice was identified for 2 of 2 areas observed and was evidenced by the following: 1). At 10:21 AM, the surveyor, MD, RFM and ADM, observed in the approximately 10' x 6' elevator room under the stairwell for device #1, that no fire sprinkler coverage was observed. 2). At 11:52 AM, the surveyor, MD, RFM and ADM, observed in the entrance corridor across from the conference room, that the approximately 5' x 5' mens bathroom was observed to not have any fire sprinkler coverage. The MD, RFM and ADM all confirmed the finding's during the observation's and they stated when observed that the area's were not provided with any fire sprinkler protection. The MD,RFM and ADM, was informed of the finding's at the Life Safety Code exit conference on 04/04/23. NJAC 8:39-31.2(e) NFPA 13 standard for the installation of sprinkler systems.	K 351	install sprinkler coverage installation on April 25, 2023 2. All residents have the potential of being affected by this deficient practice. The MD inspected all other facility areas and did not find any further areas in non-compliance. 3. Maintenance Director/Designee was educated on ensuring all life safety inspections and certifications are completed as per federal guidelines The maintenance director/designee will continue to have an outside fire sprinkler contractor perform annual visual inspections of the facility□s fire sprinkler system to ensure compliance with NFPA requirements as part of the facility□s life safety program. 4. Maintenance/Designee will present the results of the quarterly visual inspection to the quarterly QAPI committee for further recommendations and will continue until QAPI team determine substantial compliance has been achieved. The administrator is responsible for ongoing compliance.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		4/25/23

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K 353	Continued From page 15 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on interview and record review conducted on 04/03/23 in the presence of the Maintenance Director (MD), Regional Facilities Manager (RFM), it was determined that the facility failed to ensure A). that their automatic sprinkler system was inspected/tested at the required 5-year interval in accordance with the National Fire Protection Association (NFPA) 25. B). that the fire sprinkler system was in optimal condition.This deficient practice was identified for 2 of 2 areas of the fire sprinkler system observed (1 document and 1 observation) and was evidenced by the following: A). At 10:05 AM, the surveyor reviewed the facility's automatic sprinkler system inspection reports dated: 03/29/23 (annual report), 12/18/22,	K 353	1. No individual resident was identified in this alleged deficiency. An outside fire sprinkler contractor was contacted to complete the facility□s 5-year automatic sprinkler system inspection. Completion of inspection scheduled. The required wrench to the sprinkler cabinet was replaced. 2. All residents have the potential of being affected by this deficient practice. 3. Maintenance Director/Designee will review life safety scheduled inspections monthly to avoid any missed inspections. Maintenance director was educated on all sprinkler system requirements. 4. The corrective action will be monitored by the QAPI committee x 6 months. The	

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K 353	Continued From page 16 09/15/23, 06/08/22, and 03/14/23. The provided reports did not indicate when the last 5-year internal obstruction investigation of the pipe was performed. The 03/29/23 annual report indicated under part-2 of the inspectors section: e. has internal assessment of the pipe (removing a flushing connection and one sprinkler head near the end branch line) performed in the last 5-years? if no conduct internal assessment? this section was marked N/A. The surveyor interviewed the Maintenance Director who acknowledged that he was not sure when the 5-year internal obstruction investigation of the fire sprinkler pipe was last conducted including the system guages. He indicated the current 5-year inspection could not be performed due to a main drain line malfunction. No further documentation was provided. NFPA 25 requires an internal inspection of the fire sprinkler system piping every five years; this needs to be conducted to inspect for the presence of foreign organic material that can cause obstructions to pipe and sprinklers. B). The surveyor, MD, RFM and ADM, observed in the fire sprinkler room, that the fire sprinkler cabinet with extra sprinkler heads was observed to not have the required wrench. An interview was conducted with the MD during the observation, where he stated he was not sure why the wrench was not in the cabinet. On 04/04/23 the MD, RFM and ADM were informed of the findings at the Life Safety Code exit conference.	K 353	findings of the audits will be reported to the quarterly QAPI Committee meeting for review and analysis. The administrator is responsible for ongoing compliance.	

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K 353	Continued From page 17 NJAC 8:39-31.1(c); 31.2(e) NFPA 25	K 353		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 363		4/17/23

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K 363	Continued From page 18 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 04/03/23, in the presence of the Maintenance Director (MD) Regional Facilities Manager (RFM) and Administrator (ADM), it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring room doors closed completely to properly confine fire and smoke products and to properly defend occupants in place was identified in 3 of 35 resident room doors observed and was evidenced by the following: During the building tour on 04/03/23 from 9:15 AM to 2:00 PM, the surveyor in the presence of the MD, RFM and ADM toured the facility and observed the following: Resident Room doors: A-14 door warped at the top 1/2" opening A-22 door will not latch missing hardware C-15 door did not close due to frame issue At the time of observations, the surveyor interviewed the MD and RFM, who both	K 363	1. No individual resident was identified in this alleged deficiency. The MD installed a latch plate to door A-22 on 4/6. The doors to A-14 and C-22 will be serviced by our construction company with a projected date of completion on 4/17. 2. All residents have the potential of being affected by this deficient practice. 3. Maintenance staff were re-educated on self-closing requirements. The MD/designee will ensure ongoing compliance by auditing all resident doors monthly for the next six months to ensure they are able to remain closed, have no impediment to closing, or latching, and would resist the passage of smoke. 4. The corrective action will be monitored by the QAPI committee x 6 months. The findings of the audits will be reported to the quarterly QAPI Committee meeting for review and analysis. The administrator is responsible for ongoing compliance.	

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K 363	Continued From page 19 confirmed the above findings. The MD, RFM and ADM were informed of the findings at the Life Safety Code exit conference on 04/04/23. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363		
K 522 SS=F	HVAC - Any Heating Device CFR(s): NFPA 101 HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 3/29/23 in the presence of the Maintenance Director (MD), Regional Facilities Manager (RFM) and Administrator (ADM), it was determined that the facility failed to provide combustion air from the outside to fuel fired HVAC units. This deficient practice was evidenced for 1 of 1 mechanical/boiler rooms by the following: At 10:18 AM, the surveyor observed in the basement mechanical/boiler room that an approximately 6' x 4' wall ventilation system was	K 522	1. No individual resident was identified in this alleged deficiency. Facility contacted HVAC contractor to initiate the installation of a fan/vent to provide a combustion air supply taken directly from outside. 2. All residents have the potential of being affected by this deficient practice. 3. Maintenance staff were re-educated on the requirement to have air from outside. Fan/Vent to be installed by Brandt's heating and cooling. The maintenance director/designee through routine facility	4/27/23

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K 522	Continued From page 20 in place. The system had a blue/yellow ladder leaning on the vents preventing them from opening. The system had an electrical motor that would open the vents when the mechanical/boiler room required make-up air as needed. The MD indicated the system was not in operation for a few years and inoperable at the time of observation. An interview was conducted with the MD during the observation where he stated that he was unsure about the operation of the make-up air system in the mechanical/boiler room as he was not sure when the system was operating correctly. The MD, RFM and ADM were informed of the finding at the LSC exit conference on 04/04/23. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.5.2.2 (1) (c) they shall be designed and installed to provide for complete separation of the combustible system from the atmosphere of the occupied area.	K 522	rounding weekly will identify those areas that require attention/repair. Identified areas will be addressed per priority and reviewed during regular scheduled stand-up meetings. 4. The results of these audits will be reviewed in the facility□s quarterly QAPI meetings for 6 months or until 100% compliance is achieved for three consecutive months. The QAPI committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a	K 712		4/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315038	A. BUILDING **01** B. WING _____	**04/04/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SUMMIT RIDGE	**20 SUMMIT STREET** **WEST ORANGE, NJ 07052**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 21 coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on interview and document review on 04/03/23, in the presence of the Maintenance Director (MD) and Regional Facilities Manager (RFM), it was determined that the facility failed to conduct fire drills with varying activation types and simulation of specific emergency fire conditions in accordance with NFPA 101, 2012 Edition, Section 19.7.1.4 through 19.7.1.7. This deficient practice was identified for 10 of 12 fire drills and was evidenced by the following: A review of the facility fire drill reports revealed method for the simulation of emergency fire conditions were not varied and specific to location for 10 of 12 fire drills. The drills should include type of alarm transmission: pull, smoke or page; specific location, what was the topic of the drill; and how do staff respond with no specific location? The reports identified the following: 03/15/23 smoke, lobby, code red 02/06/23 trash, room C-26, receptionist 01/28/23 trash, room B-15, receptionist 12/26/22 gas, kitchen, receptionist 11/20/22 blank, room ?, receptionist 10/30/22 electrical, nursing station, receptionist 09/24/22 electrical, C-wing nursing station, receptionist 08/27/22 trash, nursing station, receptionist 07/29/22 electrical, nursing station, receptionist 06/28/22 blank, nursing station, receptionist 05/26/22 gas, kitchen, receptionist 04/30/22 blank, B-wing, receptionist	K 712	1. No individual resident was identified in this alleged deficiency. The facility contracted company was called and scheduled to complete a proper fire drill on April 18, 2023. 2. All residents have the potential of being affected by this deficient practice. 3. Education provided to the maintenance to ensure proper variance of the fire drills. Prior to the monthly fire drill being conducted, the Maintenance Supervisor will meet with the Administrator/designee to discuss the timing and oversight of the drill. The Administrator/designee will assign the time of all fire drills and ensure proper activation of pull stations occurs. Upon completion of the drill, all documentation internally and from the monitoring company will be submitted to the administration for review and compliance. 4. Maintenance/Designee will present the results of the monthly fire drills to the quarterly QAPI committee meeting for further recommendations through the next two quarters. The administrator is responsible for ongoing compliance. Please include education/in service provied to responsible staff.	

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	315038	A. BUILDING **01** B. WING _____	**04/04/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SUMMIT RIDGE	**20 SUMMIT STREET** **WEST ORANGE, NJ 07052**

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K 712	Continued From page 22 An interview was conducted with the MD and RFM after documentation review, where they stated and confirmed the findings that current fire drills included the transmission of a fire alarm signal and simulation of emergency fire conditions were not identified, varied, and specific to areas for 10 of 12 fire drills documented on the forms. In addition, 11 of 12 alarms "location of interior fire alarm or code sounded" were all receptionist location. No fire alarm pull stations were activated including any smoke detector activations. The MD, RFM and ADM were informed of the finding's at the Life Safety Code exit conference on 04/04/23. NJAC 8:39-31.2(e)	K 712		
K 911 SS=D	NFPA 101 Life Safety Code 2012 edition 19.7.1.4 Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 04/04/23, in the presence of the Maintenance Director (MD), Regional Facilities Manager (RFM) and Administrator (ADM), it was determined that the facility failed to ensure that one 1 of 11 electrical	K 911	1. No individual resident was identified in this alleged deficiency. Hydrocollator was moved to an appropriate GFCI outlet. 2. All residents have the potential of being affected by this deficient practice.	4/5/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315038	A. BUILDING **01** B. WING _____	**04/04/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SUMMIT RIDGE	**20 SUMMIT STREET** **WEST ORANGE, NJ 07052**

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K 911	Continued From page 23 outlets located next to a water source (with-in 6 feet) were equipped with Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: At 11:10 AM. the surveyor observed in the Physical Therapy room office that a Hydrocollator was plugged into a non-GFCI outlet marked R03. The Hydrocollator is filled with water and has a heating element and is required to be protected by a GFCI (ground-fault circuit interrupter) to prevent a shock. The MD, RFM and ADM confirmed the finding at the time of observation. The MD, RFM and ADM were notified of the finding at the Life Safety Code exit conference on 04/04/23. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911	3. Maintenance Director/Designee was educated on ensuring all life safety inspections and certifications are completed as per federal guidelines The Maintenance Director or designee will perform weekly rounding of all outlets located next to a water source to ensure they are equipped with proper GFCI outlets. 4. The Maintenance Director or designee will present results of audits to the quarterly QAPI Committee meeting for review and analysis over the next three months and then quarterly for a year. The administrator is responsible for ongoing compliance.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are	K 923		4/6/23

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	315038	A. BUILDING **01** B. WING _____	**04/04/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 923	Continued From page 24 separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 04/04/23 in the presence of the Maintenance Director (MD) Regional Facilities Manager (RFM) and Administrator (ADM), it was determined that the facility failed to store cylinders of compressed oxygen in a manner that would protect the cylinders against tipping, rupture and damage in accordance with NFPA 99. This deficient practice was identified for 1 of 12	K 923	1. No individual resident was identified in this alleged deficiency. The portable oxygen cylinder was removed from the therapy equipment closet and placed in an oxygen holder in the oxygen room. In-servicing was completed for the therapy staff on proper oxygen cylinder storage. 2. All residents have the potential of being affected by this deficient practice.	

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K 923	Continued From page 25 portable oxygen cylinders observed and was evidenced by the following: At 10:58 AM, the surveyor, MD, RFM and ADM, observed in the Physical Therapy equipment closet that 1 of 1 portable oxygen cylinders were observed unsecured standing in the corner of the room. The unsecured cylinder was observed to be at 1500 PSI and stored unprotected against tipping, rupture and damage. An interview was conducted with the MD during the observation, he stated that the portable oxygen cylinder observed, must be secured from tipping, rupture and damage at all times in the facility. The MD, RFM and ADM were informed of the finding at the Life Safety Code exit conference on 04/04/23. NJAC 8:39-31.2(e) NFPA 99	K 923	3. The Maintenance Director or designee will perform weekly rounding of all facility areas to ensure the oxygen cylinders are properly stored in their holders. 4. The Maintenance Director or designee will present results of audits to the quarterly QAPI Committee meeting for review and analysis over the next three months and then quarterly for a year. The administrator is responsible for ongoing compliance.	

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
315038 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/25/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SUMMIT RIDGE	20 SUMMIT STREET WEST ORANGE, NJ 07052

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0211	04/05/2023	LSC K0222	04/10/2023	LSC K0281	05/02/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0293	04/13/2023	LSC K0321	04/11/2023	LSC K0345	04/10/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	04/25/2023	LSC K0353	04/25/2023	LSC K0363	04/17/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0522	04/27/2023	LSC K0712	04/18/2023	LSC K0911	04/05/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0923	04/06/2023	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	
4/4/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO