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	315174	A. BUILDING _____ B. WING _____	09/20/2022

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS SURVEY DATE: 09/20/22 CENSUS: 212 SAMPLE SIZE: 38 An Onsite Revisit 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 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F 584		10/31/22

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

Electronically Signed | 10/14/2022

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F 584	Continued From page 1 the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other pertinent facility documentation, it was determined the facility failed to maintain an orderly and sanitary environment by leaving garbage bags, a spill, gowns, linens, and unpackaged incontinence briefs in the hallway of [redacted] unit. The deficient practice was identified for 1 of 4 wings [redacted] Wing) on the [redacted] and was evidenced by the following: On 8/31/22 at 10:26 AM, in the [redacted] Wing, the surveyor observed two trash bags filled with garbage unattended on the floor. The surveyor	F 584	Element 1. The following actions were and will be taken: 1. The 2 garbage bags were placed in the appropriate receptacle. 2. The Linen left on the top of the linen cart were removed. 3. The spilled liquid was cleaned up by staff 4. The unpacked diapers were placed in the appropriate storage area.	

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F 584	Continued From page 2 also observed linen with unpackaged incontinence briefs left on top of a plastic supply bin in the hallway. Further, the surveyor observed another opened bag of incontinence briefs on a chair in the hallway. On 09/01/22 at 9:54 AM, the surveyor observed a red trash bin used for personal protective equipment (PPE) (equipment such as, but not limited to gowns, gloves, and eye protection worn to create a barrier from pathogens) overflowing with pieces of used gowns. The surveyor also observed an opened package of incontinence briefs on a chair and towels left on a wheelchair in the hallway. On 09/02/22 at 12:10 PM, the surveyor observed two trash bags filled with used gowns unattended on the floor in the hallway. On 09/06/22 at 11:46 AM, the surveyor observed unpackaged incontinence briefs and linen left on top of a bedside table located in the hallway. On 09/07/22 at 10:10 AM, the surveyor observed spilled liquid on the floor of the hallway. On 09/12/22 at 9:11 AM, during an interview with the surveyor, the Director of Housekeeping confirmed after reviewing the surveyor's evidence that garbage bags should not be left in the hallway on the floor or tied to the railing by stating, "That's not good." He further confirmed that the spill should have been attended to with a "wet floor" sign and a notification to housekeeping. On 09/12/22 at 1:27 PM, during an interview with	F 584	Element 2. No specific residents are known to have been negatively affected by the deficient practice however, all residents have the potential to be affected by the deficient practice. The facility completed an audit of all hallways to identify any additional areas of non-compliance. Element 3: The Administrator, Director of Nursing, and Director of Housekeeping reviewed the policy on Disinfecting/ Cleaning Environmental Surfaces, and Linen Storage were reviewed and determined the facility to be compliance with state and federal guidelines. A policy was developed on trash storage and trash bag disposal to be in compliance with state and federal guidelines. The staff is being educated on maintaining an orderly and sanitary environment specifically focusing on: trash sorage and disposal, cleaning spills, appropriate storage of gowns, appropriate storage of linens, and appropriate storage of incontinence briefs. A copy of the lesson plan and attendance will be filed for reference and validation. Element 4: An audit sheet was developed for observations during environmental	

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F 584	Continued From page 3 the surveyor, the Director of Nursing confirmed linen and unpackaged incontinence briefs should not be left in the hallway. On 09/13/22 at 10:53 AM, during an interview with the surveyor, the Regional Director of Clinical Services stated that linen and unpackaged incontinent briefs should be stored appropriately due to contamination. A review of the facility policy titled "Disinfecting/Cleaning Environmental Surfaces" with a revised date of 3/2022 revealed under "Procedure" number 9; "Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled." A review of the facility policy titled, "Linen Storage" revealed under "Procedure" number 2; "Facility will supply units with a par amount of laundry that is stored in a designated closet on each unit." The facility was unable to provide a policy for the storage of full trash bags.	F 584	rounds. The audit sheet will monitor the disposal of trash, storage of linen and incontinence briefs, and unattended to spills. Audits will be completed daily by the administrator/ designee x 1 week and then weekly x 4 weeks, and monthly until compliance is met. The results of these audits will be presented at monthly QAPI. Responsible Party: Administrator	
F 609 SS=D	N.J.A.C. 8:39-31.4(a) Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown	F 609		10/31/22

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F 609	Continued From page 4 source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH) a.) an allegation of physical and verbal abuse for 1 of 1 resident (Resident #134) reviewed for abuse and b.) an unwitnessed event resulting in [NJ Exec. Order 26:4.b.1] for 1 of 3 residents (Resident #41) reviewed for [redacted] This deficient practice was evidenced by the following: 1. On 09/01/22, the surveyor requested the personnel files for five employees hired within the last four months.	F 609	Element 1: Resident #134 was evaluated by nursing and social work with no recollection of incident and [Ex.Order 26.4(b)(1)] from reported incident. Resident #41 sustained a [EX Order 26.4B1] that was [EX Order 26.4B1] in the [EX Order 26.4B1] Facility investigation did not reveal any evidence of abuse. Element 2: Medical records were reviewed for 6 months of progress notes that would indicate a potential for abuse with no	

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F 609	Continued From page 5 Review of Certified Nursing Assistant (CNA) #8's personnel file revealed an Employee Warning Record (EWR), dated [redacted] that included a conduct violation with a violation date of [redacted] at 11:00 AM in Resident #134's room. Further review of the EWR revealed "[Resident #134] stated that [CNA #8] was mean and degrading. CNA called resident nasty and refused to place resident on toilet, and pulled resident's arm and [Resident #134] was scared that CNA was going to break [his/her] arm. Resident was in tears and had to be calmed down by staff." The EWR was signed by the Director of Nursing (DON). The surveyor requested the Facility Reported Incidents (FRI) for [redacted]. The facility was unable to provide the FRI for Resident #134's allegation of [redacted] On 09/06/22 at 10:03 AM, the surveyor observed Resident #134 lying in bed. When asked about the allegation against CNA #8, the resident was unable to recall any specific details. According to the Admission Record, Resident #134 was admitted with diagnoses which included, but were not limited to, [redacted] Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], revealed the resident had a Brief Interview for Mental Status (BIMS) of [redacted] indicating the resident's [redacted]. Further review of the MDS	F 609	indication of an identifiable reportable event identified for any other resident. Employee files were reviewed for disciplines of staff that would indicate an allegation of abuse, neglect, mistreatment, or misappropriation. There were no allegations identified. The medical record was reviewed for significant injuries of with no known origin. There was no other event identified. Element 3: The policy on abuse, significant injuries of unknown origin in regards to timely reporting was reviewed by administration and determined to be in compliance with state and federal guidelines. The Administrator and Director of Nursing were educated by the Regional Director of Clinical Services regarding NJDOH reporting requirements specifically focusing on: abuse allegations and injuries of unknown origin. Staff educator / designee will educate all staff on abuse allegations and significant injury of unknown origin with regard to timely reporting to the NJDOH. A lesson plan and sign in logs will be kept on file for validation. Element 4: The administrator will conduct audits of	

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F 609	Continued From page 6 revealed the resident did [NJ Exec. Order 26:4.b.1] [redacted] with bed mobility, transfers, locomotion, dressing, toilet use, and personal hygiene. Review of the Care Plan included a focus of "Resident is at risk for misappropriation, neglect, abuse and/or exploitation r/t [related to] ltc [Long-Term Care]," dated [EX Order 26.4B1], with interventions to "investigate all allegations of abuse and neglect promptly," and, "Report to MD and initiate assessment." Further review of the Care Plan included a focus of "Resident [NJ Exec. Order 26:4.b] [redacted] ... [EX Order 26] made allegation against C.N.A.; follow up the following day revealed the resident had no recollection of the allegation," created on [EX Order 26.4B1] by the Regional Director of Clinical Services. Review of the Progress Notes, dated [EX Order 26.4B1] through [EX Order 26.4B1] did not include any mention of the resident's allegation, assessment of the resident, or notification of the allegation to the NJDOH. Review of the Assessments section in the Electronic Medical Record (EMR) revealed an Initial Event Documentation, dated [EX Order 26.4B1], which included, "Date/Time of Event OR When Nursing Became Aware Of Event: [EX Order 26.4B1] 11:00" and, "UM [Unit Manager] was made aware by resident's nurse that resident wanted to complain about [his/her] aid. UM asked nurse what happened and the nurse stated that the resident felt disrespected and embarrassed by [his/her] care. When UM went in to talk to resident, resident stated that nothing happened and didn't appear to be upset about anything."	F 609	employee written warnings for any indication of an abuse allegation and timely reporting to the NJDOH weekly x4 weeks; then monthly until compliance is met at a minimum of 6 months. The results of these audits will be submitted at monthly QAPI. The DON/ designee will audit falls for any evidence of significant injury that would be considered an injury of unknown origin and timely reporting to the NJDOH. The audits will be conducted weekly x 4 weeks and then monthly until compliance is met for a minimum of 6 months. The results of these audits will be submitted at monthly QAPI. Responsible Party: Administrator	

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F 609	Continued From page 7 Further review of the Assessments section of the EMR included a [NJ Exec. Order 26:4.b.1], dated [EX Order 26.4B1], which revealed there were no new [NJ Exec. Order]. There were no assessments that included a [NJ Exec. Order 26:4.b.1] of the resident for [EX Order 26.4B1]. During an interview with the surveyor on 09/06/22 at 11:00 AM, the DON verified there were no additional FRIs for EX Order 26.4B1 other than the ones previously provided to the surveyor. When asked about the abuse allegation made against CNA #8 in the EWR, the DON stated she was unfamiliar with the allegation and would have to speak to the supervisor who completed the EWR. The DON further stated that she was unsure if the allegation was reported to the NJDOH. At 12:45 PM, the DON provided the surveyor with a "soft file" for Resident #134's allegation that was stored in Licensed Practical Nurse/Unit Manager (LPN/UM) #3's office. Review of the soft file included a Full QA Report, with an incident date/time of "Sunday, [NJ Exec. Order 26:4.b] ." Further review of the report revealed it included the same statement made by LPN/UM #3 in the Initial Event Documentation. The report also included a witness statement from the Infection Control Preventionist (ICP) of "I was making I.C. [Infection Control] rounds when I overheard [CNA #8] from resident's room in an unprofessional tone. I removed CNA from resident's room and spoke to her regarding her tone." According to the report, the DON and the Licensed Nursing Home Administrator (LNHA)	F 609		

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were made aware of the allegation on [NJ Exec. Order 26:4.b.1] at 11:15 AM. The report did not include a statement from Resident #134's assigned nurse or any mention of notifying the NJDOH.

During an interview with the surveyor on 09/06/22 at 1:12 PM, the Registered Nurse/Unit Manager (RN/UM) explained the process for an allegation of abuse included assessing the resident for changes in skin condition and pain, collecting statements from staff and residents, notifying the supervisor, physician, and resident's representative, and filling out an incident report. The RN/UM further stated she was the current UM for Resident #134, and that the resident knows his/her name, but is [EX Order 26.4B1]

During an interview with the surveyor on 09/06/22 at 1:21 PM, LPN/UM #1 explained the process for an allegation of abuse included starting the investigation, gathering statements, notifying the DON, and reporting the allegation to the NJDOH. LPN/UM #1 further stated that she was the UM for Resident #134 at the end of July 2022, and that it was "hard to tell if [he/she] was [EX Order 26.4B1]."

During an interview with the surveyor on 09/06/22 at 1:39 PM, LPN/UM #3 explained the process for an allegation of abuse included interviewing the resident, assessing the resident for injury, ensuring the resident is safe, interviewing staff, documenting in the Initial Event Documentation or the progress notes, and notifying the DON to determine if it was a FRI. When asked about the EWR completed by LPN/UM #3 for CNA #8, LPN/UM #3 stated she was the supervisor on [EX Order 26.4B1] when Resident

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F 609	Continued From page 9 #134 stated CNA #8 '[redacted] [him/her]." LPN/UM #3 further stated that she [redacted] that CNA #8 [redacted] [him/her] [redacted]," but that there were no [redacted] issues, [redacted], or change in [redacted]. LPN/UM #3 then stated she notified the DON that same day and completed the EWR for CNA #8. She also stated that when she interviewed Resident #134 the following day, the resident was unable to recall the allegation. During an interview with the surveyor on 09/06/22 at 1:56 PM, the ICP explained the process for an allegation of abuse included completing an investigation, collecting statements, and notifying the NJDOH within two hours. When asked about the abuse allegation made by Resident #134, the ICP stated that she was performing rounds when she "happened to walk up on the conversation" between Resident #134 and CNA #8. The ICP stated that the CNA was speaking unprofessionally to the resident and that the ICP spoke to CNA #8 about professionalism. When asked if the ICP was present in the Resident #134's room the entire time CNA #8 was performing care, the ICP stated CNA #8 was already in the room when she entered and that she did not witness the care performed by the CNA in its entirety. During a telephone interview with the surveyor on 09/08/22 at 10:35 AM, CNA #8 stated that on the day of Resident #134's allegation, she was sent home and allowed to return to work two days later. The CNA stated the alleged incident did not occur and was unaware of the results of the investigation.	F 609		

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During a telephone interview with the surveyor on 09/08/22 at 11:22 AM, the Agency Nurse assigned to Resident #134 on [NJ Exec. Order 26:4.b.1] stated that she entered Resident #134's room and the resident [EX Order 26.4B1]. When the Agency Nurse asked if the resident was going to eat [his/her] meal, the resident stated [he/she] wanted to speak to a supervisor. The Agency Nurse further stated that the resident did not go into any details about the complaint, and that she notified LPN/UM #3 who was the supervisor for that shift.

During a follow-up interview with the surveyor on 09/08/22 at 12:18 PM, the ICP stated she could not recall specifically what the CNA said to the resident, but that the CNA's tone was "louder than normal," and the resident perceived the CNA's speech "as a rough manner."

During a follow-up interview with the surveyor on 09/09/22 at 12:15 PM, the DON explained the process for an allegation of abuse included separating the involved parties, interviewing anyone present including staff and residents, obtaining written statements that are signed, assessing the resident, notifying the resident's family and physician, notifying the NJDOH within two hours, completing an investigation report, and notifying the NJDOH of the conclusion to the investigation. When asked about the abuse allegation made by Resident #134, the DON stated that she was notified of the incident on [NJ Exec. Order 26:4.b.1] and was told that the resident reported that CNA #8 was rude, aggressive, and pulled the resident's [EX Order 26]. The DON further stated that she instructed LPN/UM #3 to obtain statements and send CNA #8 home pending the

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investigation. The DON then stated that the abuse allegation was not reported to the NJDOH because the ICP witnessed the incident and stated it did not occur. However, the DON stated that if the alleged incident was not witnessed in its entirety, the allegation should have been reported to the NJDOH. When asked about the conclusion to the allegation investigation, the DON stated she typed up a conclusion, emailed it to the NJDOH, and kept a copy in her office.

At that time, the surveyor accompanied the DON to her office to obtain a copy of the conclusion to the allegation investigation. The DON was unable to locate the conclusion in her office and was also unable to locate any email sent to the NJDOH after 07/29/22. The DON stated, "If I didn't report it, I wouldn't have emailed the conclusion to the NJDOH."

On 09/13/22, the facility provided a copy of a Grievance Form related to Resident #134's allegation of abuse, dated EX Order 26.4B1, which included, "Resident had alleged on EX Order 26.4B1 that a CNA was rough with [him/her] while getting care. Resident stated that CNA nasty to [him/her] and [he/she] felt degraded," and was signed by LPN/UM #3. Further review of the Grievance Form included, "To ensure abuse and neglect are ruled out promptly, does this grievance require further investigation? Yes," and, "Was the Department of Health and/or local police notified? No." The Grievance Form was signed by the LNHA on EX Order 26.4B1.

During an interview with the surveyor on 09/13/22 at 11:31 AM, the LNHA stated that he was unable to recall when he was notified of the

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alleged abuse between Resident #134 and CNA #8. The LNHA further stated that the DON was responsible for completing the investigation, but he was unable to recall when the results of the investigation were reported to him. The LNHA also stated that he did not believe the allegation or the conclusion to the investigation were reported to the NJDOH, but that "any allegation of abuse should be reported."

Review of the facility's Abuse policy, revised 02/2022, included, "Allegations/reports of suspected abuse, neglect, mistreatment, distortion, injury of unknown etiology or misappropriation shall be promptly and thoroughly investigated by facility management," and, "The Shift Supervisor/Charge Nurse is identified as responsible for immediate initiation of the reporting process upon receipt of the allegation." Further review of the policy revealed, "Notify the local law enforcement and appropriate State Agency(s) immediately (no later than 2 hours after allegation/identification of allegation) by Agency's designated process after identification of alleged/suspected incident," and, "Report results of investigation to the proper authorities as required by State law.

2. On 08/30/22 at 11:12 AM the surveyor, while on the initial tour of the facility, observed Resident #41 in his/her room. Resident #41 had EX Order 26.4B1 and was observed to be lying in bed. Resident #41 complained of EX Order 26.4B1 his/her EX Order. The surveyor questioned Resident #41 how this event occurred, but he/she was not sure how.

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F 609	Continued From page 13 Resident #41 stated, "EX Order 26.4B1." According to the most recent Admission Record, Resident 41 was admitted to the facility with the following, but not limited to, diagnoses: EX Order 26.4B1 Review of the comprehensive Significant Change MDS dated EX Order 26.4B1, revealed that Resident #41 had a BIMS score of EX Order 5 indicating NJ Exec. Order 26:4 According to Section Resident #41 required NJ Exec. Order 26:4.b.1 of staff with NJ Exec. Order 26:4.b.1 and was NJ Exec. Order 26:4.b.1 of staff NJ Exec. Order 26:4.b.1. Section revealed that Resident #41 had a history; and according to Section P, Resident #41 had no restraints or alarms in place. Review of the comprehensive interdisciplinary care plan revealed Resident #41 had a "Focus" of "is at risk for EX Order 26.4B1 NJ Exec. Order 26:4.b.1." On 09/01/22, the surveyor reviewed the Electronic Medical Record. A progress note dated EX Order 26.4B1 revealed that Resident #41 at EX Order 26.4B1 "was found by CNA EX Order 26.4B1 beside [his/her] bed. Resident was in a semi EX Order 26.4B with [his/her] back and head against bed and legs turned to the left in front of [him/her]. Resident denies EX Order 26.4B [his/her] EX Order 26 but stated [his/her] EX Order 26.4B1 The progress notes further revealed that Resident #41 was sent out to the	F 609		

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EX Order 26.4B1 to be evaluated, and Resident #41 was "admitted to EX Order 26.4B1 with dx [diagnosis] of EX Order 26.4B1]."

On 09/07/22 at 10:36 AM, the Corporate Assistant Director of Nursing provided the surveyor with Resident #41's Full QA Report, dated 05/27/22. The nurses' Investigative Statements revealed the following: "Resident was found by CNA EX Order 26.4B1 Resident was in a semi sitting position with [his/her] back and head against the bed and EX Order 26 turned to the left in front of [him/her]. Resident denies EX Order 26.4B1 but stated [his/her] EX Order 26.4B1 . According to the CNA Investigative Statement, "While doing rounds resident was observed EX Order 26.4B1 beside [his/her] bed in room. Notified nurse immediately." The QA Report concluded that "Resident displays EX Order 26 EX Order 26.4B1 . Resident was observed EX Order 26.4B EX Order 26.4B1 beside bed and c/o EX Order 26.4B1 . MD ordered for resident to be sent to NJ Exec. H EX Order 26.4B1] for evaluation and treatment. This investigation revealed that this occurrence was unavoidable due to clinical condition and noncompliance. There is no reason to believe that any alleged abuse, neglect, mistreatment, or misappropriation has occurred."

On 09/07/22 at 11:17 AM, the surveyor conducted an interview with the facility DON. The surveyor questioned the facility DON if she had reported Resident #41's EX Order 26.4B1 incident as a reportable to the NJDOH. The DON responded, "As far as I know it is not a reportable event. [He/she] NJ Exec. C " The surveyor then explained that the resident had a EX Order 26.4B1 that was unwitnessed by facility staff, how did the facility

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know that the resident [NJ Exec. O] if it was unwitnessed. The DON replied, "Looking at the report, I can see what you mean." The surveyor clarified, and the DON confirmed, that the CNA on duty that found Resident #41 [EX Order 26.4B1] did not witness Resident #41 [EX Order] The CNA "found" the resident [EX Order 26.4B1]. The surveyor asked the DON who was responsible for reporting unwitnessed events that resulted in [NJ Exec. Order 26:4.b.1] to the NJDOH. The DON responded, " I am the one responsible for reporting a reportable event if one should occur. The surveyor questioned the DON if she was aware of the time frame for reporting a reportable event that occurred in the facility. The DON explained, "The time frame is that I should call the state within 1 hour. I also report for weekends and off shifts. It has to be reported within 1 hour." The DON then agreed that she did not report the event because the facility assumed that the resident [NJ Exec. Order 26:4.b.1] it was an unwitnessed event.

On 09/12/22 at 01:34 PM, the surveyors conducted an interview with the facility DON, Licensed Nursing Home Administrator (LNHA), and Regional Director of Clinical Services. The surveyor again questioned the DON if the unwitnessed event that occurred with Resident #41 on EX Order 26.4B1 should be considered a reportable event and should have been reported to the NJDOH. The DON stated, "If it was unwitnessed, yes, it's a reportable event." The surveyor questioned why staff did not ask Resident #41 what happened during the nursing assessment. The DON stated, "I'm not sure if the NJ Exec. Order 26:4.b.1 what happened."

The surveyor reviewed the facility policy titled

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F 609	Continued From page 16 Investigation - Injuries of Unknown Etiology, Policy No: CI-3, last date revised: 11/2021. The following was revealed under the heading POLICY: "An investigation of all injuries of unknown etiology (including bruises, abrasions, and injuries of unknown source) will be conducted by an individual appointed by the Administrator, to ensure that the safety of our residents has not been jeopardized, and to investigate any potential abuse or neglect." According to the PROCEDURE: 3. "Injury of Unknown Etiology" is defined as an injury that meets both of the following conditions: a. The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and b. The injury is suspicious because of: the extent of the injury; or the location of the injury) e.g., the injury is located in an area not generally vulnerable to trauma); or the number of injuries observed at one particular point in time; or the incidence of injuries over time. The surveyor reviewed the facility policy titled Investigations, How to Conduct, POLICY NO: CI-1, last date revised: 11/2021. The policy failed to address that a resident that suffers an unwitnessed event with a major injury is a reportable event. NJAC 8:39-9.4 (f)	F 609		
F 610	Investigate/Prevent/Correct Alleged Violation	F 610		10/31/22

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F 610 SS=D	Continued From page 17 CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to thoroughly investigate an allegation of physical and verbal abuse for 1 of 1 resident (Resident #134) reviewed for abuse. This deficient practice was evidenced by the following: On 09/01/22, the surveyor requested the personnel files for five employees hired within the last four months. Review of Certified Nursing Assistant (CNA) #8's personnel file revealed an Employee Warning Record (EWR), dated 08/02/22, that included a	F 610	Element 1: Resident #134 was evaluated by nursing and social work with no recollection of incident and Ex.Order 26.4(b)(1) from reported incident. There was a grievance and staff statements that unsubstantiated abuse. An incident and accident report was completed with no evidence of abuse noted. 1:1 education was done with the Director of Nursing, IPC, Unit Manager #1 and Unit Manager #3 regarding abuse, neglect and mistreatment, conducting a comprehensive investigation and grievance management.	

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F 610	Continued From page 18 conduct violation with a violation date of 07/31/22 at 11:00 AM in Resident #134's room. Further review of the EWR revealed "[Resident #134] stated that [CNA #8] was mean and degrading. CNA called resident nasty and refused to place resident on toilet, and pulled resident's [redacted] and [Resident #134] was scared that CNA was going to [redacted]. Resident was in tears and had to be calmed down by staff." The EWR was signed by the Director of Nursing (DON). On 09/06/22 at 10:03 AM, the surveyor observed Resident #134 lying in bed. When asked about the allegation against CNA #8, the resident was unable to recall any specific details. According to the Admission Record, Resident #134 was admitted with diagnoses which included, but were not limited to, [redacted] Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], revealed the resident had a Brief Interview for Mental Status of '[redacted]' indicating the resident's [redacted] Further review of the MDS revealed the resident did [redacted] and required [redacted] bed mobility, transfers, locomotion, dressing, toilet use, and personal hygiene. Review of the Care Plan included a focus of "Resident is at risk for misappropriation, neglect, abuse and/or exploitation r/t [related to] ltc [Long-Term Care]," dated 01/21/22, with interventions to "investigate all allegations of	F 610	Element 2: Medical records were reviewed for 6 months of progress notes that would indicate a potential for abuse with no indication of an identifiable reportable event identified for any other resident. Employee files were reviewed for disciplines of staff that would indicate an allegation of abuse, neglect, mistreatment, or misappropriation. Resident grievances for the last 6 months were reviewed for completeness of thorough investigation, completion of investigation summary and timely update of resident care plan. There were no uninvestigated allegations identified and no other resident was identified. Element 3: The policies "Abuse" "Accidents and Incidents" "Grievances" and "Investigation - How to Conduct" were reviewed by administration and determined to be in compliance with state and federal guidelines. The facility initiated a new procedure in which grievances are reviewed in morning meeting. Any grievance that is determined to be an abuse allegation will have an incident report initiated with the abuse policy followed including suspension of accused employee. The incident will be reported to the NJ DOH.	

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F 610	Continued From page 19 abuse and neglect promptly," and, "Report to MD and initiate assessment." Further review of the Care Plan included a focus of "Resident [NJ Exec. Order 26:4.b.1] ... 7/31 made allegation against C.N.A.; follow up the following day revealed the resident had no recollection of the allegation," created on 09/06/22 by the Regional Director of Clinical Services. Review of the Progress Notes, dated [EX Order 26.4B1] through [EX Order 26.4B1], did not include any mention of the resident's allegation or physical assessment of the resident. Review of the Assessments section in the Electronic Medical Record (EMR) revealed an Initial Event Documentation, dated [EX Order 26.4B1] which included, "Date/Time of Event OR When Nursing Became Aware Of Event: [EX Order 26.4B1] [EX Order 26.4B1]" and, "UM [Unit Manager] was made aware by resident's nurse that resident wanted to complain about [his/her] aid. UM asked nurse what happened and the nurse stated that the resident felt disrespected and embarrassed by [his/her] care. When UM went in to talk to resident, resident stated that nothing happened and didn't appear to be upset about anything." Further review of the Assessments section of the EMR included a [EX Order 26.4B1] assessment, dated [EX Order 26.4B1], which revealed there were [NJ Exec. Order 26:4.b.1] issues. There were no assessments that included a [NJ Exec. Order 26:4.b.1] of the resident for [EX Order 26.4B1]. During an interview with the surveyor on 09/06/22 at 11:00 AM, the DON stated she was unfamiliar with the abuse allegation made by	F 610	Staff educator / designee will educate all staff on abuse, neglect and mistreatment, grievance process and conducting a thorough investigation including writing and collecting statements of staff, resident and witnesses, notification of administration, reporting to NJDOH is applicable, writing investigation summaries and updating of medical record as appropriate. Element 4: The DON/Administrator/designee will review all grievances for completion of timely thorough investigations including statements from all parties, written investigation and follow up documentation and intervention in morning meeting weekly x 12 weeks or until substantial compliance is achieved. DON/designee will read progress notes in medical record for indications of alleged abuse for completion of timely investigations including statements from all parties, written investigation summary and medical record follow up documentation and intervention prior to morning meeting weekly x 12 weeks or until substantial compliance is achieved. The results of these audits will be presented at monthly QAPI. Responsible party: Administrator The administrator will conduct audits of employee written warnings for any	

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F 610	Continued From page 20 Resident #134 and would have to speak to the supervisor who completed the EWR. At 12:45 PM, the DON provided the surveyor with a "soft file" for Resident #134's allegation that was stored in Licensed Practical Nurse/Unit Manager (LPN/UM) #3's office. Review of the soft file included a Full QA Report (incident report), with an incident date/time of EX Order 26.4B1 ." Further review of the report revealed it included the same statement made by LPN/UM #3 in the Initial Event Documentation. The report also included a witness statement from the Infection Control Preventionist (ICP) of "I was making I.C. [Infection Control] rounds when I overheard [CNA #8] from resident's room in an unprofessional tone. I removed CNA from resident's room and spoke to her regarding her tone." According to the report, the DON and the Licensed Nursing Home Administrator (LNHA) were made aware of the allegation on 07/31/22 at 11:15 AM. The report did not include a statement from Resident #134's assigned nurse or the resident's roommate, and the statements included were not written or signed by the person making the statement. The surveyor requested the name of the Resident #134's roommate at the time of the alleged incident from the Admissions Office and was provided with Resident #133's information. Review of Resident #133's Social Service Assessment, dated EX Order 26.4B1 , revealed "[Resident #133] presents EX Order 26.4B1] and is NJ Exec. Order 26:4.b.1 [his/her] needs and wants to be	F 610	indication of an abuse allegation and completion of necessary investigations with timely reporting and corrective action weekly x4 weeks; then monthly until compliance is met at a minimum of 6 months. The results of these audits will be reported to the facility QAPI for feedback and recommendations.	

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F 610	Continued From page 21 NJ Exec. Order 26:4.b.1 the staff." During an interview with the surveyor on 09/06/22 at 1:12 PM, the Registered Nurse/Unit Manager (RN/UM) explained the process for an allegation of abuse included assessing the resident for changes in skin condition and pain, collecting statements from staff and residents, notifying the supervisor, physician, and resident's representative, and filling out an incident report. The RN/UM further stated she was the current UM for Resident #134, and that the resident knows his/her name, but is EX Order 26.4B1. During an interview with the surveyor on 09/06/22 at 1:21 PM, LPN/UM #1 explained the process for an allegation of abuse included starting the investigation, gathering statements, notifying the DON, and reporting the allegation to the NJDOH. LPN/UM #1 further stated that she was the UM for Resident #134 at the EX Order 26.4B1 EX Order 26, and that it was "hard to tell if [he/she] was EX Order 26.4B1." During an interview with the surveyor on 09/06/22 at 1:39 PM, LPN/UM #3 explained the process for an allegation of abuse included interviewing the resident, assessing the resident for injury, ensuring the resident is safe, interviewing staff, documenting in the Initial Event Documentation or the progress notes, and notifying the DON to determine if it was a FRI (Facility Reportable Incident). When asked about the EWR completed by LPN/UM #3 for CNA #8, LPN/UM #3 stated she was the supervisor on 07/31/22 when Resident #134 stated CNA #8 "was rough with [him/her]." LPN/UM #3 further stated that she assessed the resident's body due	F 610		

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F 610	Continued From page 22 to a complaint that CNA #8 [EX Order 26.4B1] [him/her] too [EX Order 26.4B1]," but that there were no [EX Order 2] issues, [NJ Exec. Order 26:4.b.1], or change in [NJ Exec. Order 26:4.b.1] LPN/UM #3 then stated she notified the DON that same day and completed the EWR for CNA #8. She also stated that when she interviewed Resident #134 the following day, the resident was unable to recall the allegation. During an interview with the surveyor on 09/06/22 at 1:56 PM, the ICP explained the process for an allegation of abuse included completing an investigation, collecting statements, and notifying the NJDOH within two hours. When asked about the abuse allegation made by Resident #134, the ICP stated that she was performing rounds when she "happened to walk up on the conversation" between Resident #134 and CNA #8. The ICP stated that the CNA was speaking unprofessionally to the resident and that the ICP spoke to CNA #8 about professionalism. When asked if the ICP was present in the Resident #134's room the entire time CNA #8 was performing care, the ICP stated CNA #8 was already in the room when she entered and that she did not witness the care performed by the CNA in its entirety. During a telephone interview with the surveyor on 09/08/22 at 10:35 AM, CNA #8 stated that on the day of Resident #134's allegation, she was sent home and allowed to return to work two days later. The CNA stated the alleged incident did not occur and was unaware of the results of the investigation. During a telephone interview with the surveyor on 09/08/22 at 11:22 AM, the Agency Nurse	F 610		

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assigned to Resident #134 on [EX Order 26.4B1] stated that she entered Resident #134's room and the resident was [EX Order 26.4B1]. When the Agency Nurse asked if the resident was going to eat [his/her] meal, the resident stated [he/she] wanted to speak to a supervisor. The Agency Nurse further stated that the resident did not go into any details about the complaint, and that she notified LPN/UM #3 who was the supervisor for that shift.

During a follow-up interview with the surveyor on 09/08/22 at 12:18 PM, the ICP stated she could not recall specifically what the CNA said to the resident, but that the CNA's tone was "louder than normal," and the resident perceived the CNA's speech "as a rough manner."

During a follow-up interview with the surveyor on 09/09/22 at 12:15 PM, the DON explained the process for an abuse allegation included separating the involved parties, interviewing anyone present including staff and residents, obtaining written statements that are signed, assessing the resident, notifying the resident's family and physician, notifying the NJDOH within two hours, completing an investigation report, and notifying the NJDOH of the conclusion to the investigation. When asked about the abuse allegation made by Resident #134, the DON stated that she was notified of the incident on [NJ Exec. Order 26:4.b.1] and was told that the resident reported that CNA #8 was rude, aggressive, and pulled the resident's arm. The DON further stated that she instructed LPN/UM #3 to obtain statements and send CNA #8 home pending the investigation. The DON stated that the investigation included obtaining statements from the ICP and CNA #8, and that she believed a

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statement was obtained from the resident's roommate. The DON also stated that the resident's care plan was reviewed during the investigation. When asked about the conclusion to the allegation investigation, the DON stated she typed up a conclusion, emailed it to the NJDOH, and kept a copy in her office.

The surveyor and DON reviewed the soft file and the EMR related to Resident #134's allegation. The DON acknowledged that statements should have been obtained for the resident's nurse and roommate, and that the other statements should have been written and signed by the person providing the statement. The DON also stated the resident should have had a physical assessment completed at the time of the allegation and that it should have been documented in the resident's medical record. After reviewing the Care Plan, the DON verified the resident's Care Plan was revised on EX Order 26.4B1 by the Regional Director of Clinical Services and should have been updated within 24 hours of the allegation by the UM.

At that time, the surveyor accompanied the DON to her office to obtain a copy of the conclusion to the allegation investigation, however, the DON was unable to locate the conclusion in her office.

On 09/13/22, the facility provided a copy of a Grievance Form related to Resident #134's allegation of abuse, dated EX Order 26.4B1, which included, "Resident had alleged on EX Order 26.4B1 that a CNA was rough with [him/her] while getting care. Resident stated that CNA nasty to [him/her] and [he/she] felt degraded," and was signed by LPN/UM #3. Further review of the

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Grievance Form included, "To ensure abuse and neglect are ruled out promptly, does this grievance require further investigation? Yes."

During an interview with the surveyor on 09/13/22 at 11:31 AM, the LNHA stated he was unable to recall when he was notified of the alleged abuse between Resident #134 and CNA #8. The LNHA further stated that the DON was responsible for completing the investigation, but he was unable to recall when the results of the investigation were reported to him.

Review of the facility's Abuse policy, revised 02/2022, included, "Allegations/reports of suspected abuse, neglect, mistreatment, distortion, injury of unknown etiology or misappropriation shall be promptly and thoroughly investigated by facility management," and "Initiate the investigative process. Refer to the 'Investigation - How to Conduct' Protocol. The investigation should be thorough with witness statements from staff, residents, visitors and family members who may be interviewable and have information regarding the allegation." The policy also included, "Conclusion must include whether the allegation was substantiated or not and what information supported the decision."

Review of the facility's Investigations, How to Conduct policy, revised 11/2021, included the following:
- The investigator conducts interviews in the following order: The Resident(s) involved; Locate and arrange interviews with people involved in, or who may have witnessed, the incident (i.e. the person who found the resident ...); Witnesses should be interviewed separately and all provide

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F 610	Continued From page 26 written statements whenever possible. - Complete a physical assessment, identifying areas of injury. - Complete a comprehensive record review, which may include, but not limited to, the following elements ... Interdisciplinary Plan of Care - Interview all potential witnesses ... Employees, Roommates - Summarize analysis of facts gathered that: Establish reasonable cause for the incident; Establish need for further investigation, before a reasonable cause of the incident can be established.	F 610		
F 637 SS=D	NJAC 8:39-4.1(a)(5) Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to complete a significant change in status (SCSA)	F 637	Element 1: Resident #206 has [redacted] and is a closed chart, therefore a significant	10/31/22

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F 637	Continued From page 27 Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care. This deficient practice was identified for 1 of 1 resident (Resident #208) reviewed for EX Order 26.4B1 resident and was evidenced by the following: Within 14 days after the facility determines or should have determined that there has been a significant change in the resident's physical or mental condition, a SCSA/MDS must be completed. (For purpose of this section, a significant change is a decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) Review of the Admission Record reflected that Resident #208 was admitted to the facility with diagnoses which included, but were not limited to, EX Order 26.4B1 [redacted]. Review of the Physician Progress Note dated EX Order 26.4B1 at 3:18 PM reflected that the Chief Complaint/Nature of presenting problem was EX Order 26.4B1 status post EX Order 26.4B1	F 637	change MDS cannot be completed. Element 2: All residents have the potential to be affected by this deficient practice. All residents were reviewed for 6 months prior to determine if Ex.Order 26.4(b)(1) [redacted] was initiated and a significant change was completed in conjunction with the referral. Identified deficient practice was immediately corrected. Element 3: The facility policy on MDS Completion and submission was reviewed and determined to be in compliance with state and federal guidelines. A new procedure was implemented for review of significant changes. Unit managers will review residents with new orders for Ex.Order 26.4(b)(1) consult and/or Ex.Order 26.4(b)(1) consults. The Interdisciplinary Team (IDT) consisting of Administration and department heads, will discuss and determine if a significant change MDS should be initiated. The in-service coordinator/ designee will educate all unit managers, nursing administration, and MDS -on significant change MDS with emphasis on competition of a significant change MDS when a Ex.Order 26.4(b)(1) [redacted] evaluation is ordered.	

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F 637	Continued From page 28 EX Order 26.4B1 ." The progress note further reflected under "Plan" which included, but was not limited to, EX Order 26.4B1 EX Order 26.4B1 evaluation. Review of the General Documentation progress note dated EX Order 26.4B1 reflected that resident had EX Order 26.4B1 and an EX Order 26.4B1 EX Order 26.4B1 The Resident had EX Order 26.4B1 disease and was given a EX Order 26.4B1 EX Order 26.4B1 " per the hospital. The facility attempted to set resident up with EX Order 26.4B1 care for the resident on EX Order 26.4B1 with a EX Order 26.4B1 care agency, with no response from the agency. The Social Worker reached out to the agency, who indicated that they do not accept resident's insurance. The facility notified the Advanced Practice Nurse (APN) of the NJ Exec. Order 26:4.b.1 and the inability to have resident assessed for EX Order 26.4B1 today. The APN gave a new order to send Resident #208 to the NJ Exec. Order 26:4.b.1. Resident's family was notified, and requested resident be sent to a specific NJ Exec. Order 26:4.b and to "hold off on transfer until she arrives to facility." Review of General Documentation progress note dated NJ Exec. Order 26:4.b.1 reflected that Resident's mother arrived to the facility and met with the Unit Manager, Director of Nursing (DON) and the Social Worker, stating that resident is EX Order 26.4B1 and would not want to go. The Resident's code status was changed to EX Order 26.4B1 and to continue EX Order 26.4B1 as prescribed. The facility consulted a EX Order 26.4B1 company and EX Order 26.4B1 was on the way to evaluate resident for	F 637	Element 4: The MDS coordinator will audit 10% of all residents for Ex.Order 26.4(b)(1) care evaluations to ensure a significant change MDS was completed. The audits will be completed weekly x 4 weeks and then monthly until compliance is met, for a minimum of 6 months. The results of these audits will be submitted at monthly QAPI. The Administrator is responsible for execution and monitoring of this POC.	

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F 637	Continued From page 29 the treatment of EX Order 26.4B1 Review of Social Services Documentation progress note dated EX Order 26.4B1 reflected that the Team met with resident's mother this afternoon as resident was "EX Order 26.4B1 EX Order 26.4B1 Team discussed "options as far as EX Order 26.4B1, EX Order 26.4B1 and going to the NJ Exec. Order 26:4.b.1 Resident had been a full code but mother stated that resident has said he/she wouldn't want to go back to the hospital and doesn't want to die at the hospital. Decision was made to keep resident at facility and have him/her evaluated by a EX Order 26.4B1 agency for possible EX Order 26.4B1 care at our facility. An end of life planning form was also completed with orders for DNR, DNI, DNH (do not hospitalize). The EX Order 26.4B1 agency sent their nurse right out to evaluate resident] but resident doesn't meet the criteria at this time for general inpatient care. Emotional support was provided to the resident and mother. The Social Worker to remain available as needed for additional support. Review of the facility's Electronic Medical Record (EMR) under the tab "MDS" reflected that the following MDS assessments were completed for Resident #208: an Entry MDS, an Admission MDS, a Medicare 5-Day MDS, and a Death in Facility MDS. The EMR did not reflect that a NJ Exec. Order 26:4.b.1 was completed when the Team identified that the resident EX Order 26.4B1 as evidenced in the progress notes on . During an interview with the surveyor on 08/31/22 at 11:53 AM, the MDS Coordinator Registered Nurse (MDSRN) #2 stated that she	F 637		

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completed Resident #208's MDS assessments. MDSRN #2, in the presence of the surveyor, reviewed Resident #208's progress notes. MDSRN #2 stated, "I remember this resident was [NJ Exec. Order 26:4.b.1] when the resident was admitted; and I remember the resident was [NJ Exec. Order 26:4.b.1]." [EX Order 26.4B1] #2 further stated that Resident #208 was supposed to be admitted to [EX Order 26.4B1] but never was because of his/her insurance. MDSRN #2 stated, "I think we wanted to do a significant change MDS, we talked about the resident going on [EX Order 26.4B1] and we waited to see if the resident went on [EX Order 26.4B1]. We waited and waited and resident never went on [EX Order 26.4B1] but was evaluated. We figured the resident would go on [EX Order 26.4B1] after a while and the resident [EX Order 26.4B1]." The MDSRN #2 stated that in retrospect, when I read all of the progress notes, I should have done a significant change MDS as the progress notes clearly indicate the resident was [NJ Exec. Order 26:4.b.1] and I should have completed the significant change MDS. MDSRN #2 stated that a significant change MDS was completed when a resident goes on [EX Order 26.4B1] within two weeks of when the resident [EX Order 26.4B1]

During an interview with the surveyor on 09/09/22 at 12:09 PM, the Director of Nursing stated that her expectation was that the MDS Coordinator would have completed the significant change MDS and it was important to complete this MDS to continue the resident's plan of care.

During the Exit Conference on 09/13/22, in the presence of the survey team, the Licensed Nursing Home Administrator stated that the facility had 14 days to determine if the resident had a [NJ Exec. Order 26:4] and another 14 days to complete

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F 637	Continued From page 31 the significant change MDS. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17.1, October 2019, reflected on page 2-18 that a SCSA MDS must be completed "no later than" the 4th calendar day after determination that a significant change in resident's status occurred. The manual further reflected on page 2-22 that "A significant change is a major decline or improvement in a resident's status." NJAC 8:39-11.2(i)	F 637		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		10/31/22

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F 656	Continued From page 32 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to consistently revise and/or update resident care plans for 2 of 38 residents (Resident #6 and Resident #62) reviewed for comprehensive care plans. This deficient practice was evidenced by the following: 1. According to the Admission Record, Resident #6 was admitted with diagnoses that included, but were not limited to EX Order 26.4B1 [redacted] Review of the Significant Change in Status	F 656	Element 1: 1. Resident #6 had the comprehensive care plan for alteration in physical function updated to include the intervention for Ex.Order 26.4(b)(1), the comprehensive care plan for at risk for alteration in Ex.Order 26.4(b)(1) updated to include the intervention for Ex.Order 26.4(b)(1)s and the Ex.Order 26.4(b)(1) comprehensive care plan include Ex.Order 26.4(b)(1) as an intervention. 2. Resident #62 was evaluated by occupational therapist and the MD and the Ex.Order 26.4(b)(1) was no longer determined to be necessary. The order was discontinued.	

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F 656	Continued From page 33 Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated EX Order 26.4B1, revealed staff identified Resident #6 as EX Order 26.4B1, with EX Order 26.4B1, required NJ Exec. Order 26:4.b.1 for bed mobility and dressing and was at risk of developing EX Order 26.4B1 Review of an Inservice Form for Resident #6's NJ Exec. Order 26:4.b.1 (EX Order 26.4B1, dated EX Order 26.4B1 revealed that the therapist provided education to the nursing staff for the topic of EX Order 26.4B1 EX Order 26.4B1 with removal for EX Order 26.4B1 and EX Order 2 checks." Review of the Order Summary Report for active orders as of EX Order 26.4B1 revealed an EX Order 26.4B1 physician order (PO) for EX Order 26.4B1 NJ Exec. Order 26:4.b.1 to be worn 8:00 AM to 4:00 PM with removal for EX Order 26.4B1. Review of the Care Plan (CP), initiated 11/08/16, included a focus of that Resident #6 had EX Order 26.4B1 function related to NJ Exec. Order [EX Order 26.4B1] EX Order 26.4B1. The surveyor observed that Resident #6's CP did not include documentation of the EX Order 26.4B1. Review of the Visual/Bedside Kardex report did not include documentation of Resident #6's EX Order 26 EX Order 26.4B1 Review of Resident #6's 12/07/21 "Full QA Report" (incident report) provided by the Director of Nursing (DON) revealed the resident had a EX Order 26.4B1 that was found by the Certified Nurse Assistant (CNA)	F 656	Element 2: All residents have the potential to be affected by this deficient practice. All residents with Ex.Order 26.4(b)(1) were reviewed to ensure that care plans and Kardex reflected the use of Ex.Order 26.4 . Identified deficient practice was immediately corrected. All residents with Ex.Order 26.4(b)(1)s were reviewed to ensure comprehensive care plans and Kardex reflect the use of Ex.Order 26.4(b)(1) Identified deficient practice was immediately corrected. All residents with Ex.Order 26.4(b)(1) were reviewed to ensure comprehensive care plans and Kardex reflect the use of side Identified deficient practice was immediately corrected. Element 3: The Director of Nursing reviewed the facility's policy regarding Comprehensive Care Plans and noted the policy to be in compliance with state and federal guidelines. A new procedure was implemented in which the rehab director and unit managers will communicate new resident interventions for adaptive devices and safety devices to morning meeting. The	

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F 656	Continued From page 34 while dressing the resident. The incident report indicated under the "Actions" section that the CP was updated, EX Order 26.4B1 applied and EX Order 26.4B1 on bed/equipment. Review of the Order Summary Report for active orders as of EX Order 26.4B1 revealed an EX Order 26.4B1 physician order (PO) for NJ Exec. Order 26:4.b.1 in place for prevention every shift for prevention. Review of the Care Plan (CP) included a focus, initiated on EX Order 26.4B1, that Resident #6 was at risk for NJ Exec. Order 26:4.b.1 related to EX Order 26.4B1 skin. The CP also included a focus, initiated on EX Order 26.4B1 that Resident #6 used NJ Exec. Order 26:4.b.1 . The surveyor observed that Resident 6's CP did not include documentation of Resident #6's NJ Exec. Order 26:4.b . Review of the Visual/Bedside Kardex report did not include documentation of Resident #6's EX Order 2 NJ Exec. Order 26:4.b.1 . During an interview with the surveyor on 09/09/22 at 10:44 AM, the Registered Nurse/Unit Manager (RN/UM) stated that any nurse could update the CP but usually the UMs would complete any updates. The RN/UM stated intervention for EX Order 26.4B1 , such as the use of NJ Exec. Order 26:4.b.1 would be documented and updated in the CP. The RN/UM reviewed Resident #6's CP, in the presence of the surveyor, and stated that she was unable to find a CP that addressed the resident's use of the NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.	F 656	interdisciplinary team will review and ensure the care plans are updated to reflect the residents current care needs. All nursing staff received Inservice education by the In-Service Director regarding the development and review of comprehensive care plans. The lesson plan will concentrate on the following: Comprehensive person-centered care plans are to be developed and implemented for each resident to meet the residents' medical, nursing, and psychosocial needs that are identified in the comprehensive assessments. A copy of the lesson plan and attendance will be filed for reference and validation. Element 4: The DON/ Designee will complete weekly audits of 10% of all residents with EX.Order 26.4 to ensure the comprehensive care plans were developed and interventions are implemented that represent the resident's current medical, nursing, and psychosocial needs. The results of these audits will be presented at monthly QAPI. The Director of Nursing is responsible for oversight of this POC.	

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	315174	A. BUILDING _____ B. WING _____	09/20/2022

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F 656	Continued From page 35 During an interview with the surveyor on 09/09/22 at 12:41 PM, the Director of Nursing (DON) stated that Resident #6's CP should have been updated to address the resident's use of a NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1. During an interview with the surveyor on 09/13/22 at 11:19 AM, the Regional Director of Clinical Services stated that Resident #6's CP should have been updated when the interventions were initiated. 2. On 08/30/2022 at 11:05 AM, Surveyor #2 observed Resident #62 without any EX Order 26.4B1 devices on the EX Order 26.4B1. On EX Order 26.4B1 EX Order 26.4B1 and 1:13 PM, Surveyor #2 observed Resident #62 without any EX Order 26.4B1 devices on the EX Order 26.4B1. Review of the medical record indicated that Resident #62 was admitted to the facility with diagnoses, which included but not limited to, EX Order 26.4B1 The resident's most recent annual MDS, dated NJ Exec. Order 26:4.b.1, reflected Resident #62 was identified as being in a EX Order 26.4B1 and was NJ Exec. Order 26:4.b.1. The MDS further indicated that Resident #62 had NJ Exec. Order 26:4.b.1 in EX Order 26.4B1 EX Order 26.4B1 The MDS also revealed that Resident #62 required NJ Exec. Order 26:4.b.1 and was NJ Exec. Order 26:4.b.1 on staff for activities of	F 656		

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F 656	Continued From page 36 daily living. Review of a physician order sheet dated EX Order 26.4B1 revealed a physician order for the resident to wear EX Order 26.4B1 NJ Exec. Order 26:4.b.1 with EX Order 26.4B1 EX Order 26.4B1 PM/daily with EX Order 26 checks pre and post application; with/removal for hygiene as needed. Review of Resident's #62's electronic medical record (EMAR) did not reveal any identification in the Medication Administration Record (MAR), Treatment Administration Record (TAR), or Care Plan that the EX Order 26.4B1 were applied per physician orders. During an interview with the surveyor on 09/07/22 at 11:41 AM, the Director of Rehabilitation (DOR), confirmed that the EX Order 26.4B1 EX Order 26.4B1 was not identified on the current Medication Administration Record (MAR). When asked who was responsible for applying the EX Order 26.4B1 the DOR responded that Resident #62 was discharged from EX Order 26.4B1 in EX Order 26.4B1, "therefore it would be the responsibility of the nursing staff to apply." During an interview with the surveyor on 09/07/22 at 11:50 AM, Registered Nurse (RN #2) stated that she was familiar with Resident #62, but was not aware of orders to apply EX Order 26.4B1 RN #2 stated that she had never seen any orders for the application of EX Order 26.4B1 any of the residents on her EX Order 26 RN #2 further stated that the orders would not be to apply EX Order 26.4B1 but rather to "check placement" of EX Order 26.4B1. When asked who is responsible for updating the orders and care plans, RN #2 responded, the unit manager (UM).	F 656		

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F 656	Continued From page 37 During an interview with the surveyor on 09/07/22 at 12:30 PM, Licensed Practical Nurse/UM (LPN/UM #3) confirmed that she was responsible for transcribing orders/updating care plans according to the physician orders and that "the nurses [do not] have the responsibility for updating the orders and care plan". When asked what the timely expectation for physician orders to be transcribed/approved, LPN/UM #3 responded 24-48 hours. During a follow-up interview with the surveyor on 09/12/22 at 10:15 AM, LPN/UM #3 confirmed that the aides or nurses are responsible for applying EX Order 26.4B1 to residents upon discharge from rehabilitation. Upon reviewing the orders for Resident #62, LPN/UM #3 reported that the orders for EX Order 26.4B1 were placed on hold on EX Order 26.4B1 and confirmed that the orders should have been carried out and identified on the care plan prior to the hold date. A review of a policy titled, "Care Plans-Comprehensive" created on 10/2015, Last Revised on 10/2021, revealed under "Policy" that, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident". Further, the policy revealed under "Procedure", number eight, letter "m","The comprehensive, person-centered care plan will: [m] Enhance the optimal functioning of the resident by focusing on a rehabilitative program". NJAC 8:39-27.1(a)	F 656		

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F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to consistently complete EX Order 26.4B1 evaluations (EX Order 26.4B1) after EX Order 26.4B1 for 1 of 6 residents (Resident #189) reviewed for accidents. This deficient practice was evidenced by the following: On 08/31/22 at 11:46 AM, the surveyor observed Resident #189 resting comfortably in bed with the head of bed (HOB) slightly elevated. The surveyor observed NJ Exec. Order 26:4.b.1 positioned on both sides of the resident's bed. According to the Admission Record, Resident #39 was admitted with diagnoses which included, but were not limited to, EX Order 26.4B1 [redacted] Review of Resident #189's Significant Change Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated	F 684	Element 1: Resident #189 was sent to the Ex.Order 26.4(b)(1) following incident and returned to the facility with Ex.Order 26.4(b)(1) noted. Element 2: All residents with Ex.Order 26.4(b)(1) have potential to be affected by this deficient practice. All Ex.Order 26.4(b)(1) were reviewed for 6 months prior to ensure that Ex.Order 26.4(b)(1) were completed to meet MD order and Ex.Order 26.4(b)(1) discharge instructions if applicable. The Ex.Order 26.4(b)(1) were also reviewed to ensure there were no duplication of Ex.Order 26.4(b)(1). No other deficient practice was noted. Element 3: The facility policy on Quality of Care was reviewed and determined to be in compliance with state and federal guidelines.	10/31/22

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F 684	Continued From page 39 EX Order 26.4B1 included the resident had a Brief Interview for Mental Status of EX Order which indicated that the resident's EX Order 26.4B1 EX Order 26.4B1. Further review of the MDS revealed that the resident had sustained EX Order 26 in the last EX Order 26.4B1. Review of Resident #189's Care Plan (CP) included a focus, dated EX Order 26.4B1 that the resident was EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4B1.) The CP also included a focus, dated EX Order 26.4B1 that the resident EX Order 26.4B1 EX Order 26.4B1." Review of Resident #189's Progress Note (PN), dated EX Order 26.4B1 at 5:27 PM, revealed a Nursing Clinical Evaluation note that the Certified Nurse Assistant (CNA) found the resident on the floor. The PN further revealed that the resident was EX Order 26.4B1 with EX Order 26.4B1 ." NJ Exec. Order 26:4.b.1 " Review of Resident #189's hard copy chart located at the nursing station, on EX Order 26.4B1 at 1:02 PM, revealed a EX Order 26.4B1 EX Order 26.4B1 Assessment Sheet EX Order 26.4B1), with plotted dates and times from EX Order 26.4B1 to EX Order 26.4B1). The EX Order 26.4B1 sheet indicated that EX Order 26.4B checks were not completed from EX Order 26.4B1 EX Order 26.4B1 due to the resident being at the NJ Exec. Order 26:4.b.1. However, there was no documentation that EX Order 26.4B1 (EX Order 26.4B	F 684	A new procedure was implemented for review of Ex.Order 26.4(b)(1) . Unit managers will review completed Ex.Order 26.4(b)(1) ensure they are accurate and complete including suspension of Ex.Order 26.4(b)(1) while the resident is in the Ex.Order 26.4(b)(1). The unit manager will also ensure there is no duplication of Ex.Order 26.4(b)(1). The unit manager will then ensure the Ex.Order 26.4(b)(1) is uploaded into the electronic medical record under the miscellaneous tab. The in-service coordinator/ designee will educate all licensed nurses-on quality of care with emphasis on Ex.Order 26.4(b)(1) specifically focusing on the suspension of Ex.Order 26.4(b)(1) transfer and resumption based Ex.Order 26.4(b)(1) transfer paperwork and MD order. Element 4: The DON/ designee will audit 10 Ex.Order 26.4(b)(1) implementation of Ex.Order 26.4(b)(1), suspension for Ex.Order 26.4(b)(1) transfer, resumption based on MD order, and duplication of Ex.Order 26.4(b)(1). The audits will be completed weekly x 4 weeks and then monthly until compliance is met, for a minimum of 6 months. The results of these audits will be submitted at monthly QAPI. The DON is responsible for execution and monitoring of this POC.	

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F 684	Continued From page 40 EX Order 26.4B1 were completed for the following shifts once the resident returned to the facility: 02/28/22 3:00 PM -11:00 PM (evening) and night shifts, 03/01/22 7:00 AM - 3:00 PM (day), evening, and night shifts, 03/02/22 evening and days shifts. Review of the 02/27/22 "Full QA Report" (incident report), on 09/07/22 at 10:11 AM, provided by the Director of Nursing (DON), revealed a different NJ Exec. Order 26:4.b.1 sheet. The surveyor observed that the included EX Order 26.4B1 sheet was completed in its entirety and had the same handwriting for all times/shifts for the entire observation period. The included EX Order 26.4B1 sheet further revealed that EX Order 26.4B1 were completed for Resident #189 from EX Order 26.4B1 while the resident was out of the facility being evaluated. Review of the 06/16/22 and 08/13/22 incident reports, provided by the DON, also included EX Order 26.4B1 sheets. The surveyor observed that the included EX Order 26.4B1 sheets had the same handwriting for all times/shifts for the entire observation periods. The surveyor further observed that the EX Order 26.4B1 and EX Order 26.4B1 EX Order 26.4B1 had the exact same handwriting for all the documented EX Order 26.4B1 throughout the observation periods. During an interview with the surveyor on 09/08/22 at 10:37 AM, Licensed Practical Nurse (LPN #1) stated EX Order 26.4B1 were initiated for EX Order 26.4B1 and that nurses would document per the instructions on the	F 684		

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F 684	Continued From page 41 EX Order 26.4 - EX Order 26.4B1 sheet. LPN #1 added that if resident was transferred out of the facility, she would document that the resident was out of the facility or hospitalized on the EX Order 26.4B1 sheet and would continue with the EX Order 26.4B1 assessments upon the resident's return to the facility. Review of the NJ Exec. Order 26:4.b.1 sheet indicated that NJ Exec. Order 26:4.b.1 should be completed as follows: -Every 15 minutes for one hour -Every 20 minutes for two hours -Every hour for two hours -Every shift for 72 hours During an interview with the surveyor on 09/08/22 at 10:44 AM, the Registered Nurse/Unit Manager (RN/UM) stated the nurse should assume the resident hit their head with any unwitnessed EX Order 26 The RN/UM further stated that EX Order 26.4B1 were started immediately and that the nurses would follow the guidelines on the EX Order 26.4B1 sheet. The nurse would check the resident's vital signs [blood pressure, pulse, temperature, respirations], pupil response, mental status and motor response. The RN/UM added that when residents were transferred out of the facility for evaluation, the nurse would document that the resident was out of facility on the neuro check sheet and would continue the neuro checks upon the resident's return to the facility. During an interview with the surveyor on 09/08/22 at 1:20 PM, the DON stated the nurses would follow the guidelines on the EX Order 26.4B1 sheet when completing their assessments. The	F 684		

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F 684	Continued From page 42 DON added that EX Order 26.4B1 would stop when the resident transferred out, the nurse would document that the resident was at the NJ Exec. Order 26:4.b on the EX Order 26.4B1 k sheet and continue the [redacted] pon the resident's return to the facility. The DON further stated that EX Order 26.4B1 should not be documented as completed while the resident was out of the facility. The surveyor questioned the two different EX Order 26.4B1 sheets, one obtained by the surveyor from the resident's chart and the EX Order 26.4B1 sheet included in the incident report that was provided by the DON for Resident #189's EX Order 26.4B1 The DON responded that she would have to look into it and get back to the surveyor. During a follow-up interview with DON, on 09/09/22 at 9:01 AM, the DON stated the nurse who completed the included EX Order 26.4B1 sheet was an agency nurse and that she attempted to call that agency nurse but did not get a response. During a follow-up interview with DON, on 09/09/22 at 12:41 PM, the DON stated she did not know where the EX Order 26.4B1 sheet, that was included in the incident report, came from. The DON added that EX Order 26.4B1 were completed for three days for an NJ Exec. Order 26:4.b.1 and that it was not normal practice to document that a NJ Exec. Order 26:4.b.1 was completed when the resident was not present in the facility. When questioned about the EX Order 26.4B1 sheets having the same handwriting for the entire observation period, the DON replied that incident reports were reviewed by the Unit Manager, the Assistant Director of Nursing and herself and that no one questioned the fact that the EX Order 26.4B1 sheets had the same nurse's handwriting for the	F 684		

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F 684	Continued From page 43 entire observation period. During an interview with the surveyor on 09/13/22 at 11:05 AM, in the presence of the survey team, the Regional Director of Clinical Services (RNCS) stated there was no way to go back and find more information about who completed the NJ Exec. Order 26:4.b.1 because that nurse no longer worked at the facility. The RNCS further stated she had no idea why there was EX Order 26.4B1 sheets for Resident #189's EX Order 26.4B1 . When questioned about nursing continuing EX Order 26.4B1 after Resident #189 EX Order 26.4B1 , the RNCS stated that nursing would not continue EX Order 26.4 checks because the hospital wound have done a NJ Exec. Order 26:4.b.1 (EX Order 26.4B1 to rule out any EX Order 26.4B1 issues. The RNCS further stated staff would follow the discharge instructions and would continue EX Order 26.4B1 if instructed to do so in the EX Order 26.4B1 instructions. The RNCS added that EX Order 26.4B1 s should not be documented as completed for residents who were out of the facility because the nurse would not be able to assess the resident. The RNCS further stated they were unable to determine what nurse documented NJ Exec. Order 26:4.b.1 when the resident was out of the facility. Review of Resident #189's EX Order 26.4B1 EX Order 26.4B1 s revealed a visit date of EX Order 26.4B1 for a diagnosis of EX Order 26 . The discharge instructions indicated that an EX Order 26.4B1 (EX Order 26.4B1 EX Order 26.4B1) was completed during the NJ Exec. Order 26:4.b.1 visit and included EX Order 26.4B1 care patient educations material.	F 684		

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F 684	Continued From page 44 During a follow up interview with the DON, on 09/13/22 at 11:30 AM, the surveyor questioned the 02/27/22, 06/16/22, and 08/13/22 EX Order 26.4B [redacted] sheets with exact same handwriting for all the documented EX Order 26.4B checks. The DON stated she did not notice that all three EX Order 26.4B check sheets had the same exact handwriting. During a follow up interview with the RNCS on EX Order 26.4B1, the surveyor questioned the EX Order 26.4B1 and EX Order 26.4B1 NJ Exec. Order 2 [redacted] with exact same handwriting for all the documented EX Order 26.4B checks. The RNCS stated that they were at the point where they could not explain the handwriting being the same for all three incidents or why EX Order 26.4B checks were documented as completed while the resident was not in the facility. Review of the facility's " NJ Exec. Order 26:4.b.1 [redacted] revised on 03/2022, indicated that NJ Exec. Order 26:4.b.1 would be completed as followed: "a. Every 15 minutes' x first hour b. Every 30 minutes' x 2 hours c. Every hour x 2 hours d. Every shift x 72 hours e. Then as primary healthcare provider orders" Review of the facility's NJ Exec. Order [redacted] Management and Prevention" policy, revised 01/2021, include under the "Post NJ Exec. O [redacted] " section, to "7. obtain NJ Exec. Order 26:4.b.1 per policy for any unwitnessed NJ Exec. Order 26:4.b.1 with evidence of NJ Exec. Order [redacted] and "13. Resident NJ Exec [redacted] will be evaluated for 72 hours' post NJ Exe [redacted] l, including full vital signs every shift."	F 684		

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F 684	Continued From page 45	F 684		
F 688 SS=E	NJAC 8:39-29.2(d) Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to follow a physician's order for the application of a EX Order 26.4B1) for 2 of 3 residents (Resident #6 and Resident #62) reviewed for EX Order 26.4B1	F 688	Element 1: 1. Resident #6 had the EX Order 26.4B1 placed. Rehab evaluated the resident with Ex.Order 26.4(b)(1) noted. 2.Resident #62 was evaluated by EX Order 26.4B1 The resident was determined to Ex.Order 26.4(b)(1) require the order for a EX Order 26.4B1 . The MD was notified and the Ex.Order 26.4(b)(1) was discontinued.	10/31/22

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	315174	A. BUILDING _____ B. WING _____	09/20/2022

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F 688	Continued From page 46 The deficient practice was evidenced by the following: 1. During tour of the [redacted] unit on 08/30/22 at 11:14 AM, the surveyor observed Resident #6 in bed with the head of bed (HOB) elevated. The surveyor observed that Resident #6 had limitation to the [redacted] and did not have on a [redacted]. When interviewed, Resident #6 was unable to provide any information about his/her care. The [redacted] Certified Nurse Assistant ([redacted] CNA) was present in the room and stated the resident required [redacted] with activities of daily living. According to the Admission Record, Resident #6 was admitted with diagnoses that included, but were not limited to, [redacted]. Review of the Significant Change in Status Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], revealed staff identified Resident #6 as [redacted], with [redacted], required [redacted] of one staff for [redacted] and [redacted] and was at risk of developing [redacted]. Review of an Inservice Form for Resident #6's [redacted], dated [redacted], revealed that the [redacted] provided education to the nursing staff for the topic of [redacted] with removal for [redacted] and [redacted] checks." Review of the Order Summary Report for active orders as of [redacted] revealed a [redacted]	F 688	Element 2: All residents with Ex.Order 26.4(b)(1) [redacted] orders have the potential to be affect by this deficient practice. All residents with Ex.Order 26.4(b)(1) orders were evaluated to ensure Ex.Order 26.4(b)(1) were in place and instructions were on the resident's Kardex. Residents with orders for Ex.Order 26.4(b)(1) were evaluated that they were in place. Negative findings were immediately corrected. Element 3: The facility policy on Appliances-appliances, Ex.Order 26.4(b)(1) was reviewed and determined to be in compliance with state and federal guidelines. A new procedure was implemented for application of Ex.Order 26.4(b)(1) [redacted]. Residents will have [redacted] n the resident's task requiring a signature from the C.N.A. The in-service coordinator/ designee will educate all nursing staff on residents with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. The inservice will specifically focus on application of Ex.Order 26.4(b)(1) to prevent decline in	

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F 688	Continued From page 47 physician order (PO) for EX Order 26.4B1 to be worn 8:00 AM to 4:00 PM with removal for EX Order 26.4B1 . Review of the EX Order 26.4B1 and EX Order 26.4B1 Treatment Administration Record (TAR) did not include the aforementioned PO. Review of the Care Plan (CP), initiated 11/08/16, included a focus of that Resident #6 had EX Order 26.4B1 . The surveyor observed that Resident #6's CP did not include documentation of the EX Order 26.4B1. Review of the Visual/Bedside Kardex report did not include documentation of Resident #6's EX Order 26.4 EX Order 26.4B1 On 08/31/22 at 11:37 AM, the surveyor observed Resident #6 resting in a recliner. The resident did not have on a EX Order 26.4B1 . The surveyor made the same observations on EX Order 26.4B1 On 09/06/22 at 9:21 AM, the surveyor observed Resident #6 resting in bed. The resident did not have on a EX Order 26.4B1 . The surveyor made the same observation on 09/08/22 at 10:30 AM. During a follow-up interview with the surveyor on 09/08/22 at 10:31 AM, the EX Order 26.4B1 CNA stated that she worked at the facility since NJ Exec. Order 26:4.b.1 and that the resident required NJ Exec. Order 26:4.b.1 with care. The EX Order 26.4B1 CNA further stated that the	F 688	physical function. Element 4: The DON/ designee will audit 5 residents with Ex.Order 26.4(b)(1) to ensure the Ex.Order 26. are applied as per MD order and C.N.A. task. Audits will be completed weekly x 4 weeks and then monthly for a minimum of 6 months or until compliance is met. The results of these audits will be submitted at monthly QAPI. The DON is responsible for execution and monitoring of this POC.	

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F 688	Continued From page 48 resident had a EX Order 26.4B1 and when the resident relaxed his/her EX Order 26.4B the EX Order 26.4B1 CNA was able to clean it with a with towel. The EX Order 26.4B1 CNA added that the resident did not have a EX Order 26.4B1 and that she planned on following up with the EX Order 26.4B1 Registered Nurse to request something be placed in the resident's EX Order 26.4 During an interview with the surveyor on 09/08/22 at 10:40 AM, Licensed Practical Nurse (LPN) #1 stated Resident #6 was a NJ Exec. Order 26:4.b.1 with care and had EX Order 26.4B1 LPN #1 further stated that Resident #6 previously had a EX Order 26.4B1 that EX Order 26.4B1 applied, and nursing would remove. LPN #1 added the therapist would provide education to the nursing staff about the application of the NJ Exec. Order 26:4.b.1, nursing would sign off on the education and would then be the responsible for applying the EX Order 26.4B1 per PO. During an interview with the surveyor on 09/08/22 at 10:49 AM, the Registered Nurse/Unit Manager (RN/UM) stated Resident #6 was NJ Exec. Order 26 on staff for care. The RN/UM added the resident had a NJ Exec. Order 26:4.b.1 that was applied from NJ Exec. Order 26:4.b.1 daily. The RN/UM stated the nurse, or the CNA would usually apply the NJ Exec. Order 26:4.b.1 and that it was the nurse's responsibility to make sure it was applied per the PO. The surveyor requested the RN/UM accompany the surveyor to the resident's room. As the surveyor and the RN/UM walked down the hall, the NJ Exec. Order 26:4.b.1 CNA was pushing Resident #6 down the hallway in a recliner. At which time, the RN/UM confirmed that the resident did not have a NJ Exec. Order 26:4.b.1 applied to	F 688		

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F 688	Continued From page 49 the [redacted] and stated the resident should have on the [redacted]. During an interview with the surveyor on 09/09/22 at 12:41 PM, the Director of Nursing (DON) stated that she expected the resident's [redacted] to be in the room and available. During an interview with the surveyor on 09/13/22 at 11:19 AM, the Regional Director of Clinical Services stated that Resident #6's [redacted] should have been applied per the physician order. 2. On 08/30/22 at 11:05 AM, Surveyor #2 observed Resident #62 without any [redacted] devices on [redacted]. On 08/31/22 at 12:13 PM, 09/01/22 at 10:46 AM, 12:31 PM, and 1:13 PM, Surveyor #2 observed Resident #62 without any [redacted] on [redacted]. Review of the medical record indicated that Resident #62 was admitted to the facility with diagnoses, which included but were not limited to [redacted] Review of the resident's most recent Annual MDS, dated [redacted], Resident #62 was identified as being in a [redacted] and was [redacted]. The MDS further indicated that Resident #62 had [redacted]. The MDS also revealed that	F 688		

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F 688	Continued From page 50 Resident #62 required NJ Exec. Order 26:4.b.1 and was NJ Exec. Order 26:4.b.1 on staff for activities of daily living. Review of a physician order sheet dated 05/06/22 timed at 01:40 AM, revealed a physician order for the resident to NJ Exec. Order 26:4.b.1 daily with NJ Exec. Order 26:4.b.1 pre and post application; with/removal for hygiene as needed. Review of Resident's #62's Electronic Medical Record (EMAR) did not reveal any identification in the Medication Administration Record (MAR), Treatment Administration Record (TAR), or Care Plan that the NJ Exec. Order 26:4.b.1 were applied per physician orders. During an interview with the surveyor on 09/07/22 at 11:41 AM, the Director of Rehabilitation (DOR) confirmed that the [redacted] was not identified on the current Medication Administration Record (MAR). When asked who was responsible for applying the [redacted], the DOR responded that Resident #62 was discharged from NJ Exec. Order 26:4.b.1 in NJ Exec. Order 26:4.b.1, "therefore it would be the responsibility of the nursing staff to apply". During an interview with the surveyor on 09/07/22 at 11:50 AM, the Registered Nurse (RN) #2 stated that she was familiar with Resident #62, but was not aware of orders to apply [redacted] RN #2 stated that she has never seen any orders for application of [redacted] to any of the residents on her wing. RN #2 further stated that the orders would not to apply [redacted], but rather "check placement" of [redacted] When asked who is	F 688		

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F 688	Continued From page 51 responsible for updating orders and care plans, RN #2 responded, the unit manager (UM). During an interview with the surveyor on 09/07/22 at 12:30 PM, the LPN/UM(LPN/UM) #3 confirmed that she was responsible for transcribing orders/updating care plans according to physician orders and that "the nurses [do not] have the responsibility for updating the orders and care plan." When asked what the timely expectation for physician orders to be transcribed/approved, LPN/UM #3 responded 24-48 hours. During an interview with the surveyor on 09/12/22 at 10:00 AM, the Certified Nursing Assistant (CNA) #5 confirmed that Resident #62 had orders for [redacted], but "they were taken out last week because [redacted] During a follow up interview with the surveyor on 09/12/22 at 10:15 AM, LPN/UM #3 confirmed that the CNAs or nurses were responsible for applying [redacted] to residents upon discharge from [redacted]. Upon reviewing the orders for Resident #62, LPN/UM #3 reported that the orders for [redacted] were hold on 09/02/22 and confirmed that the orders should have been carried out and identified on the care plan prior to the hold date. A review of a facility policy titled, "Physician Orders" created on 1/2021 revealed under "Policy" that, "It is the policy of this facility to secure physician orders for care and services for residents as required by state and federal law..." Further, the policy revealed under "Procedure" number 8, that "Licensed Nurse	F 688		

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F 688	Continued From page 52 receiving/accepted order is required to transcribe the order to the MAR or electronic medical record (EMAR) containing all required information." A review of a facility policy titled, "[redacted]" created on 8/2015, last revised on 4/2022, revealed under "Policy" is "To assure all [redacted], etc. are used appropriately and cared for properly and upper and lower extremities are maintained in a functional position". Further, the policy revealed under "Procedure" and "Nursing" number one, that "Ensures proper schedule for donning and doffing appliance is known by CNA staff and provides appropriately sign of task options".	F 688		
F 689 SS=D	NJAC 8:39-27.2(m) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) follow a physician's order for [redacted] for one resident, 1 of 6 residents (Resident #6) reviewed for accidents.	F 689	Element 1: Resident #6 had [redacted] applied to the [redacted]. Resident had a [redacted] completed with [redacted] noted.	10/31/22

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F 689	Continued From page 53 The deficient practice was evidenced by the following: During tour of the [redacted] unit on 08/30/22 at 11:14 AM, the surveyor observed Resident #6 in bed with the head of bed (HOB) and bilateral half side rails elevated. The surveyor observed that Resident #6 was leaning to the right side and there was NJ Exec. Order 26:4.b.1. When interviewed, Resident #6 was NJ Exec. Order 26:4.b.1 any information about his/her care. According to the Admission Record, Resident #6 was admitted with diagnoses that included, but were not limited to EX Order 26.4B1 [redacted] Review of the Significant Change in Status Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 08/14/2022, revealed staff identified Resident #6 as EX Order 26.4B1, had NJ Exec. required NJ Exec. Order 26:4.b.1 for NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 was at risk of developing EX Order 26.4B1. Review of Resident #6's 12/07/21 "Full QA Report" (incident report) provided by the Director of Nursing (DON) revealed the resident had a EX Order 26.4B1 that was found by the Certified Nurse Assistant (CNA) while dressing the resident. The incident report indicated under the "Actions" section that the Care Plan (CP) was updated, NJ Exec. Order 26:4.b.1 was initiated, NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1.	F 689	Resident #6 care plan and Kardex were updated to reflect the resident's intervention for Ex.Order 26.4(b)(1). Element 2: This deficient practice has the potential to affect all residents with orders for Ex.Order 26.4(b)(1) [redacted] No other resident was identified as requiring Ex.Order 26.4(b)(1). Element 3: The policy on accidents and incidents was reviewed by the administrator and Director of Nursing and determined to be in compliance with state and federal guidelines. A new procedure for Ex.Order 26.4(b)(1) was implemented indicating that the resident's physician order for Ex.Order 26.4(b)(1) would include placing the Ex.Order 26.4(b)(1) on the resident's care plans and the tasks to ensure the C.N.A.s are instructed to apply the Ex.Order 26.4(b)(1). The Inservice coordinator/ designee initiated inservice to all nursing staff on accident prevention specifically focusing on: The resident environment remains as free of accident hazards as is possible; and Each resident receives adequate supervision and assistance devices to prevent accidents including applying and monitoring of Ex.Order 26.4(b)(1) and the new facility procedure for implementing and	

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F 689	Continued From page 54 Review of the Order Summary Report for active orders as of 09/08/22 revealed an 12/07/21 physician order (PO) for NJ Exec. Order 26:4.b.1 in place for prevention every shift for NJ Exec. Order 26:4.b.1. Review of the CP included a focus, initiated on 01/26/22, that Resident #6 was at risk for EX Order 26.4B1 The CP also included a focus, initiated on 02/20/17, that Resident #6 used NJ Exec. Order 26:4.b.1 for increased NJ Exec. Order 26:4.b.1. The surveyor observed that Resident 6's CP did not include documentation of Resident #6's NJ Exec. Order 26:4.b.1. Review of the Visual/Bedside Kardex report did not include documentation of Resident #6's NJ Exec. Ord [redacted] On 09/06/22 at 09:21 AM, the surveyor observed Resident #6 resting in bed. The surveyor observed that there was NJ Exec. Order 26:4.b.1 applied to the resident's NJ Exec. Order 26:4.b.1 while in bed. The surveyor made the same observation on 09/08/22 at 10:30 AM. During an interview with the surveyor on 09/08/22 at 10:31 AM, the EX Order 26.4B1 Certified Nurse Assistant EX Order 26.4B1) stated that she worked at the facility since EX Order 26.4B1 and that the resident required NJ Exec. Order 26:4.b.1 with care. When questioned about the NJ Exec. Order 26:4.b.1, the NJ Exec. Order 26:4.b.1 CNA stated that Resident #6 did not have NJ Exec. Order 26:4.b.1. During an interview with the surveyor on 09/08/22 at 10:49 AM, the Registered Nurse/Unit Manager (RN/UM) stated Resident #6 was NJ Exec. Order 2 [redacted] on staff for care, had no EX Order 26.4B1, and	F 689	monitoring Ex.Order 26.4(b)(1) Element 4: The DON/ designee will audit all residents with interventions for Ex.Order 26.4(b)(1) to ensure Ex.Order 26.4(b)(1) are in place and interventions are listed on the care plan as well as the C.N.A. task. The audits will be completed weekly x 4 weeks and then monthly until compliance is met for a minimum of 6 months. The results of these audits will be submitted at monthly QAPI. The DON is responsible for execution and monitoring of this POC.	

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F 689	Continued From page 55	F 689		

that the resident had a history of [NJ Exec. Order 26:4.b.1] [redacted] The RN/UM added that interventions included [EX Order 26.4B1] [redacted] and that the resident's [NJ Exec. Order 26:4.b.1]. The RN/UM stated the resident normally had b[NJ Exec. Order 26:4.b.1] [redacted] and it was the nurses' responsibility to make sure they were in place. The surveyor requested the RN/UM to accompany the surveyor to the resident's room. At which time, the RN/UM confirmed that the resident did not have [NJ Exec. Order 26:4.b.1] and stated that the resident had them on at one point in time. The RN/UM was unable to locate [NJ Exec. Ord] [redacted] in the resident's room and stated that no one had informed her that the [NJ Exec. Order] [redacted] were missing. The RN/UM further stated she did not know how long the [NJ Exec. Order 26:4.b.1] were not in place.

Review of the August 2022 and September 2022 Treatment Administration Record (TAR) revealed the aforementioned PO with the administration times of 7:00 AM, 3:00 PM, and 11 PM. The TAR further revealed that nurses signed daily that the [NJ Exec. Order 26:4.b.1] [redacted] were in place.

During an interview with the surveyor on 09/09/22 at 12:41 PM, the Director of Nursing (DON) stated that she expected the [NJ Exec. Order 26:4.b.1] [redacted] to be in the resident's room and available.

During an interview with the surveyor on 09/13/22 at 11:19 AM, the Regional Director of Clinical Services stated that Resident #6's [NJ Exec. Ord] [redacted] should have been applied per the physician order and that the nurses should not have been signing the [NJ Exec. Order 26:4.b.1] [redacted] as completed on the TAR if they were not applied as

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F 689	Continued From page 56 ordered. NJAC 8:39-27.1(a)	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel	F 690		10/31/22

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	315174	A. BUILDING _____ B. WING _____	09/20/2022

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F 690	Continued From page 57 receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to ensure that a resident with an EX Order 26.4B1 had physician orders for the care of the . The deficient practice was identified for 1 of 2 residents (Resident #136) reviewed for . This deficient practice was evidenced by the following: On 08/30/22 at 10:27 AM, during the initial tour of the 1st floor, the surveyor observed Resident #136 in bed. At that time, the surveyor observed a EX Order 26.4B1 attached to the bed frame. The EX Order 26.4B1 was also observed on EX Order 26.4B1 A review of Resident #136's electronic medical record (EMAR) under "Diagnosis" revealed a diagnosis of but not limited to, EX Order 26.4B1 A review of Resident #136's most recent Minimal Data Set, an assessment tool, dated EX Order 26.4B1 revealed Resident #136 had an EX Order 26.4B1 r. A Review of Resident's #136's physician's orders	F 690	Element 1: Resident #136□s orders were updated to ensure there were instructions for the presence of a EX Order 26.4B1 and care of the EX Order 26.4B1 Element 2: All with Ex.Order 26.4(b)(1) have potential to be affected by this deficient practice. There was no other identified resident that did not have orders for the presence and care of their Ex.Order 26.4(b)(1). Element 3: The facility policy for Ex.Order 26.4(b)(1) were reviewed and determined to be in compliance with state and federal guidelines. An in-service will be conducted with all nursing staff on Ex.Order 26.4(b)(1) specifically focusing on ensuring the residents orders reflect the presence of a Ex.Order 26.4(b)(1) and the care of the Ex.Order 26.4(b)(1). Element 4: The Director of Nursing/ Designee will complete audits of all Ex.Order 26.4(b)(1) to ensure orders for the presence and the care of the Ex.Order 26.4(b)(1). The audits will be completed weekly x 4 weeks and then	

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F 690	Continued From page 58 located in the EMAR, did not reveal any orders for care of the EX Order 26.4B1 [redacted]. A Review of Resident #136's Care Plan, with an initiation date of 07/25/22, revealed Resident #136 had EX Order 26.4B1. The Care Plan further revealed Resident #136 had a EX Order 26.4B1 [redacted]. On 09/01/22 at 10:04 AM, during an interview with the surveyor, Resident #136 stated his [redacted] needs to be changed but the nurse cannot do it since it is a EX Order 26.4B1. On 09/07/22 at 10:02 AM, during an interview with the surveyor, Licensed Practical Nurse/Unit Manager (LPN /UM) #1 confirmed Resident #136 had a EX Order 26.4B1. LPN/UM #1 stated "We changed it yesterday" when asked if there are any orders for the [redacted]. LPN/UM #1 confirmed Resident #136 needed to have physician's orders for [redacted] care. LPN/UM #1 said "Other than me not finishing his chart check." in response to being asked if there was a reason the resident did not have physician orders. On 09/12/22 at 1:27 PM, during an interview with the surveyor, the Director of Nursing stated, "Orders to check, to make sure there is no leakage, signs and symptoms of infection, the type, when it needs to be changed, and a diagnosis" in response to being asked what the expectation is for the medical record when someone is admitted with a EX Order 26.4B1.	F 690	monthly at a minimum of 6 months or until compliance is met. The results of these audits will be presented at monthly QAPI. The Director of Nursing is responsible for execution and monitoring of this POC.	

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F 690	Continued From page 59 A review of a facility policy titled, "Physician Orders" created on 1/2021 revealed under "Policy" that, "It is the policy of this facility to secure physician orders for care and services for residents as required by state and federal law..." Further, the policy revealed under "Procedure" number 8, that "Licensed Nurse receiving/accepted order is required to transcribe the order to the MAR or EMAR containing all required information." N.J.A.C. 8:39-27.1	F 690		
F 695 SS=D	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 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 documentation, it was determined that the facility failed to implement infection control measures for the handling and storage of [redacted] for 2 of 4 residents reviewed for [redacted], (Resident # 10 and Resident # 180). This deficient practice was evidenced by the following: 1. On 09/06/22 at 12:29 PM, Surveyor #1 observed the [redacted] of Resident #10's [redacted] propped in an upright	F 695	Element 1: 1.Resident #10 was evaluated with no negative effect noted. The resident[redacted] was immediately changed and placed in the plastic bag provided to avoid contamination. 2. Resident #180 was evaluated with no negative effect noted.	10/31/22

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F 695	Continued From page 60 position by the machine. The [NJ Exec. Order 26:4.b.1] was not contained in a bag and was exposed to the surrounding environment. A [EX Order 26.4B1] machine delivers [NJ Exec. Order 26:4.b.1] It is used to treat [NJ Exec. Order 26:4.b.1] conditions such as [NJ Exec. Order 26:4.b.1] etc. On 09/08/22 at 8:04 AM, Surveyor #1 observed the [NJ Exec. Order 26:4.b.1] of Resident #10's [EX Order 26.4B1] draped over the [EX Order 26.4B1] r machine. The [NJ Exec. Order 26:4.b.1] was not contained in a bag and exposed to the surrounding environment. On 09/07/22 at 10:56 AM, Surveyor #1 observed the [NJ Exec. Order 26:4.b.1] of the Resident #10's [EX Order 26.4B1] draped over the [EX Order 26.4B1] machine. The [NJ Exec. Order 26:4.b.1] was not contained in a bag and exposed to the surrounding environment. According to the admission record, Resident #10 was admitted to the facility with diagnosis, including but not limited to; [EX Order 26.4B1]. A review of the most recent Minimum Data Set (MDS), an assessment tool used to facilitate residents care, dated [EX Order 26.4B1] revealed a Brief Interview for Mental Status (BIMS) as a [EX Order 26.4B1] which indicated Resident # 10 was [EX Order 26.4B1]. The MDS also revealed the use of [EX Order 26.4B1] within the past 14 days. A review of the current Order Summary Report	F 695	The resident□s [EX Order 26.4B1] was immediately changed and the resident was educated on ensuring [EX Order 26.4B1] is placed in the plastic bag provided to avoid contamination. Element 2: All residents on [Ex.Order 26.4(b)(1)] treatments and [Ex.Order 26.4(b)(1)] equipment have potential to be affected by this deficient practice. Element 3: The facilities policy on [Ex.Order 26.4(b)(1)] was reviewed by administration and determined to be in compliance with state and federal guidelines. The in-service coordinator-initiated education to all nursing staffing on [Ex.Order 26.4(b)(1)] and [EX Order 26.4B1] storage in a plastic bag while not in use. The lesson plan and attendance record have been completed for validation. Element 4: The DON/ designee will audit 20% of residents on [Ex.Order 26.4(b)(1)] treatments to evaluate that the [Ex.Order 26.4(b)(1)] is bagged when not in use. The audit reports will be completed weekly x 4 weeks; then monthly at a minimum of 6 months or until compliance is met. The results of these audits will be submitted at monthly QAPI.	

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F 695	Continued From page 61 revealed a physician's order for EX Order 26.4B1 EX Order 26.4B1 NJ Exec. Order 26:4.b.1 via EX Order 26.4B1 every EX hours as needed for EX Order 26.4B1 . During an interview with the surveyor on 09/07/22 at 11:50 AM, the Registered Nurse (RN #2) confirmed that EX Order 26.4B1 are to be stored in bags. During an interview with the surveyor on 09/12/22 at 10:15 AM, the Licensed Practical Nurse Unit Manager (LPN/UM #3) confirmed that NJ Exec. Order 26:4.b.1 are to be stored within a bag. When asked if the NJ Exec. Order 26:4.b.1 are to be stored either uncovered hanging over the machine or upright on the machine, LPN/UM #3 stated, no it is not. 2. On 09/01/22 at 1:25 PM, the surveyor observed an EX Order 26.4B1 in Resident # 180's room. The EX Order 26.4B1 was not in use and the EX Order 26.4B1 was observed on top of the EX Order 26.4B1 and EX Order 26.4B1 a portion was lying on the windowsill exposed and uncovered. On 09/06/22 at 9:04 AM, the surveyor observed Resident #180's EX Order 26.4B1 . The EX Order 26.4B EX Order 26.4 was observed on the windowsill with the in contact with windowsill exposed and uncovered. According to the Admission Record Resident # 180 was admitted to the facility with diagnosis including but not limited to: EX Order 26.4B1	F 695	The DON is responsible for the execution of this POC.	

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F 695	Continued From page 62 EX Order 26.4B1. A review of the most recent MDS dated EX Order 26.4B1 revealed a BIMS score of EX Order 26.4 indicating the Resident is EX Order 26.4B1. The MDS further revealed the resident used EX Order 26.4B1 in the past 14 days. A review of the Order Summary Report with active orders as of EX Order 26.4B1 revealed a physician's order for EX Order 26.4B1 EX Order 26.4B1) NJ Exec. Order 26:4.b.1 every shift for monitoring. During an interview with the surveyor on 09/09/22 at 9:54 AM, LPN #3 said the process for EX Order 26.4B1 is change every other day on the 11 PM-7 AM shift and when not in use the EX Order 26.4B is supposed to be stored in plastic bag with date on it. During an interview with the surveyor on 09/09/22 at 9:58 AM, LPN/UM #2 said EX Order 26.4B1 EX Order 26.4B is replaced every week 11 PM-7 AM shift on Sundays. She went on to say the nurses should date EX Order 26.4B and the bag with name and date on it. LPN/UM #2 further stated EX Order 26.4B1 EX Order 26.4B should be in bag when not in use. During an interview with Director of Nursing (DON) on 09/12/22 at 10:45 AM, the DON said that the expectation of EX Order 26.4B1 and/or EX Order 26.4B1 is that they will be in the resident's room in a bag. The facility was not able to provide a policy regarding NJ Exec. Order 26:4.b.1 storage when not in use.	F 695		

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F 695	Continued From page 63 NJAC 8:39-25.2(b)	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to obtain a physician order to monitor the dialysis access site and failed to ensure the dialysis transfer forms of ongoing records of communication between the facility and dialysis center were consistently completed for 1 of 1 resident reviewed for dialysis care, (Resident #119). This deficient practice was evidenced by the following: During an interview with the surveyor on 09/06/22 at 9:21 AM, Resident #119 said he/she goes to [NJ Exec. Order 26:4.] on Monday-Wednesday-Friday (MWF). Resident #199 went on to say that he/she gets [EX Order 26.4B1] through a [NJ Exec. Order 26:4.b.1] is not ready for use. According to the Admission record Resident #119 was admitted to the facility with diagnoses, including but not limited to [EX Order 26.4B1]	F 698	Element 1: Resident #119 was evaluated and the resident's [Ex.Order 26.4(b)(1)] and there was [Ex.Order 26.4(b)(1)]. The physician was notified and the residents orders were updated to ensure the resident's [Ex.Order 26.4(b)(1)] is checked for [Ex.Order 26.4(b)(1)]. The resident's communication book was updated to ensure there are communication forms to communicate between the facility and the [Ex.Order 26.4(b)(1] Element 2: All [Ex.Order 26.4(b)(1] residents have the potential to be affected by this deficient practice. All other [Ex.Order 26.4(b)(] resident's orders were checked for monitoring with no other deficient practice. [Ex.Order 26.4(b)(1)] residents were reviewed to ensure communication books were up to date and the facility has regular communication with the [Ex.Order 26.4(b)(1)].	10/31/22

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F 698	Continued From page 64 A review of the most recent Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [EX Order 26.4B1] revealed a Brief Interview for Mental Status score of [EX Order 26.4] indicating Resident #119 was EX Order 26.4B1. The MDS further revealed the resident received [EX Order 26.4B1] a resident. A review of the current Order Summary Report with Active Orders as of [EX Order 26.4B1] revealed a physician order for the Resident to attend [EX Order 26.4B1] 3 times a week on (MWF) with a pickup time at 10:30 for a chair time of 4 hrs one time a day every Mon, Wed, Fri for [NJ Exec. Order 26:4.b]. A further review of the Order Summary Report did not include physician orders for care or monitoring of the EX Order 26.4B1 access. A review of the Medication Administration Records for August 2022 and September 2022 did not include documentation of care or monitoring of the EX Order 26.4B1 access. A review of the Care plan for Resident #119 revealed a focus area of the resident needs NJ Exec. Order 26:4.b.1 with an initiated date of [NJ Exec. Order 26:4.b.1]. Under the interventions/task section revealed monitor and document/report to physician as needed any signs/symptoms of NJ Exec. Order 26:4.b.1 The care plan further indicated Monitor/document/report to MD as needed for signs/symptoms of the following: NJ Exec. Order 26:4.b.1 A review of Resident #119 [NJ Exec. Order 26:4.b]	F 698	Identified deficient practice had immediate corrective action. Element 3: The facility policy on [Ex.Order 26.4(b)(1] was reviewed and determined to be in compliance with state and federal guidelines. The facility implemented a new policy in which [Ex.Order 26.4(b)(1)] residents are reviewed monthly by the interdisciplinary team to ensure the appropriate monitoring orders are in place and communication consistently occurs. The inservice coordinator educated license nursing on ensuring that [Ex.Order 26.4(b)(1] residents receive service consistent with professional standards including monitoring the [Ex.Order 26.4(b)(1)] for function and [Ex.Order 26.4(b)(1)] Element 4: The Director Of Nursing /designee will audit 5 [Ex.Order 26.4(b)(1)] residents to ensure the necessary monitoring orders are in place and communication consistently occurs between the facility and [Ex.Order 26.4(b)(1)]. The audits will be completed weekly x 4 weeks then monthly for a minimum of 6 months or until compliance is met. The results of these audits will be presented at monthly QAPI. The Director Of Nursing is responsible for	

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F 698	Continued From page 65 Transfer/Communication Form revealed missing documentation for the following dates: 08/05/22 from nursing, 08/12/22 from nursing and [NJ Exec. Order 26:4.b.] 08/17/22 from [NJ Exec. Order 26] s, 08/26/22 from nursing and [NJ Exec. Order 26:4.] , 09/02/22 from nursing and [NJ Exec. Order 26:4.b.] , 09/04/22 from nursing and [NJ Exec. Order 26:4.b] , and 09/07/22 from nursing. During an interview with the surveyor on 09/08/22 at 9:04 AM, Licensed Practical Nurse (LPN #1) stated we check to make sure there is NJ Exec. Order 26:4.b.1 return or before he/she leaves depending on time of departure. We document once resident returns. During an interview with the surveyor on 9/08/22 at 9:35 AM, RN/UM stated we make sure the site is NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 . For a [NJ Exec. Order 26:4.b.1] every shift. When asked about a NJ Exec. Order 26:4.b.1 access) she replied I don't think we do anything but monitor those. We have NJ Exec. Order 26:4.b.1 and [NJ Exec. Ord] assessments they (nurses) do and there should be physician order for the monitoring of NJ Exec. Order 26:4.b.1 . On 09/08/22 at 9:40 AM, the surveyor and the RN/UM reviewed the Order Summary Report for Resident #119. The RN/UM acknowledged there were no physician's orders to monitor the [EX Order 26.4B] and the EX Order 26.4B1 . The RN/UM stated the physician's order only included [NJ Exec. Order 26:4.b.] . RN/UM went on to say it is important that the [NJ Exec. Order 26] gets	F 698	the execution and monitoring of this POC.	

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F 698	Continued From page 66 monitored so we know the device is working correctly and [NJ Exec. Order 26:4.b.1] and [NJ Exec. Order 26:4.b.1] because if [NJ Exec. Order 26:4.b.1] have to put [NJ Exec. Order 26:4.b.1] and call 911. The resident has both a [NJ Exec. Order 26] and [NJ Exec. Order 26:4.b.1] and should be monitored. During an interview with the surveyor on 09/12/22 at 1:07 PM, the Director of Nursing (DON) said yes, the expectation is to have care/monitoring of [NJ Exec. Order 26:4.b.1]. We usually check [NJ Exec. Order 26:4.b.1] every shift. Check site and remove bandage and monitor for [NJ Exec. Order 26:4.b.1] every shift. [NJ Exec. Order 26:4.b.1] is monitored for [NJ Exec. Order 26:4] g every shift. The DON further said yes, there should be physician's order and the physician's order would be documented on the TAR (Treatment Administration Record). The DON said a communication book with separate sheet for each [NJ Exec. Order 26] s treatment is when he/she attends [NJ Exec. Order 26:4.b] The DON stated it is the Unit Manager or the Supervisor's responsibility to ensure the communication book is sent with the resident to [NJ Exec. Order 26:4.b] and reviewed for completeness upon the resident's return. A review of a facility policy titled [NJ Exec. Order 26:4.b] Management with last revised date of 5/2022 revealed under the Procedure section: 1. on admission resident will be assessed to determined access type([NJ Exec. O] EX Order 26.4B1) EX Order 26.4B1 . Site will be observed for function and signs and symptoms [NJ Exe] 2. The nurse will obtain orders for monitoring of site and interventions as appropriate. Orders to include: observe NJ Exec. Order 26:4.b.1 .	F 698		

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DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

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F 698	Continued From page 67 observe for [NJ Exec. Order 26:4.b.1] and every shift; report any abnormal findings to physician and/or [NJ Exec. Order 26:4.b] Observe EX Order 26.4B1 for [NJ Exec. Order 26:4]g and placement q (every) shift. if dislodged apply [NJ Exec. Order 26:4.b.1] and call 911. 4. Facility will establish open communication with the resident's [NJ Exec. Order 26:4.b] center utilizing a [NJ Exec. Order 26:4.b.1] Communication Book" completing the [NJ Exec. Order 26:4.b] Communication Form (CD-3A) a. The nurse will establish [NJ Exec. Order 26:4.b.1] vital signs, (blood pressure, pulse temperature, respirations) b. Advanced Directive status c. any pertinent resident information. 5. On return from the [NJ Exec. Order 26:4.b.1] the nurse will review the communication returning from [NJ Exec. Order 26:4.b.1]. The nurse should review specifically, pre and post vital signs, treatment tolerance, any meds (medications) giving [given] and any new orders for resident care.	F 698		
F 755 SS=D	N.J.A.C. 8:39-27.1(a) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 755		10/31/22

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F 755	Continued From page 68 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 other facility documents, it was determined that the facility failed to supervise the administration of medication for 1 of 10 residents (Resident #19) reviewed for medications. This deficient practice was evidenced by the following: On 09/06/22 at 9:50 AM, the surveyor observed Resident #19 lying in bed. There was a medicine cup with pills in it on the resident's over-the-bed table. When asked about the medicine cup, the resident stated the nurse left the medication at the bedside because the resident was waiting for his/her breakfast tray before taking the medications.	F 755	Element 1: Resident #19 was evaluated; medications were administered with no negative result from incident. LPN #3 was re-educated on safe medication and a medication administration compentency was completed. Element 2: All residents have the potential to be affected by this deficient practice. All other resident□s rooms were checked and no other unsupervised medications were identified.	

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F 755	Continued From page 69 During an interview with the surveyor on 09/06/22 at 9:51 AM, Licensed Practical Nurse (LPN) #3 stated she completed the morning medication pass for her assignment. She further stated that the medication administration process included making sure the resident swallowed their medications before leaving the resident's room because "sometimes they can choke," or "drop the medication," and that medication should not be left with the resident. When asked about Resident #19's medication that was left at the bedside, LPN #3 stated she should have waited until the resident's breakfast tray was delivered before administering the medications. During an interview with the surveyor on 09/06/22 at 10:00 AM, the Registered Nurse/Unit Manager (RN/UM) stated the nurse administering medications should watch the resident take their medications because the resident could pocket their medication in their cheeks, choke on the medication, or drop the medication. The RN/UM explained that if the Medication Administration Record (MAR) showed the nurse's initials and a check mark, it meant the medication was signed as administered. The RN/UM further stated that if the resident refused to take their medication, the nurse should take back the medications and re-attempt to administer the medications later. The RN/UM then stated that there were no residents on her unit that were allowed to self-administer medications. At that time, the surveyor accompanied the RN/UM to Resident #19's room. The RN/UM acknowledged the medications were left at the bedside but was unable to identify the quantity or	F 755	Element 3: The facility policy on medication administration was reviewed and determined to be in compliance with state and federal guidelines. The in-service coordinator/designee educated licensed nurses on principles of safe medication administration including supervising of resident ingesting the medication and completion of a medication administration competency. Element 4: The Director of Nursing/designee will audit 10 med passes on alternating hallways to ensure no medications are left at bedside without observation of the ingestion of the medications/ biologicals weekly x 12 weeks or until substantial compliance is achieved. The in-service coordinator/designee will complete 5 medication administration competencies weekly x 12 weeks or until substantial compliance is achieved. The results of these audits will be presented at monthly QAPI. The Director of Nursing is responsible for the execution and monitoring of this POC.	

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F 755	Continued From page 70	F 755		

what specific pills were in the medicine cup. The RN/UM then took the medicine cup out of the room and gave it to LPN #3. The RN/UM stated that LPN #3 should have taken the medications back and reoffered the medications to the resident when the breakfast tray was delivered. The RN/UM reviewed Resident #19's MAR and verified that the morning medications were signed out as administered and stated that LPN #3 should have documented the medications as refused.

According to the Admission Record, Resident #19 was admitted with diagnoses which included, but were not limited to, EX Order 26.4B1 [redacted]

Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] revealed the resident had a Brief Interview for Mental Status of [redacted] which indicated that the resident's EX Order 26.4B1

Review of the Care Plan included a focus of "NJ Exec. Order 26:4.b.1 [redacted] R/T [related to] [redacted]," dated [redacted], and an intervention to "Administer medications as ordered." Further review of the care plan did not include that the resident was able to self-administer medications.

Review of the Order Summary Report, dated 09/06/22, did not include an order that the resident was able to self-administer medications.

Review of the September 2022 MAR revealed the following medications were signed as

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F 755	Continued From page 71 administered for the morning medication pass: 1. EX Order 26.4B1 [redacted] During an interview with the surveyor on 09/06/22 at 10:56 AM, the Director of Nursing (DON) stated that the nurse should monitor the resident while they take their medications for resident safety. The DON further stated that if the resident refused to take their medication at that time, the nurse should remove the medications and reapproach the resident later. When the surveyor informed the DON of the above observation of Resident #19's medications that were left at the bedside, the DON stated that LPN #3 should have taken the medications out of the resident's room and should not have signed the medications as administered.	F 755		

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F 755	Continued From page 72 Review of the facility's Medication Administration policy, revised 12/2021, included, "For residents not in their rooms or otherwise unavailable to receive medications on the pass, the MAR may be 'flagged.' After completing the medication pass, the nurse returns to the missed resident to administer the medication," and, "If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose." Further review of the policy included, "Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely." NJAC 8:39-27.1(a); 29.2 (d)	F 755		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to: a.) follow professional standards of nursing practice by administering expired [redacted] medication and b.) ensure that [redacted] medication was administered to residents within an appropriate time frame according to physician's order and manufacturer specifications.	F 760	Element 1: Resident #12 was evaluated for [redacted] status post administration of short acting administration outside the prescribed before meals (AC) time frame with no lasting negative effect noted. Resident #93 was evaluated for	10/31/22

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F 760	Continued From page 73 This deficient practice was identified for 4 of 35 sampled residents, (Residents #12, #93, #182 and #168) reviewed for the administration of NJ Exec. Order 26:4.b.1) during medication administration and was evidenced by the following: 1. On 09/07/22 at 11:40 AM, the surveyor, in the presence of the Licensed Practical Nurse (LPN #2), observed within the Wing medication cart, one opened box of EX Order 26.4B1 (ml) inside a plastic bag for Resident #12. The box was labeled with an opened date of . At that time LPN #2 stated that Resident #12 only received when needed because he/she was on a) and that had an expiration date of 30 days after opened. During an interview with the surveyor on 09/08/22 at 12:44 PM, LPN #2 stated the NJ Exec. Order 26:4.b.1 for Resident #12 was the only for this resident in the medication cart and no other EX Order 26.4B1 was on the unit for Resident #12. LPN #2 stated that she had used this EX Order 26.4B1 vial to give Resident #12's doses. LPN #2 stated that the was expired and should have been discarded. According to the Admission Record, Resident #12 was admitted to the facility with diagnoses which included, but were not limited to,	F 760	Ex.Order 26.4(b)(1) status post administration of short acting administration outside the prescribed before meals (AC) time frame with no lasting negative effect noted. The expired were discarded as per facility policy. Resident #182 was evaluated for Ex.Order 26.4(b)(1) status post administration of short acting administration outside the prescribed before meals (AC) time frame with no lasting negative effect noted. Resident #168 was evaluated for Ex.Order 26.4(b)(1) status post administration of short acting administration outside the prescribed before meals (AC) time frame with no lasting negative effect noted. Element 2: All Ex.Order 26.4(b)(1) residents have the potential to be affected by this deficient practice. All other Ex.Order 26.4(b)(1) administration times were evaluated and residents with negative findings were evaluated for Ex.Order 26.4(b)(1) with no lasting negative effect noted. Element 3: The facility policy on medication administration was reviewed and determined to be in compliance with state	

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F 760	Continued From page 74 Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated EX Order 26.4B1, revealed that Resident #12 had EX Order 26.4B1 EX Order 26.4B1 and had received Ex.Order 26.4(b)(1) days during the assessment period. Review of Resident #12's August 2022 Medication Review Report reflected a physician order, dated EX Order 26.4B1, to EX Order 26.4B1 EX Order 26.4B1/ML EX Order 26.4B1 before meals for [redacted]. Review of Resident #12's August and September 2022 Medication Administration Record (MAR) reflected the corresponding 08/11/22 physician order for EX Order 26.4B1 Ex.Order 26.4(b)(1) with an administration time of 07:30 AM, 11:30 AM, and 1630 (4:30 PM) Further review of the August and September 2022 MAR reflected that the nurses administered the expired EX Order 26.4B1 on the following dates: 08/30/22, 08/31/22, 09/01/22, 09/02/22, 09/03/22, 09/04/22, 09/05/22, 09/06/22, and 09/07/22. During a follow up interview with the surveyor on 09/07/22 at 12:44 PM, LPN #2 stated that the expired EX Order 26.4B1 should have been discarded and a new EX Order 26.4B1 should have been ordered for Resident #12. During an interview with the surveyor on 09/08/22 at 1:42 PM, LPN #3 stated that EX Order 26.4B1 has an expiration date of 28	F 760	and federal guidelines. The facility implemented a new procedure in which the kitchen will page over head that the meal truck is leaving the kitchen for a specific unit. The licensed nurses will complete Ex.Order 26.4(b)(1) checks and administration of [redacted] after the meal truck leaves the kitchen. The inservice coordinator educated license nursing on ensuring Ex.Order 26.4(b)(1) [redacted] is administered according to the physician order. Element 4: The Director of Nursing (DON)/designee will audit 10 Ex.Order 26.4(b)(1) residents to ensure the physician order is followed. The audits will be completed weekly x 4 weeks then monthly for a minimum of 6 months or until compliance is met. The results of these audits will be presented at monthly QAPI. The DON is responsible for the execution and monitoring of this POC.	

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days once opened.

During an interview with the surveyor on 09/09/22 at 12:44 PM, the Director of Nursing (DON) stated that Resident #12's EX Order 26.4B1 with an opened date of 08/02/22 had an expiration date of 28 days and should have been discarded on 08/30/22. The DON further stated the nurse should not have administered the medication because it was expired.

2(a). Review of the Admission Record revealed Resident #12 was admitted to the facility with a diagnosis of EX Order 26.4B1

Review of the August 2022 Medication Review Report for Resident #12 revealed an order dated EX Order 26.4B1 .

Review of the Quarterly MDS, dated EX Order 26.4B1 revealed that Resident #12 had Ex.Order 26.4(b)(1) and had received Ex.Order 26.4(b) days during the assessment period.

Review of Resident #12's August and September 2022 MAR reflected the corresponding EX Order 26.4B1 physician order for EX Order 26.4B1 EX Order 26.4B1 before meals with an administration time of 07:30 AM, 11:30 AM, and 1630 (4:30 PM). On 09/07/22, the MAR revealed that the 11:30 AM dose included the nurses' s initials indicating that Resident#12 received EX Order 26.4B1 of EX Order 26.4B1 insulin.

On 09/07/22 the MAR's Location of

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F 760	Continued From page 76 Administration Report revealed that the 11:30 AM EX Order 26.4B1 was administered at 10:50 AM by LPN#2 EX Order 26.4B1 During an interview with the surveyor on 09/07/22 at 12:45 PM, LPN #2 stated that EX Order 26.4B1 can peak(EX Order 26.4B1) around 30 minutes after administered. If EX Order 26.4B1 Ex.Order 26.4(b) EX Order 26.4B1) was administered too early, then the resident would Ex.Order 26.4(b)(1) " (EX Order 26.4B1). LPN #2 stated " I really don't know how I would give the Ex.Order 26.4(b) when we don't know what time the food trucks would arrive on the floor." During an interview with the surveyor on 09/08/22 at 1:15 PM, Resident #12 stated " the nurse just took my Ex.Order 26.4(b)(1) around 10:30 AM and I received my Ex.Order 26.4(b)(1) Resident #12 stated that his/her lunch had not been delivered yet. On 09/07/22 at 1:27 PM the surveyor observed the lunch cart for EX Order 26.4B1 floor EX O wing arrive to the unit. On 09/07/22 at 1:31 PM the surveyor observed Resident #12 received his lunch tray. During an interview with the surveyor on 09/07/22 at 3:05 PM, LPN #2 stated that when Ex.Order 26.4(b) is ordered before meals, the Ex.Order 26.4(b)(1) to be given Ex.Order 26.4(b)(1) . The surveyor, in the presence of LPN #2, reviewed Resident #12's MAR Location of Admission Record, and LPN #2 confirmed that the 11:30 AM Ex.Order 26.4(b)(was documented as administered at 10:50 AM.	F 760		

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F 760	Continued From page 77 During an interview with the surveyor on 09/07/22, the Licensed Practical Nurse/Unit Manager(LPN/UM #2) stated that it [redacted] was ordered before meals, then the [redacted] should be administered [redacted] before meals. It may depend on when the meal trays arrive to the floor because sometimes the meal trays are late. When the meal cart would arrive to the unit hallway, then the [redacted] should be given. 2(b). A review of the Admission Record revealed Resident #93 was admitted to the [redacted] A review of a Physician Order Sheet (POS) with active orders as of [redacted], revealed an order for [redacted] md (medical doctor), [redacted] before meals and at bedtime for [redacted] A review of the most recent MDS dated [redacted] revealed a BIMS score of [redacted] indicating Resident #93 was [redacted]. A review of the MAR dated 09/01/22-09/30/22 revealed the [redacted] order and was timed at 7:30 AM, 11:30 AM, 1630 (4:00 PM) and 2100 (9:00 PM). On the MAR under the date of 09/08/22, revealed that at 7:30 AM, Resident #93 had a [redacted] of [redacted] and nurses' initials and [redacted] units indicating that Resident #93 received [redacted] units of [redacted].	F 760		

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F 760	Continued From page 78 A review of the Location of Administration Report dated 09/01/22-09/30/22 revealed that on 09/08/22 Resident #93 received his/her Ex.Order 26.4(b)(at 6:46 AM. During an interview with the surveyor on 09/08/22 at 7:49 AM, Licensed Practical Nurse (LPN #1) who was assigned to Resident # 93, said she gave her Ex.Order 26.4(b)(at 7:30 AM due to being on a Ex.Order 26.4(b)(1) to Resident #93. During an interview with the surveyor on 09/08/22 at 8:10 AM, Resident #93 said, "I think so" when asked if he/she received an Ex.Order 26.4(b)(his morning. He/she also said, "No, I have not had anything to eat today. I am not sure if I did get Ex.Order 26.4(b)(, they usually wait until my breakfast tray comes." On 09/08/22, the surveyor observed that Resident #93's breakfast tray arrived at 9:46 AM. During an interview with the surveyor on 09/09/22 at 09:37 AM, LPN #1, the nurse who administered the Ex.Order 26.4(b)(on 09/08/22 at 6:56 AM, said "Yes," she gave the Ex.Order 26.4(b) before Resident #93's meal was on the unit. She went on to say that it depends on the Ex.Order 26.4(b)(1), but "I usually hold the Ex.Order 26.4(b)(until breakfast." During a follow up interview with the surveyor on 09/09/22 at 10:15 AM, LPN #1 said, "Yes I should have waited until his/her breakfast tray came to administer the Ex.Order 26.4(b)(1)." 2(c). A review of Resident #182's Admission Record, reflected that the resident had diagnoses, which included but were not limited	F 760		

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F 760		F 760		

Continued From page 79

to, EX Order 26.4B1 EX Order 26.4B1.

Review of Resident #182's most recent MDS, dated EX Order 26.4B1 indicated that Resident #182 had a BIMS score of EX Order 26.4B which indicated the resident was EX Order 26.4B1. A further review of the resident's MDS, Section N - Medications, reflected that the resident had received EX Order 26.4B out of seven days.

A review of Resident #182's Order Summary Report dated 09/08/22, reflected a physician order for the Ex.Order 26.4(b)(1) ALL HCP (Health Care Provider), EX Order 26.4B1 before meals and at bedtime for EX Order 26.4B1.

A review of the resident's MAR for the period of 09/1/22-09/30/22, reflected that on 09/08/22, two units of EX Order 26.4B1) was administered at 8:21 AM for a EX Order 26.4B1 of EX Order 2 According to the manufacturer's specifications, EX Order 26.4B1 should be administered within Ex.Order 26.4(b)(1) a meal or immediately after.

A review of the resident's Care Plan indicated a focus area that the resident had EX Order 26.4B1 EX Order 26.4B1 and was Ex.Order 26.4(b)(1). The goal of the resident's Care Plan was that the resident would demonstrate a Ex.Order 26.4(b)(1) within acceptable ranges. The interventions of the resident's Care Plan included to monitor for signs and symptoms of EX Order 26.4B1

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F 760	Continued From page 80 administer meds per MD orders, provide Ex.Order 26.4(b)(1) as ordered, and to Ex.Order 26.4(b)(1) [redacted] On 09/08/22 at 10:35 AM, the surveyor observed the resident in his/her room. The resident was exiting the bathroom and a breakfast tray was set up, covered on a nearby table. The resident stated that his/her Ex.Order 26.4(b)(1) earlier in the morning. The resident stated that he/she had not eaten. 2(d). Review of the Admission Record reflected that Resident #168 was admitted with a diagnosis of EX Order 26.4B1 . Review of a Medication Review Report dated 09/09/22 revealed an order for EX Order 26.4B1 Ex.Or [redacted] units EX Order 26.4B1 with meals for Ex.Order 26 [redacted] The Medication Review Report further reflected an order for Ex.Order 26.4(b)(1) [redacted] EX Order 26.4B1 before meals for DM. Review of the most recent MDS revealed a BIMS score of EX Order 26.4 [redacted] indicating Resident #168 had EX Order 26.4B1 . Review of the MAR dated EX Order 26.4B1 reflected that the Ex.Order 26.4(b)(1) order, with meals for Ex.Order 26 [redacted] was plotted for administration at 7:30 AM,	F 760		

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F 760	Continued From page 81 11:30 AM and 1630 (4:30 PM). On 09/08/22 the MAR revealed that at 7:30 AM, the nurse recorded her initials, indicating that Resident #168 received EX Order 26.4B1 . The MAR further revealed the sliding scale EX Order 26.4B1 EX Order 26.4B order was plotted for administration at 7:30 AM, 11:30 AM, and 1630 (4:30 PM). On 09/08/2022, the MAR revealed that at 7:30 AM, the nurse recorded Ex.Order 26.4(b)(1) of EX Order , the nurse's initials and units, indicating Resident #168 received units of EX Order 26.4B1 . Review of the Location of Administration Report dated EX Order 26.4B1 revealed that EX Order 26.4B1 LPN #1 documented that Resident #168 received his/her Ex.Order 26.4(b) at 7:27 AM and 7:28 AM. On 09/08/22, the surveyor observed that Resident #168's breakfast tray arrived on the unit at 9:05 AM. During an interview with the surveyor on 09/08/22 at 12:27 PM, the Consultant Pharmacist (CP) stated that Ex.Order 26.4(b)(1) should be administered Ex.Order 26.4(b)(1) prior to a meal. If the medication was administered earlier and the meal tray does not come to the unit until later, the nurse should be offering crackers to the resident, unless the resident's diet required differently. The CP further stated that in the worst case scenario, the resident would have become Ex.Order 26.4(b)(1) During an interview with the surveyor on 09/09/22 at 10:17 AM, LPN #1, the assigned nurse who administered the Ex.Order 26.4(b)(at 7:27 AM and 7:28 AM, stated she administered Resident	F 760		

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F 760	Continued From page 82 #168's EX Order 26.4B1 before the resident's breakfast tray came to the floor. LPN #1 further stated that she should have waited until the breakfast tray came to the floor. During an interview with the surveyor on 09/09/22 at 12:09 PM, the DON stated that the nurse should have waited until the food trays were on the floor prior to administering Ex.Order 26.4(b)(and that the nurse could have provided the residents crackers, pudding, applesauce, or a sandwich if the food trays were late. The DON stated that she expected the nurses wait until the food carts are on the unit prior to administering the Ex.Order 26.4(b. The DON stated that if the Ex.Order 26.4(b was given too early, that the resident would become EX Order 26.4B1. Review of the facility's policy titled Ex.Order 26.4(b)(Administration", revised 1/2022, reflected to check expiration date if drawing from an opened multi- dose vial and follow manufacturers recommendations for expiration after opening. Review of the facility's policy titled " Medication Administration," revised on 12/2021, revealed that the expiration date on the medication label must be checked prior to administering. The policy further reflected that medications must be administered in accordance with the orders, including any required time frame. NJAC 8:39-29.2(d)	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F 761		10/31/22

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F 761	Continued From page 83 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure expired and discontinued medications were removed from active inventory and medications were appropriately labeled and dated when opened in 1 of 4 medication carts reviewed. This deficient practice was evidenced by the following: On 09/07/22 at 11:40 AM, the surveyor, in the presence of the Licensed Practical Nurse (LPN #2), observed the following within the EX Order 26.4B1	F 761	Element 1: Resident# 12□s, 131□s, 41□s expired medications were discarded and replacement medications were ordered. Resident #12 was evaluated with no noted physical effect. Resident #131 was evaluated with no lasting negative physical effect.	

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F 761	Continued From page 84 medication cart: -One opened box of EX Order 26.4B1 [redacted] located inside a plastic bag for Resident #12. The box was labeled with an opened date of 08/02/22. At that time LPN #2 stated that Resident #12 only received [redacted] when needed because he/she was on a [redacted]) and that [redacted] had an expiration date of 30 days once opened. -Ex.Order 26.4(b)(1) [redacted] micrograms (mcg) (used to treat [redacted] or EX Order 26.4B1 [redacted] for Resident #131 labeled with an opened date of 07/10/22. LPN #2 stated "I think this medicine was discontinued and Resident #131 does not get this medicine anymore." -One opened and undated box of EX Order 26.4B1 [redacted] for Resident #41. LPN #2 stated that the [redacted] should have been dated at the time the [redacted] medication was opened. Review of Resident #12's August and September 2022 Medication Administration Report (MAR) revealed a physician's order (PO), dated 08/11/22, for EX Order 26.4B1 [redacted] EX Order 26.4B1 [redacted]) inject [redacted] units EX Order 26.4B1 [redacted] before meals for [redacted] [redacted] Resident #131's EX Order 26.4B1 MAR revealed that EX Order 26.4B1 [redacted] mcg was discontinued on [redacted]	F 761	Resident #41 was evaluated with no lasting negative physical effect. Element 2: All residents have the potential to be affected by this deficient practice however, no other resident was identified to be affected. Element 3: The facility policy on storage of medication was reviewed and determined to be in compliance with state and federal guidelines. The facility implemented a new procedure in which the unit manager checks the medication carts weekly and removes any expired medications. The in-service coordinator educated license nursing on ensuring medications are within the guidelines for manufacturer instructions including discarding after expiration dates. Element 4: The Director of Nursing/designee will audit 2 medication carts to ensure there are no expired medications in the medication cart. The audits will be completed weekly x 4 weeks, then monthly for a minimum of 6 months or until compliance is met. These audits will be submitted at monthly	

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F 761	Continued From page 85 Review of Resident #41's September 2022 MAR revealed a PO, dated 09/03/22, for Ex.Order 26.4(b)(1) [redacted]. During a follow up interview with the surveyor on 09/07/22 at 12:44 PM, LPN #2 stated that the EX Order 26.4B1 was expired, should have been discarded, and a new Ex.Order 26.4(b)(should have been ordered for Resident #12. LPN #2 further stated that the EX Order 26.4B1 should have been removed from the cart when it was discontinued, and the EX Order 26.4B1 should have been dated when opened. During an interview with the surveyor on 09/08/22 at 11:42 PM, LPN #3 stated that when a nurse opened a new medication such as an Ex.Order 26.4(b)(1), the nurse would write the date the medication was opened on the medication package. LPN #3 further stated that discontinued medications should not be kept in the medication cart and that EX Order 26.4B1 had an expiration date of 28 days after opened. During an interview with the surveyor on 09/09/22 at 12:44 PM, the Director of Nursing (DON) stated that when a medication such as Ex.Order 26.4(b)(1) was opened, the nurse would immediately write the date it was opened on the medication. The DON stated that EX Order 26.4B1 had an expiration date of 28 days after opened and that the EX Order 26.4B1 for Resident #12 was expired, and should have been discarded. The DON further stated that expired and discontinued medications should be removed from the medications carts and placed	F 761	QAPI. The Director of Nursing is responsible for the execution and monitoring of this POC.	

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F 761	Continued From page 86 in the medication storage rooms to be returned to pharmacy. A review of the facility's policy titled "Medication Storage," revised 10/2021, revealed that expired, discontinued and/or contaminated medications will be removed from the medication storage areas and disposed of in accordance with facility policy. On 09/09/22 at 12:18 PM, the Assistant Administrator stated that the facility did not have any other policies for labeling, dating, and storing of medications. NJAC 8:39-29.4(g)	F 761		
F 802 SS=F	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii).	F 802		10/31/22

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F 802	Continued From page 87 This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility had insufficient staffing in the kitchen to carry out the duties of the food service operations competently. This deficient practice was evidenced by the following: Cross-reference: F 760, F803, F804, F809 and F812 On 08/30/22 at approximately 10:00 AM, during the initial brief tour of the kitchen, the surveyor questioned the Director of Food Services (DOFS) why the kitchen staff were still assembling breakfast trays at 10:00 AM. The DOFS explained, "We are normally done breakfast tray line by 9 AM. I had to call in (2) staff and borrow a cook from a sister facility. Staffing has been an issue for the month I've been here. It is slowing and affecting our production." On 08/30/22 at 11:24 AM, the surveyor observed CNA #3 assisting resident #92 with the breakfast meal at 11:24 AM. The surveyor asked CNA #3 if that was breakfast or lunch. CNA #3 stated, "It's breakfast. They didn't send a puree tray and we had to wait for another. We get the trays based on how many people show up to work in the kitchen." On 09/01/22 at 10:22 AM, the surveyor conducted an interview with the DOFS in the kitchen to determine why the breakfast trays were late to arrive on the [redacted] unit, as per the meal delivery schedule provided to the surveyor on entrance. The surveyor questioned the DOFS if trays had arrived late because the kitchen was	F 802	Element 1: The facility schedules were reviewed by the administrator and staff was added to have sufficient staffing in the kitchen. Additional recruitment efforts were employed including: heavily recruiting new dietary staff, Additional Ads posted on many job platforms, Sign on bonuses have been added to help recruit new staff, The facility has entered a new union contract which raised the rates / benefits for new and existing dietary staff, The facility is conducting weekly orientations which is more frequent than usual. The Facility reviewed and implemented the policy relation to staffing of the food service operation. Element 2: All residents have the potential to be affected by this deficient practice. The facility schedules were reviewed by the administrator and staff was added to have sufficient staffing in the kitchen Element 3: The Food Service and HR Director were educated by the Administrator on ensuring that sufficient Kitchen staffing levels are reached. The facility policy on staffing of the food service operation was reviewed and determined to be in compliance with state	

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F 802	Continued From page 88 short of staff, as previously told to the surveyor on the initial kitchen tour. The DOFS responded, "Yes we are short of staff today. The trays arrived on the [redacted] unit late because I don't have enough staff. I would say this is an industry wide problem. I am also short cooks. I have 5 people in orientation right now. I have made the administrator aware. He told me to look at an online job search company." On 09/02/22 at 10:57 AM, the surveyor conducted an interview with the DOFS. The surveyor questioned the DOFS why some resident's (Resident #92) received their breakfast meal on a paper plate. The FSD responded, "It's not a lack of plates, it's a lack of staff." The DOFS explained that he didn't have sufficient staff and all the dishes were not cleaned, therefore they utilized paper plates at the breakfast meal because there were not enough cleaned and sanitized regular dishware to serve the breakfast meal to all residents in the facility. The DOFS further explained that "I'm the director, I'm the cook, and I'm the dishwasher right now." On 09/06/22 at 09:55 AM, the surveyor interviewed the DOFS. The surveyor asked the DOFS if he was short of staff in the kitchen. The DOFS responded, "Yes, we are short of staff today. We are short a cook, a dishware, and a server. I'm down 3 employees and I have had to be the cook almost daily. I do have a cook going through orientation. I didn't even to get to take a holiday. My Labor Day will be Friday. Saturday (09/03/2022) I had 5 call outs. I had to have nursing come down and help me." On 09/08/22 at 10:08 AM, the surveyor	F 802	and federal guidelines. The Food Service / HR Directors will audit daily dietary schedules to ensure adequate staffing levels are reached. Element 4: The Administrator / Designee will audit dietary schedules to ensure there is sufficient kitchen staff. Audits will be completed weekly x 4 weeks and then monthly for the next three month. Any findings will be brought to the monthly QA Meeting. The Administrator/Designee is responsible for this POC.	

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F 802	Continued From page 89	F 802		

interviewed the DOFS in the main dining room. The surveyor made the DOFS aware that a test tray had been conducted to assess food temperatures on the unit. The surveyor told the DOFS that the hot and cold food temperatures were not in compliance with industry standards. The DOFS replied, "Ahh geeez, they were ice cold. You know it was hot when we made it. I'm losing it across the board. It boils down to manpower and I'm still short of staff right now. I had to call my assistant in because today was delivery day, and I didn't have enough staff." I don't get any days off unless I have an appointment.

On 09/09/22 at 10:43 AM, the surveyor interviewed the Assistant Food Service Director (AFSD). The surveyor asked the AFSD if the kitchen had adequate staffing on this day. The AFSD told the surveyor, "We are very short today. We are down 4 positions, that's why the trays are late. I had to use paper products at breakfast because we would not be able to get the dishes clean in time for the lunch meal. The lunch meal would get pushed back too far, so we used paper products this morning to save time, which is because we are down 4 people today."

On 09/12/22 at 10:57 AM, the surveyor entered the kitchen accompanied by DOFS to assess the operation of the high temperature dish machine. The surveyor questioned the DOFS if the dish machine was in operation. The DOFS stated, "Let me go fire it up. I'm 4 people short today."

On 09/12/22 at 01:38 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA). The surveyor asked the

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F 802	Continued From page 90 LNHA if the facility was experiencing a staffing shortage in the kitchen. The LNHA replied, Yes, we have staffing issues in the kitchen over the past month, but we have hired some new employees." The surveyor asked the LNHA if he was aware that the kitchen was 4 staff short on this day. The LNHA replied, "I was not aware that we were 4 short today." The facility did not provide a policy or procedure in relation to staffing of the food service operation. The surveyor reviewed the facility pest management service invoice, dated 08/26/22. The invoice under General Comments/Instructions revealed the following by the technician on duty: " .... From speaking with the employees, I understand that the kitchen is currently very short handed." NJAC 8:39-17.3	F 802		
F 803 SS=F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and	F 803		10/31/22

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F 803	Continued From page 91 ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a) ensure that staff were following the menu over multiple meal observations which affected all residents of the facility and b) failed to obtain approval of menu substitutions in accordance with facility policy. This deficient practice was evidenced by the following: 1. On 08/30/22 at 11:24 AM, Surveyor #1 observed a Certified Nursing Assistant (CNA #3) assisting resident #92 with the breakfast meal. The surveyor asked CNA #3 if that was the breakfast or lunch meal. CNA #3 stated, "It's breakfast. They didn't send a puree tray and we had to wait for another." According to the Admission Record, Resident #92 was admitted to the facility with diagnosis including but not limited to EX Order 26.4B1 [redacted]	F 803	Element 1: Meal tickets and trays were adjusted to make sure the tray matched the ticket and the menu was being followed. The following residents were evaluated by the RD and their Ex.Order 26.4(b)(1) [redacted]: Resident #92 Resident #56 Resident #12 Resident #4 Resident #124 Resident #41 Element 2: All residents have the potential to be affected by this deficient practice. Meal tickets and trays were adjusted to make sure the tray matched the ticket and the menu was being followed. Element 3:	

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F 803	Continued From page 92 EX Order 26.4B1. According to the interdisciplinary care plan for Resident #92, Resident #92 was care planned for a Ex.Order 26.4(b)(1): "Related to EX Order 26.4B1 EX Order 26.4B1 ,Ex.Order 26.4(b)(1) " Care planned interventions/ tasks included, "Provide regular Ex.Order 26.4(b)(1) with meals, not Ex.Order 26.4(b)(1)-prefers per [spouse], double portions, x 2 juice with meals and Ex.Order 26.4(b)(1) with meals. During a tour of the facility on 08/30/22 at 11:25 AM, Surveyor #3 observed Resident #56 sitting up in bed. During the interview, the resident stated the meal trays were always missing items and that the trays often did not match the meal tickets. Review of Resident #56's Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated EX Order 26.4B1 revealed Resident #56 had a Brief Interview for Mental Status score of '[redacted]' which indicated that the resident's EX Order 26.4B1 On 08/31/22 at 09:33 AM, Surveyor #1 observed Resident #92 lying in bed with his/her eyes closed. Breakfast tray was at bedside on over the bed table. The breakfast tray consisted of Ex.Order 26.4(b)(1) [redacted], as per meal ticket. No Ex.Order 26.4(b)(1) was observed on Resident #92's meal tray.	F 803	The Food Service Director and RD were educated on ensuring menus are followed and to have menu substitutions approved by the facility RD before making changes to the menu. All Nursing and Dietary staff were educated to ensure accuracy of each food tray. The following policies were reviewed and determined to be in compliance with state and federal guidelines: 1) Tray Assembly Identification and Service Policy 2) Menu Substitution Policy Audit tools were developed for the FSD to ensure tray accuracy. Element 4: The Food Service Director / Designee will audit 10% of food trays to ensure accuracy of food trays. Audits will be completed weekly x 4 weeks and then monthly for the next three month. Any findings will be brought to the monthly QA Meeting. The Food Service Director is responsible for this POC.	

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F 803	Continued From page 93 On 08/31/22 at 1:06 PM, Surveyor #3 observed Resident #56's lunch meal service. The resident's tray was positioned on the overbed table next to the bed. Surveyor #3 observed resident #56's meal and tray observed noted with missing items. The resident did not receive a dinner roll or frosted slice of cake as documented on the meal ticket slip. On 09/01/22 at 10:08 AM, Surveyor #1 observed CNA #3 provide [redacted] with eating the breakfast meal for Resident #92. According to Resident #92's meal plan ticket for the breakfast meal, dated 09/01/22, Resident #92 was to receive the following diet: [redacted] liquids. Review of the 09/01/22 breakfast meal ticket revealed that Resident #92 was to receive a [redacted] with his/her meal. Resident #92 received puree scrambled eggs, cream of wheat in a Styrofoam style take-out container, puree muffin, (2) nectar thick apple juices, (1) nectar thick lemon-flavored water and (2) margarines. Resident did not receive [redacted] as indicated on meal plan ticket. No salt and pepper were provided. The roommate of Resident # 92 also did not receive salt or pepper packet on tray, as observed by the surveyor. On 09/01/2022 at 10:22 AM, Surveyor #1 conducted an interview with the Director of Food Services (DOFS) in the main dining room. The surveyor questioned whether the facility had [redacted] in supply. The DOFS stated, "We have [redacted] in supply, yes."	F 803		

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F 803	Continued From page 94 On 09/02/22 at 1:23 PM, Surveyor #3 observed Resident #56's lunch meal service. The resident's tray was positioned on the overbed table next to the bed. Surveyor #2 observed resident #56's meal and tray observed noted with missing items. The resident did not receive the chef choice of vegetables or dinner roll. Resident #56 stated he/she has made multiple requests for vegetables but did not always receive it. On 09/06/2022 at 10:51 AM, Surveyor #1 observed resident #41 eating breakfast meal in their room. The surveyor observed Resident #41's meal tray and the breakfast meal was served on a Styrofoam plate. The meal consisted of scrambled eggs and a muffin, and hot cereal served in a take-out style Styrofoam box. Surveyor #1 reviewed the facility provided menu for breakfast on 09/06/22, Week 4. The menu revealed that the breakfast meal on Tuesday 09/06/22 should have included bacon slices. Surveyor #1 went to the facility kitchen and conducted an observation and interview with the DOFS. The DOFS stated to Surveyor #1 when questioned whether there was bacon available for the breakfast meal, "No, we ran out." On 09/07/22 at 10:10 AM, Surveyor #1 observed that Resident #92 received his/her breakfast tray at 10:10 AM. Resident #92 received what CNA described as "ground up pancakes." Meal ticket revealed that Resident was to receive egg and cheese biscuit and Ex.Order 26.4(b)(1). Resident #92 had no Ex.Order 26.4(b)(1) on meal tray at this meal and received ground pancakes instead of a puree egg and cheese muffin.	F 803		

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F 803	Continued From page 95 A review of the menu for breakfast on 09/07/2022, revealed the following to be served: Apple juice, oatmeal, egg cheese biscuit, 2% milk, and coffee. Observation of Resident #124's meal ticket revealed that they were to receive an egg and cheese biscuit as the breakfast entree on 09/07/2022. Resident #124 did not receive an egg and cheese biscuit and did not receive salt or pepper with the meal, as indicated on the meal ticket. Surveyor #1 interviewed the DOFS on 09/07/22 at 10:22 AM. The surveyor explained to the DOFS that the breakfast menu on Wednesday 09/07/2022 revealed that facility residents were to receive an egg and cheese biscuit, however no residents received an egg and cheese biscuit at breakfast. The DOFS explained, "You are correct, I can't argue with you, I was wrong. I didn't have enough eggs to make an egg and cheese biscuit today. I don't have enough biscuits, I didn't have enough to serve everybody, so I went with pancakes, white bread, and eggs. I substituted pancakes for the egg and cheeses biscuit." Surveyor #1 questioned whether the DOFS had approved the menu substitution with the facility Registered Dietitian (RD). The DOFS replied, "I did not approve it with the dietitian. I came in at 5:30 AM. I never contacted the dietitian because she doesn't come in until 8 AM." Surveyor #1 then questioned whether it was facility policy to have menu substitutions approved by the facility RD before making changes to the menu. The DOFS responded, "Yes, our facility policy is to have menu	F 803		

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substitutions approved by the dietitian before making substitutions. I didn't this time because I was too busy cooking, because I'm short of staff. I'm a happy camper today because I have a cook in orientation." Surveyor #1 then asked the DOFS if a resident had a Ex.Order 26.4(b)(1) on their menu was the kitchen supposed to provide the supplement for that resident. The DOFS explained, "If the meal ticket stated a resident is to receive a Ex.Order 26.4(b)(1), then it should be on the tray. Did we miss it? I have a whole case in the box." Surveyor #1 asked the DOFS if he was aware that the posted menu was not being served regularly. The DOFS answered, "I am aware that I do not follow the facility menu. I follow it the best I can." I can make menu adjustments, but I am supposed to email a corporate employee for approval if I get them to her in time. I just found that out yesterday."

On 09/07/22 at 01:21 PM, Surveyor #1 observed Resident #4's lunch meal. The facility menu revealed that Resident #4 was to receive "Jell-O w/ topping" as the dessert at the lunch meal. Observation of the meal tray revealed Resident #4 did not receive Jell-O w/topping, no salt/no pepper, no Lactaid milk, and no water, as per the meal ticket.

In addition, Surveyor #2 observed the following at the lunch meal:

On 09/07/22 at 1:15 PM, Surveyor #2 observed Resident #12 lying in bed awake and alert. Resident #12 stated that he/she received breakfast around 10:30 AM and did not receive what was on the menu ticket. Resident #12 further stated that he /she was supposed to

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receive eggs and bacon but only received 3 little pancakes. Resident #12 stated" I never get what is on the menu."

On 09/07/22 at 1:31 PM, Surveyor #2 observed Resident #12's lunch tray. Surveyor #2 observed the lunch tray included chocolate pudding and cranberry juice. Resident #12's meal ticket noted that the resident should have received "Jell-O" with topping and apple juice.

On 09/07/22 at 02:40 PM, Surveyor #1 interviewed the facility RD. Surveyor #1 questioned the RD what the purpose of a Ex.Order 26.4(b)(1) was and if they were a care planned intervention as prescribed for a resident to receive as part of the meal plan. The RD explained, "The Ex.Order 26.4(b)(1) is put in place for Ex.Order 26.4(b)(1) and is to be provided at all meals including breakfast, lunch and dinner, as ordered." The RD further said, "It is of benefit to the resident to have the Ex.Order 26.4(b)(1) and yes, it is a care planned intervention." Surveyor #1 asked the RD if she had ever completed any audits to assess whether residents who were prescribed the Ex.Order 26.4(b)(1) were receiving them. The RD responded, "I did audits to see if resident received them consistently with the previous DOFS. I have not had any issues yet with the present DOFS.

On 09/07/22 at 02:45 PM, Surveyor #1 further interviewed the facility RD. Surveyor#1 questioned the RD if she had been contacted by the DOFS to approve a menu substitution for the AM breakfast. The RD stated, "I was asked to fill out the substitution log today before lunch." The surveyor asked the RD if she had ever been

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asked previously to approve any facility menu substitutions. The RD responded, "This is the only time I was asked to fill out the substitution log since the new foodservice director started approximately a month ago." Surveyor #1 asked the RD if the DOFS was qualified to make menu substitutions without approval of the facility RD. The RD replied, "He is not qualified to make substitution decisions. The facility policy for menu substitutions is that the RD should be contacted for approval of the menu change before the menu change is made. The DOFS did not call me this morning but had me approve the substitution around lunch time. 5:30 AM was a little early so he probably didn't want to call me at that time."

On 09/09/22 at 10:28 AM, the meal cart for breakfast arrived on unit [redacted] at 10:28 AM. Resident #92 received his/her breakfast meal at 10:30 AM. Resident #92's meal ticket revealed that he/she was to receive a puree sausage patty x 2. The surveyor and CNA #4 both observed the breakfast tray and determined that no sausage puree was provided. The surveyor reviewed the facility menu for Friday 09/09/22 and the menu included "sausage patty" at the breakfast meal.

During a follow up interview with Surveyor #3 on 09/09/22 at 10:33 AM, Resident #56 stated the facility did not have enough staff in the kitchen which resulted in them receiving meals late. The resident added that at times breakfast got delivered around 10:30 AM and dinner got delivered around 6:00-6:30 PM. Resident #56 further stated that residents were not inform of menu changes, received the wrong items, or have items missing from the meal trays.

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F 803	Continued From page 99 The surveyor reviewed the facility policy titled Tray Assembly Identification and Service Policy; last date revised: 1/2022. The following was revealed under the heading POLICY: "There will be a means of identifying resident meals and trays for therapeutic requirements and resident preferences." The following was revealed under the heading PROCEDURE: Food Service 3. Meal tickets are printed for Breakfast, Lunch and Dinner daily and as needed during the day for new admits. 4. Resident diet order and food preferences are obtained and entered [Company] Meal Program. 5. Tickets are used to identify correct items for resident diet. 7. Food service staff will check trays for correct diets before the food carts are transported to their designated areas. Nursing 11. The licensed nurse will confirm individual name and diet on the tray card/ticket to verify that the meal is served to the correct person, and check items on the plate/tray to assure accuracy for the therapeutic diets or texture or consistency modifications. 12. Nursing will check each food tray for the correct diet before serving the residents.	F 803		

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F 803	Continued From page 100 The surveyor reviewed the facility policy titled Menu Substitution Policy; last date revised: 4/2022. The following was revealed under the heading PROCEDURE: 1. The Food Services Manager, in conjunction with the Clinical Dietitian/Registered Diet Technician, may make food substitutions as appropriate or necessary. The Food Services Shift Supervisor on duty will make substitutions only when unavoidable. 2. Deviations from menus that have already been posted will be noted on menu substitution log form (including the reason for the substitution and/or deviation) in the kitchen and/or in the record book used solely for recording such changes. Menu substitutions will be approved and signed by the Registered Dietitian on the approved menu substitution log. 3. When in doubt about an appropriate substitution, the Food Services Manager will consult with the Dietitian prior to making the substitution. NJAC 18:39-17.2 (b) NJAC 18:39-17.4 (a) (1)	F 803		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §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;	F 804		10/31/22

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F 804	Continued From page 101 §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: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to consistently serve foods at a safe and appetizing temperature. This deficient practice was evidenced by the following: Cross Reference F 802 On 08/30/22 at approximately 10:05 AM, the surveyor conducted the initial tour of the kitchen. The surveyor questioned the Director of Food Services (DOFS) why the kitchen staff were still assembling breakfast trays at 10:00 AM. The DOFS explained," We are normally done breakfast tray line by 9 AM. I had to call in (2) staff who were scheduled off today and borrow a cook from our sister facility. Staffing has been an issue for the month I've been here. It is slowing and affecting our production." On 09/01/22 at 10:22 AM, the surveyor conducted an interview with the DOFS to determine why the breakfast trays were late to arrive on the Ex Order unit, as per the meal delivery schedule provided to the surveyor on entrance. The surveyor questioned the DOFS if trays had arrived late because the kitchen was short of staff, as previously told to the surveyor on the initial kitchen tour. The DOFS responded, "Yes we are short of staff today. The trays arrived on the Ex Order unit late because I don't have enough staff. I would say this is an industry wide problem.	F 804	Element 1: The facility thermometers were determined to be within range of the manufacturer guidelines. There was no identified resident on unit Ex Order with food borne illness following distribution of trays on 9/20/22 at 10:02 am. Element 2: All residents have the potential to be affected by this deficient practice. Facility-wide Food temperature audits were conducted for each unit to ensure food temperatures were in compliance with the facility policy. Identified temperatures outside the range indicated in the policy had immediate corrective action. Element 3: The following policies were reviewed and determined to be in compliance with state and federal guidelines: 1) Food Safety-Food Handling Policy 2) Food Temperatures Policy. The dietary department amended procedures to ensure that food trays leave the kitchen when the tray line for the unit is complete to ensure that	

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F 804	Continued From page 102 I am also short cooks. I have 5 people in orientation right now. I have made the administrator aware. He told me to look at a job search engine." The surveyor then asked the DOFS why some residents received trays with only a top pellet cover and no bottom pellet cover and why the hot cereal was served in a Styrofoam take out style container. The DOFS responded, "We are short on pellets, yes. I also ran out of plastic lids that is why we had to use the Styrofoam containers for the hot cereals. I don't have plastic lids for the bowls." The surveyor questioned who was responsible for placing the food service orders. The DOFS explained "I am responsible for the ordering, and I admit that I messed up. I've got an order coming in later today." The surveyor questioned the DOFS why the use of a top and bottom pellet is important in food service and the DOFS responded, "The pellets are necessary to keep the food warm." On 09/02/22 at 10:57 AM, the surveyor conducted an interview with the DOFS. The surveyor questioned the DOFSA why some resident's (Resident #92 was observed at breakfast in room) received their breakfast meal on a paper plate. The DOFS responded, "It's not a lack of plates, it's a lack of staff." The DOFS explained that he didn't have sufficient staff and all the dishes were not cleaned. Therefore, they utilized paper plates at the breakfast meal because there was not enough regular dishware to serve all the residents' breakfast in the facility. On 09/08/22 the surveyor at approximately 09:41 AM, the surveyor entered the kitchen to conduct a test tray to evaluate food temperatures. The	F 804	temperatures remain optimal. The inservice coordinator educated ll dietary and nursing staff on ensuring Food is served at a safe and appetizing temperature. Element 4: The Food Service Director / Designee will audit 10% of food trays to ensure the Food is served at a safe and appetizing temperature. Audits will be completed daily x 1-week, weekly x 4 weeks and then monthly for the next three months. Any findings will be brought to the monthly QA Meeting. The Food Service Director is responsible for this POC.	

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F 804	Continued From page 103	F 804		

surveyor had previously entered the kitchen at 07:24 AM and took tray line temperatures of the breakfast meal and observed dietary staff assembling trays with hot cereal, milks, juices, and coffee at 08:08 AM. Hot cereals were being boxed in Styrofoam at 07:24 AM as the surveyor arrived in kitchen. As of 08:09 AM the breakfast line had not been initiated for resident meal service. The breakfast tray line was initiated at 08:15 AM with 1 cook and 3 dietary staff. The surveyor selected the Ex.Order 26.4(b)(1) to conduct the test tray, as the meal delivery schedule designated this cart as the last cart to be delivered for the lunch meal service. The surveyor requested the dietary staff to assemble a test tray and the test tray was loaded on the Ex.Order Cart 2 and left the kitchen at 09:49 AM. The surveyor was accompanied by the Assistant Director of Food Service (ADOFS) and the Ex.Order meal cart arrived on the Ex.O -unit at 09:52 AM. Certified Nursing Staff were observed to distribute trays at 09:54 AM to the Ex.Order unit. The last tray on the Ex.Order unit meal cart was delivered at 10:01 AM. At that point the surveyor requested that the ADOFS remove the test tray from the meal cart. The surveyor and ADOFS then walked the test tray to the nurse's station to conduct food temperatures at 10:02 AM. According to the meal delivery schedule for the facility the Ex.Order 2 floor Ex.Order Cart Ex.O was to arrive on the unit at 8:45 AM. All temperatures were conducted by the ADOFS utilizing the same digital thermometer that was utilized to take food temperatures on the tray line prior to meal service, where temperatures were all deemed to be within acceptable hot and cold parameters. The following temperatures were recorded:

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F 804	Continued From page 104 Oatmeal: 89.8 (F) Fahrenheit French Toast Stick: 85.8 F Sausage Patty: 82.8 F Milk Whole: 50.2 F Coffee: 158 F The surveyor conducted an interview with the DOFS on 09/08/22 at 10:08 AM. The surveyor reviewed the temperature results of the test tray with the DOFS. Upon being made aware of the test tray temperature results the DOFS responded, "Ahh geeez, they were ice cold. You know it was hot when we made it. I'm losing it across the board (temperatures). It boils down to manpower and I'm still short of staff right now. I had to call my assistant in because today was delivery day." The surveyor reviewed the facility policy titled Food Safety-Food Handling Policy; last date revised: 09/2021. The following was revealed under the heading PROCEDURE: 1. This facility recognizes that the critical factors implicated in foodborne illness are: a. Poor personal hygiene of food service employees. b. Inadequate cooking and improper holding temperatures. c. Contaminated equipment; and d. Unsafe food sources. 2. With these factors as the primary focus of preventative measures, this facility strives to minimize the risk of foodborne illness to our residents.	F 804		

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F 804	Continued From page 105 3. All employees who handle, prepare, or serve food will be trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents. The surveyor reviewed the facility policy titled FOOD TEMPERATURES POLICY, last date reviewed: 2/2022. The following was revealed under the heading POLICY: "Food temperatures of cold and hot food items will be recorded on all menu items and substitutions for meal service to maintain a high level of quality assurance and to monitor potentially hazardous food temperatures as per state and federal health regulations thus ensuring that foods are provided in a safe, palatable manner." The following was revealed under the heading PROCEDURE: 2. "Meal temperatures will be recorded at the beginning of meal service to ensure proper temperatures are achieved and repeated midway through at point of service if meal service exceeds 2 hours." The surveyor reviewed the facility pest management service invoice, dated 08/26/22. The invoice under General Comments/Instructions revealed the following by the technician on duty: "While the building itself looks attractive inside the kitchen is in a very unsanitary condition. From speaking with the	F 804		

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F 804	Continued From page 106 employees, I understand that the kitchen is currently very short handed."	F 804		
F 809 SS=F	NJAC 8:39-17.4 (a) 2 Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review and review of other facility documentation, it was determined that the facility failed to serve meals at regular times in a manner that meets the residents needs for 2 of 2 residents (Resident #92 and Resident #74) observed during mealtime. This deficient practice was evidenced by the following:	F 809	Element 1: Facility-wide Food delivery audits were conducted and were in compliance with the facility policy and meal time schedules. The following residents were evaluated by the Dietitian (RD) and their Ex.Order 26.4(b) and	10/31/22

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F 809	Continued From page 107 Cross reference F760, F802 1. On 08/30/22 at 11:24 AM, while on the initial tour of the facility on the 2nd floor, the surveyor observed a Certified Nursing Assistant (CNA #3) assisting Resident #92 with eating his/her meal at 11:24 AM. The surveyor asked CNA #3 if that was the breakfast or lunch meal. CNA #3 responded, "It's breakfast. They didn't send a puree tray and we had to wait for another. We get the trays based on how many people show up to work in the kitchen." According to Resident #92's Admission Record, Resident #92 was admitted to the facility with the following diagnoses: EX Order 26.4B1 [redacted] In addition, the AR revealed that Resident #92 resided on the [redacted] Unit of the facility. According to the facility meal delivery schedule, provided to the surveyors at entrance conference, Resident #92's meal cart was scheduled as EX Order 26.4B1 and was scheduled to leave the kitchen at 8:45 AM. On 08/31/22 at 09:52 AM, CNA #3 was observed to assist breakfast to Resident #92. On 09/01/22 at 09:28 AM, the surveyor arrived on the [redacted] unit. Resident #92 had not received his/her breakfast meal tray at this time. A follow-up observation was conducted at 09:45 AM. The surveyor questioned CNA # 4 if she was still waiting on the [redacted] unit Cart [redacted] meal cart to	F 809	Ex.Order 26.4(b)(1) [redacted] Residents #74 Resident #92 Element 2: All residents have the potential to be affected by this deficient practice. Facility-wide Food delivery audits were conducted and were in compliance with the facility policy and meal time schedules. Element 3: All dietary and nursing staff were educated on ensuring Food/snacks are delivered at its proper time. The facility has initiated an “all hands on deck” approach to meal service. In the event the facility does not have adequate staff to do the tray line or transport food service racks to the unit, contingency staff from offices and administration will be assigned to assist the kitchen to ensure meals are served within the indicated times. Audit tools were developed for the FSD to audit so we can ensure Food is delivered at its proper time. Element 4: The Food Service Director / Designee will audit 10% of food trays to ensure meals are delivered at regular times in a manner that meets the residents needs. Audits will be completed daily x 1-week, weekly x 4 weeks and then monthly for the next	

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F 809	Continued From page 108 arrive. CNA #4 responded, "Yes, I am still waiting for a breakfast meal cart. This is typical and it has been like this since I have been here, which is a year. Sometimes on the weekend the breakfast trays won't arrive until lunch time." On 09/01/22 at 01:17 PM, the surveyor went to Resident #92's room to observe the lunch meal. Resident #92's meal tray had not arrived at the unit at this time. According to the meal delivery schedule the [redacted] Floor [redacted] Cart [redacted] was scheduled to leave the kitchen at 12:35 PM. On 09/02/22 at 09:54 AM, the surveyor attempted to observe Resident #92 at the breakfast meal. Resident #92 had not received his/her breakfast tray from the kitchen at this time. On 09/06/22 at 10:40 AM, Resident #92 was observed on the [redacted] unit at 10:20 AM. Resident #92 had not received his/her breakfast tray at this time. An interview conducted with the facility Director of Food Services confirmed that the facility is short of staff in the kitchen and meal preparation/delivery is delayed because of being short staffed. On 09/07/22, the surveyor observed Resident #92 had received his/her breakfast tray at 10:10 AM. On 09/09/22 at 10:28 AM, the [redacted] meal cart arrived on the unit for breakfast. Resident #92 received their breakfast meal tray at 10:29 AM. 2. On 09/01/22 at approximately 09:47 AM, Resident #74 asked CNA #4 when his/her	F 809	three months. Any findings will be brought to the monthly QA Meeting. The Food Service Director is responsible for this POC.	

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F 809	Continued From page 109 breakfast would arrive. CNA #4 stated, "One cart has been delivered but we are still waiting for the other cart to arrive with your meal. The surveyor conducted an interview with Resident #74 at 9:51 AM. Resident #74 told the surveyor, "I'm hungry. I can't even get a coffee." The surveyor questioned Resident #74 if the meals were always late to arrive on his/her unit. Resident #74 replied, "Yes, the meals arrive late. They don't give me a reason. Dinner arrives around 6:45 PM, sometimes a few minutes earlier. You get hungry." According to the facility meal delivery schedule, the EX Order 26.4B1 Cart EX O (all rooms on unit) was to leave the kitchen at 5:35 PM. According to the Admission Record, Resident #74 resided on the EX Order 26.4B1 and had the following diagnoses: EX Order 26.4B1 [redacted] On 09/02/22 at 09:23 AM, the surveyor interviewed Resident #74 who said that he/she had not received his/her breakfast meal tray up to this point and told the surveyor, "Hey, I'll let you know. I'm a wee bit agitated and hungry all the time." On 09/06/22 at 09:46 AM, Resident #74 approached the surveyor in the EX Order 26.4B1 hallway in his/her wheelchair and stated, "It would be nice to get my meal on time." Resident #74 had not received his/her breakfast meal at 9:47 AM. In addition, Resident #74 stated, "I got dinner last night at 6:20 PM. They provided me with no reason why. It's every day."	F 809		

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F 809	Continued From page 110 On 09/12/22 at 01:38 PM the surveyor interviewed the facility Licensed Nursing Home Administrator (LNHA). The surveyor asked the LNHA if they had an issue with an understaffed facility kitchen. The LNHA responded, "Yes, we have had staffing issues in the kitchen over the past month."	F 809		
F 812 SS=F	NJAC 8:39-17.4(a) (1) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe	F 812	Element 1: 1)The Styrofoam cup without a lid that contained an unidentified liquid was removed.	10/31/22

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F 812	Continued From page 111 and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 08/30/22 from 09:18 AM to 10:08 AM the surveyor, accompanied by the Director of Food Service (DOFS), observed the following in the kitchen: 1. On a middle shelf of a multi-tiered rack in the dry storage room a Styrofoam cup without a lid contained an unidentified liquid. The cup had not been labeled or dated. The DOFS stated, "That doesn't belong there." 2. On a middle shelf (2) gallon containers of Fresh Kosher Chips had a received date of "6/24/21." The inside of the plastic gallon jug appeared to have a green/black mold and there was unidentified white debris surrounding the upper neck below the lid of the jug internally and unidentified debris externally. The DOFS stated, "I would agree they appear to have mold. I'm going to throw them away." 3. On an upper shelf of a multi-tiered wire rack, an opened container of imported basil leaves had a received date of 4/10/21 and a UB (use by) date of 04/10/22. The DOFS stated, "That is going in the trash." In addition (2) unopened containers of Ground ginger had a received date of 11/5/20 and 3 containers of ground cloves had a received date of 11/5/20. When questioned by the surveyor on how long herbs and spices are kept the DOFS stated, "We usually go 2 years on those. I'm not sure what our policy is because I just got here. I have to check." The facility failed to provide a policy for shelf life of herbs and	F 812	2)The Fresh Kosher Chips dated "6/24/21" was removed. 3)The outdated basil leaves, Ground ginger, and ground cloves were removed. 4)The opened cardboard box on the floor of the dry storage room that contained plastic beverage lids were removed. 5)The stand-up fan near the handwashing sink was removed. 6)The meat slicer was covered. 7)The ice cream freezer was cleaned and added to the cleaning schedule. 8)The following items were removed from the walk-in-freezer: rag, wax beans, frozen shrimp, and meatless burgers. 9)The FSD and other identified staff put on a hair nets. 10)Staff are properly entering temperatures to the 2nd FL panty temperature log. 11)The rice and another unidentifiable food from the 2nd FL pantry refrigerator were removed. 12)The unidentified white debris was removed from the coffee machine. The coffee machine was cleaned. 13)The stack of sheet pans was cleaned and dried. 14)The Frappuccino was removed from the dish room. The pellet lids and bases were properly stacked and covered. 15)The Ham and Tuna salad were removed. 16)The below items were removed from the 2-door refrigerator #2: orange cheese slices, container of macaroni salad, Peeled Garlic, sausage patties, white cheese slices, deli turkey.	

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F 812	Continued From page 112 spices. 4. An opened cardboard box on the floor of the dry storage room contained plastic beverage lids. The plastic bag to the lids was removed and the lids were exposed. The FSD stated, "They are for the trash." The surveyor asked why they weren't in the trash and still in the dry storage room. The DOFS stated, "Because I'm not done yet." 5. A stand up fan next to the designated handwashing sink was turned on and blowing. The fan had a large accumulation of dust and unidentifiable debris on the blade guard grills and the blades of the fan. 6. A cleaned, sanitized and re-assembled meat slicer on a metal prep table had no cover and was exposed to dust and splash contamination. When interviewed the DOFS stated, "Yes sir, our policy is to keep it covered when not in use." 7. The ice cream freezer had a large buildup of ice and was stained with brown and pink unidentified substances throughout the bottom and sides of the freezer. The freezer was observed to contain chocolate and strawberry ice cream. The surveyor questioned the DOFS how often the ice cream freezer is cleaned. The DOFS replied, "I try to put it on the schedule weekly." The surveyor questioned if it was currently on the weekly schedule. The DOFS explained, "No sir. I'm still trying to institute policies." 8. In the walk-in freezer on an upper shelf, a yellow/green rag was in front of a box of frozen broccoli. On a lower shelf, a bag of unopened	F 812	17)The following items were removed from the windowsill: Corn starch, fly swapper, bottle of cleaner/disinfectant, a gallon jug of multi-Purpose cleaner, Deodorizer, and a bottle of[brand name] Classic Antibacterial spray cleaner. 18)The white unidentified substance on the floor beneath the dish machine was removed. The cleaned and sanitized silverware were covered. The Zevo ant, roach, and fly insect killer on the top of the dish machine and the opened bag of Herr's barbecue potato chips were removed. The exterminator treated the area for roaches. 19)The base of the dish machine below the exit area for cleaned and sanitized dishes was cleaned. 20)The wall to the left of the entry door from the hallway and wall behind the spraying area were cleaned. 21)The High Temperature Dish Machine Temperature Log is being utilized according to facility policy. 22)The four wheeled 3 shelved utility cart was cleaned. The empty chemical spray bottle was removed. The utility closet door was closed. The exposed coffee filters were removed. 23)The cleaning schedule was revised to include the coffee maker. Staff are following the daily cleaning schedule. Element 2: All residents have the potential to be affected by this deficient practice. Facility-wide audits were implemented	

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F 812	Continued From page 113 frozen wax beans was removed from its original container and had no dates. The wax beans had a significant ice buildup on the inside of the bag and wax beans. On an upper shelf an opened bag of frozen shrimp was wrapped in plastic wrap. The shrimp had no dates. On the same shelf on the opposite side of the refrigerator, a bag of meatless burgers was opened and exposed to the air. On 09/02/22 at 10:57 AM, the surveyor went to the kitchen to interview the DOFS. The surveyor observed the DOFS in the kitchen from the opened entry door. The DOFS had no hair net, and his hair was fully exposed. On 09/06/22 from 10:01 AM to 10:16 AM the surveyor, accompanied by the Registered Nurse (RN) observed the following on the [redacted] floor resident pantry: 1. The Temperature Log for Refrigerator and Freezer, dated "Sept. 22" was incomplete. The following temperatures were not recorded: PM temp on 9/1, AM temp on 9/3, AM temp on 9/4, and AM temp on 9/5 for the refrigerator. The freezer temperatures were not completed on the following dates: 9/1 PM, 9/3 AM, 9/4 AM, 9/5 AM. On interview the RN stated, "I'm not sure who records the temperatures. I believe the 11-7 shift is responsible for the AM temperatures and the PM temperatures are completed by the 3-11 shift. Can I double check?" The RN then confirmed that the information was accurate and further explained that the unit managers during the day shift are to check to see if the temperatures were completed.	F 812	pertaining to Food service. Element 3: All staff were educated on the proper use of hair nets in the kitchen. The Kitchen staff were educated on properly recording temperatures for the dish machine. Kitchen staff were educated on proper cleanliness of the kitchen. Nursing staff and dietary staff were educated to properly monitor and document refrigerators/freezers for appropriate temperatures. All staff were educated on properly dating and storing food. The following policies were reviewed and determined to be in compliance with state and federal guidelines: 1) Use by date policy (the policy was updated to include shelf life of herbs and spices, which is 6 month) . 2) Poisonous and Toxic Materials 3) Cleaning Policy 4) Food-From Outside 5) Dish washing and storage. 6) Food storage 7) sanitization Policy 8) food temperatures Audit tools were developed for the FSD to audit so we can ensure compliance of all kitchen operations. Element 4: The Food Service Director / Designee will	

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F 812	Continued From page 114 2. On a middle shelf of the pantry refrigerator a black plastic take-out style container with a clear lid contained what appeared to be rice and another unidentifiable food. The container had no name, date, or use-by date. On interview the RN stated, "Yes, things are to be thrown away in 48 hours. Our policy is to label and date everything. I'm going to throw that away." On 09/06/22 at 11:04 AM, the surveyor entered the kitchen to interview the DOFS. Upon entering the kitchen, the surveyor observed a female staff with lengthy hair reaching their midback. The female staff did not have a hairnet and their hair was fully exposed. In addition, the surveyor observed a male staff standing in the kitchen. The male staff had lengthy hair. The male staff was not wearing a hair net and their hair was fully exposed. The DOFS was observed to instruct the employees to don hairnets in the presence of the surveyor. On 09/07/22 at 10:22 AM, the surveyor went to the kitchen to conduct an interview with the DOFS. Upon arrival to the kitchen the surveyor observed the DOFS in the kitchen. The DOFS had no hair net, and his hair was fully exposed. When interviewed the DOFS stated, "You are correct, I can't argue with you I was wrong." On 09/08/22 from 07:24 AM to 08:17 AM the surveyor, accompanied by the DOFS observed the following in the kitchen: 1. An unidentified white debris was on the coffee machine starting at the faucet and extending down from the faucet to the base of the machine. On the top of the coffee machine the surveyor	F 812	conduct audits on the following items but not limited to: cleanliness, fridge/freezer temperature logs, dish machine logs, storage and dating of items, hair nets, storage and usage of Poisonous and Toxic Materials. Audits will be completed daily x 1-week, weekly x 4 weeks and then monthly for the next three month. Any findings will be brought to the monthly QA Meeting. The Food Service Director is responsible for this POC.	

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observed what appeared to be dried coffee grounds and brown stains that were dry. The machine was currently in use for the breakfast meal.

2. On a middle shelf of a multi-tiered drying rack, a stack of sheet pans was determined to be wet to the touch between sheet pans with a water-like substance, termed wet nesting. The bottom of the second sheet pan in the stack was covered in a greasy unidentified substance and was removable by touch. The DOFS stated, "Yep, they are wet. Anytime I put my hand on something and it comes away wet, it's wet."

3. In the dish room on the clean end of the table where dishes exit the machine after being cleaned and sanitized, an unopened bottle of [stores name] Frappuccino was observed next to the clean dishware. In addition, 6 stacks of pellet lids and bases, used to hold and keep plates of resident food warm during transportation, were not stacked in an inverted position and were exposed to contamination.

4. A deep 1/2 pan in the 2-door refrigerator #1 contained sliced deli ham. The 1/2 pan of ham was covered with clear plastic wrap and had no dates. In addition, on the lower right bottom of the refrigerator a plastic storage type bin with a hard plastic snap-on cover contained tuna salad. The container had no dates.

5. An opened pack of orange cheeses slices in the 2-door refrigerator #2 was not completely wrapped and was exposed on an upper shelf. The cheese had no open or use by date. On a lower shelf an opened container of macaroni

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salad had no lid and was exposed. The top surface of the macaroni salad was observed to be dried out. On an upper left shelf an opened container of Peeled Garlic had a manufacturer's date of MAR/05/22. The garlic did not have an opened or use by date. A 1/4 pan on a lower shelf contained what appeared to be sausage patties (7). The pan was covered with plastic wrap. The pan had no dates. On the upper right shelf an opened package of white cheese slices was wrapped in plastic wrap and had no dates. On the same shelf an opened and previously sliced deli turkey was wrapped in plastic wrap and had no dates. When interviewed the DOFS stated, "When in doubt, throw it out."

6. The stand-up fan in front of the designated hand washing sink was observed to have dust and unidentified debris on the fan blades and fan blade guard, as previously observed on the initial kitchen tour on 08/30/22

7. On a windowsill next to the food production area table/shelf an opened and exposed box of corn starch was observed next to a bottle of cleaner/disinfectant, a gallon jug of multi-Purpose cleaner and Deodorizer, and a bottle of [brand name] Classic Antibacterial spray cleaner. In addition, a fly swatter was also on the windowsill next to the opened box of corn starch. On interview the DOFS proceeded to remove the items from the windowsill and dispose of the corn starch.

On 09/08/22 from 09:39 AM to 9:49 AM, the surveyor, accompanied by the DOFS, observed the following in the kitchen:

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F 812	Continued From page 117 1. At 09:41 AM the surveyor observed an Activity Aide (AA) enter the kitchen from the dining room door. The activity aide had shoulder length hair. The activity aide did not have a hair net and all their hair was exposed. On interview the surveyor verbalized that she needs a hair net to enter the kitchen. The AA stated, "I know." On 09/12/22 from 10:57 AM to 11:26 AM the surveyor, accompanied by the DOFS observed the following in the kitchen: 1. Prior to entry to the kitchen the surveyor questioned the DOFS in the hallway if the dish machine was in operation. The DOFS stated, "Let me go fire it up. I'm 4 people short today." Upon entry to the dish room the surveyor observed a white unidentified substance on the floor beneath the dish machine and under the table where the dirty dishware is scraped and sprayed prior to dishwashing. The surveyor also observed cleaned and sanitized silverware, plates, and pellet covers on the clean end of the dish machine. The silverware, plates and pellets were not bagged, covered, inverted, or placed on the drying rack and were exposed. During observation of the dish room the surveyor observed a live cock roach on the cleaned and sanitized end of the dish machine table in addition to a dead cock roach in the same area. The DOFS stated that the exterminators were here this morning and had just sprayed the floor of the dish room. The surveyor observed a bottle of Zevo ant, roach, and fly insect killer on the top of the dish machine and an opened bag of Herr's barbecue potato chips. The DOFS stated "They shouldn't be there."	F 812		

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F 812	Continued From page 118 2. The base of the dish machine below the exit area for cleaned and sanitized dishes was covered with a white unidentified substance. 3. The wall to the left of the entry door from the hallway was observed to be stained with a brownish unidentified substance, extending from the baseboard tiles and up the wall. In addition, the wall behind the spraying area where dishes are washed down before being loaded into the dish machine had a black unidentified substance extending up the wall. 4. The surveyor reviewed the High Temperature Dish Machine Temperature Log, undated. The log revealed that the kitchen staff had not recorded any dish machine temperatures for the AM, Midday, or PM since 09/06/22, a period of 6 days. When interviewed the DOFS stated, "I didn't know that they were not being recorded but I do now. Our policy is that temperatures are to be recorded prior to the initiation of dishwashing to ensure the machine runs at proper temperature." 5. A four wheeled 3 shelved utility cart was next to the 3-compartment sink. The cart had an unidentified white substance spilled on the middle and lower shelf. On the floor at the base of the wheel of the cart was an empty chemical spray bottle. A utility closet used to store paper goods had the door open. The surveyor observed a large stack of coffee filters that were removed from their original packaging and were exposed. The surveyor reviewed the facility policy titled Poisonous and Toxic Materials, revised December 2008. The following was revealed	F 812		

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F 812	Continued From page 119 under the heading Policy Statement: "Poisonous and toxic materials shall be stored in areas away from the food service area." The following was revealed under the heading Policy Interpretation and Implementation: 1. "Only poisonous and toxic materials that are required to maintain kitchen sanitation shall be permitted in the pot washing and dishwashing areas but may not be stored or used in the presence of food." 3. When not in use, poisonous and toxic materials will be stored on shelves that are used for no other purpose, or stored in a place outside the food storage, food preparation, and cleaned equipment and utensil storage areas." The surveyor reviewed the facility policy titled Cleaning Policy; last date revised: 01/2020. The following was revealed under the heading POLICY: "The nutrition and food services staff will maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule." The following was revealed under the heading PROCEDURE: 1. "The director of food and nutrition services will determine all cleaning and sanitation tasks needed for the department." 2. "Tasks shall be designated to be the	F 812		

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responsibility of specific positions in the department."

3. "Staff will be trained on the frequency of cleaning as necessary."

4. "A cleaning schedule will be posted for all cleaning tasks, and staff will initial the tasks as completed."

5. "Staff will be held accountable for cleaning assignments."

The surveyor reviewed the facility provided Daily Cleaning Schedule* (*Clean all items at least daily, preferably after each use.) for the weeks of August 1-4 and September 1 and 2. The Daily Cleaning Schedule did not address the coffee maker. Review of the facility provided Monthly Cleaning Schedule, dated Aug 2022 revealed that the fan was cleaned on 08/20/22. The schedule also revealed that baseboards were cleaned on 08/09/22 and walls were also cleaned on 08/09/22.

The surveyor reviewed the facility policy titled Food-From Outside, last date revised: 1/2022. The following was revealed under the heading PROCEDURE:

9. "All refrigeration units will have internal thermometers to monitor temperatures. All units must be maintained at internal temperatures that are deemed safe for food storage according to state and federal standards."

11. "Food brought by family/visitors that is left with the resident to consume later will (sic)

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labeled and stored in a manner that it is clearly distinguishable from facility-prepared food. (Label will identify resident name, room number, item, date received and discard date)"

"All refrigerated foods will be discarded within 48 hrs."

b. "Perishable foods must be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item, and the "discard" date.""

12. "Nursing staff will monitor resident's room, unit pantry, and refrigeration units for food and beverage disposal."

13. "The nursing staff will discard perishable foods on or before the "discard" date.""
14. "The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs of potential foodborne danger (for example, mold growth, foul odor, past due package expiration dates)."

The surveyor reviewed the facility provided policy titled DISH WASHING AND STORAGE POLICY, last date revised: 10/2021. The following was revealed under the heading POLICY:

"Dishes, pots and pans will be washed and dried using procedures, chemicals and equipment that result in clean, sanitized dishes, pans, flatware and utensils."

The following was revealed under the heading PROCEDURE:

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F 812	Continued From page 122 Dish Machine Washing: 3. "Dish machine temperatures are logged at each meal on the Dish Machine Temperature Log." 4. "Staff will monitor dish machine temperatures throughout the dishwashing process." "Dishes, pots, pans, utensils and flatware must be air dried before being stored. Do not dry with towels." 6. "Dish machine is drained and cleaned between each meal service period." 7. "Employees are trained in proper dishwashing and drying procedures." The surveyor reviewed the facility policy titled FOOD STORAGE; last date revised: 03/09/22. The following was revealed under the heading PROCEDURE: 5. "Chemicals must be clearly labeled, kept in original containers, when possible, kept in a locked area and stored away from food." 7. "All stock must be rotated with each new order received. Rotating stock is essential to assure the freshness and highest quality of all foods." a. "Old stock is always used first (first in-first out method). 12. "Leftover food will be stored in covered containers or wrapped carefully and securely. Each item will be clearly labeled and dated	F 812		

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F 812	Continued From page 123 before being refrigerated. Leftover food is used within 24-72 hours or discarded as per the 2013 Federal Food Code. 13. Refrigerated food storage: d. "Each nursing unit with a refrigerator/freezer unit will be supplied with thermometers and monitored for appropriate temperatures." f. "All foods should be covered, labeled, and dated. All foods will be checked to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable), or discarded." 14. Frozen Foods: c. "All foods should be covered, labeled, and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded." The surveyor reviewed the facility policy titled SANITIZATION POLICY, last date revised: 02/2021. The following was revealed under the heading POLICY: "The food service area shall be maintained in a clean and sanitary manner." The following was revealed under the PROCEDURE heading: "All kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other	F 812		

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F 812	Continued From page 124 insects." 3. "All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions after each use." "Equipment near prep areas shall remain covered once cleaned and air dried to prevent cross contamination." 10. "Food preparation equipment and utensils that are manually washed will be allowed to air dry whenever practical." 17. "The Food Services Manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas. Food service staff will be trained to maintain cleanliness throughout their work area during all tasks." The surveyor reviewed the facility pest management service invoice, dated 08/26/22. The invoice under General Comments/Instructions revealed the following by the technician on duty: "While the building itself looks attractive inside the kitchen is in a very unsanitary condition. From speaking with the employees I understand that the kitchen is currently very short handed. My concern is that should a regulatory agency enter the building they would likely cite the facility for the unsanitary conditions. The kitchen cleanliness needs to improve ASAP."	F 812		

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F 812	Continued From page 125 The surveyor reviewed the facility policy titled FOOD TEMPERATURES POLICY, last date reviewed: 2/2022. The following was revealed under the heading POLICY: "Food temperatures of cold and hot food items will be recorded on all menu items and substitutions for meal service to maintain a high level of quality assurance and to monitor potentially hazardous food temperatures as per state and federal health regulations thus ensuring that foods are provided in a safe, palatable manner." The following was revealed under the heading PROCEDURE: 2. "Meal temperatures will be recorded at the beginning of meal service to ensure proper temperatures are achieved and repeated midway through at point of service if meal service exceeds 2 hours."	F 812		
F 880 SS=D	NJAC 18:39-17.2(g) 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.	F 880		10/21/22

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F 880	Continued From page 126 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 127 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and other pertinent facility documents, it was determined that the facility failed to ensure personal protective equipment (PPE) (equipment such as, but not limited to gowns, gloves, and eye protection worn to protect the wearer from the spread of infection or illness) was used appropriately and failed to ensure handwashing was performed before and after exiting and entering resident rooms that were on Ex.Order 26.4(b)(1) and between changing gloves. The deficient practice was observed on 1 of 4 units on the first floor. The deficient practice was evidenced by the following: On 08/30/22 at 10:17 AM during the initial tour, the surveyor observed a resident room with a	F 880	Element 1: Identified facility staff (C.N.A. #1, C.N.A. #2) were counseled for nor wearing gowns appropriately or washing hands between gowns, and consistently wearing a gown in Ex.Order 26.4(b)(1) rooms. Element 2: All residents have the potential to be affected by this deficient practice however, no negative deficient practice was noted. Element 3: Corporate policies titles Ex.Order 26.4(b)(1) olicies were reviewed by facility administration and determined to be in	

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DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

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F 880	Continued From page 128 Ex.Order 26.4(b)(1) sign (notification sign that specific precautions must be followed prior to entering or leaving the room) that revealed, Ex.Order 26.4(b)(1) Everyone Must: including visitors, doctors, and staff Clean hands when entering and leaving the room, Wear mask, Wear eye protections, Gown and glove at the door..." At that time, the surveyor observed Certified Nursing Assistant (CNA) #1 in the room performing care on Resident #657. CNA #1 did not have a gown on while in the room. During an interview with the surveyor, CNA #1 stated, "Oh wow! At first I was thinking it (the room) was cut off from Ex.Order 26.4(b)(1." when the surveyor referred to the Ex.Order 26.4(b)(1) sign outside of the room. On 08/31/22 at 10:32 AM, in the COVID area called the "RED ZONE", the surveyor observed CNA #2 exit room Ex.Order 2 Room Ex.Order also had the same Ex.Order 26.4(b)(1) sign in the doorway. At that time, CNA #2 removed the gown and gloves, then took a new gown and gloves and put them on. CNA #2 then entered room Ex.Order. CNA #2 did not perform hand hygiene after exiting or entering the rooms or changing gloves. On the same date at 10:57 AM, during an interview with the surveyor, CNA #2 stated, "I forgot to wash my hands." On 08/31/22 at 12:36 PM, the surveyor observed an unidentified CNA passing meal trays from room to room. The CNA had a gown on that was not tied in the back. The gown was in contact with the floor as the CNA took a tray off the cart.	F 880	compliance. The Regional Director of Clinical Operations held an Ad Hoc QAPI meeting in which a review of the deficiency occurred with a root cause analysis developed, and corrective actions developed including but not limited to audits. DIRECTED PLAN OF EDUCATION The Regional Consultant Board Certified in Infection Control educated all staff on deficiency, contributing factors, adherence to infection control practices specifically focusing on hand hygiene with donning and doffing PPE, using rear closure when donning gowns, consistently wearing gowns in Ex.Order 26.4(b)(1 rooms. The facility shall provide in-service training to appropriate staff and validated competency by the DON, medical director, or Infection Preventionist, as follows: 1. Nursing Home Infection Preventionist Training Course Module 1 - Infection Prevention & Control Program https://www.train.org/main/course/1081350/ Provide the training to: Topline staff and infection preventionist 2. CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID-19 Out! https://youtube/7srwrF9MGdw Provide the training to: Frontline staff 3. CDC COVID-19 Prevention Messages	

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F 880	Continued From page 129 The CNA then entered a resident room. On 09/12/22 at 1:27 PM, during an interview with the surveyor, the Director of Nursing (DON) stated gowns should be tied in the back. A review of the "Red Zone" sign outside of the unit doorways revealed, "Full PPE, N95 (fit tested) Gowns or Coveralls need to be changed between each resident and if wet soiled or damaged, and when leaving the RED ZONE." A review of the facility "Outbreak Response Plan" revealed under "Contact Precautions" number 5 to, "Wear a gown if body/clothing contact with infective material is likely." The plan further revealed under number 7. to, "Wash hands before entering room and after removing gloves..." A review of the facility "Outbreak Response Plan" revealed under "Droplet Precautions" number 7 to, "Wash hands before entering room and after removing PPE" N.J.A.C. 8:39-19.4(k)	F 880	for Front Line Long-Term Care Staff: Sparkling Surfaces https://youtube/t7OH8ORr5Ig Provide the training to: Frontline staff 4. CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Clean Hands https://youtube/xmYMUly7qiE Provide the training to: Frontline staff 5. CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Use PPE Correctly for COVID-19 https://youtube/YYTATw9yav4 Provide the training to: Frontline staff 6. Nursing Home Infection Preventionist Training Course Module 5 - Outbreaks https://www.train.org/cdctrain/course/l08l803/ Provide the training to: Topline staff and infection preventionist 7. Nursing Home Infection Preventionist Training Course Module llB - Environmental Cleaning and Disinfection https://www.train.org/main/course/1081815/ Provide the training to: All staff including topline staff and infection preventionist 8. Nursing Home Infection Preventionist Training Course Module 4 - Infection Surveillance https://www.train.org/cdctrain/course/1081802/ Provide the training to: Topline staff and	

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F 880	Continued From page 130	F 880	infection preventionist only 9. Nursing Home Infection Preventionist Training Course Module 7 - Hand Hygiene https://www.train.org/main/course/1081806/ Provide the training to: All staff including topline staff and infection preventionist 10. Nursing Home Infection Preventionist Training Course Module 6A - Principles of Standard Precautions https://www.train.org/main/course/108l804/ Provide the training to: All staff including topline staff and infection preventionist 11. Nursing Home Infection Preventionist Training Course Module 6B - Principles of Transmission Based Precautions https://www.train.org/main/course/1081805/ Provide the training to: All staff including topline staff and infection preventionist Consultant/Instructor: Kathleen Flanagan RN CIC- Regional Director of Clinical/ Designee Dates of Training Sessions: To be commenced effective October 6, 2022 and ongoing Targeted staff: Facility Administrative team, Nursing Leadership to include, DON, ADON, Unit Managers and Supervisors and Nursing Staff (RNs, LPNs), nursing assistants, agency staff, contractors, social work, recreation, and admissions.	

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F 880	Continued From page 131	F 880	Objectives a. All above staff will understand the significant effect of this deficiency b. All the above staff will understand their responsibilities in regards to contributing factors to the deficiency. c. All above staff will understand and verbalize importance of adherence to infection control practices d. Employees will understand the importance of staff donning of face masks. e. Employees will understand the importance of performing hand hygiene following touching their own mask. f. Employees will be re-educated on appropriate infection control requirements including performing hand hygiene between residents during meal tray service. Course Outline a. Review of Statement of Deficiency; review Root Cause; and Contributing Factors b. Review of hand hygiene requirement with donning and doffing PPE. c. Review of PPE requirement for closure of gowns in the back. d. Review of donning PPE while in Ex.Order 26.4(b)(1) [redacted] rooms. e. Infection Preventionist, unit managers, nursing supervisors or designee will provide oversight related to staff adherence to infection control guidelines f. Corrective action will be initiated upon identification of deficient practice. g. Evaluation/auditing tool will be utilized	

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F 880	Continued From page 132	F 880	to monitor effectiveness of these interventions. h. The Regional Director will oversee effectiveness of above interventions. i. Review of audit processes will be completed by facility's Regional Director. j. The Regional Director will perform review of above implementation and provide feedback on plan of correction. Element 4: Infection Preventionist /designee will perform Ex.Order 26.4(b)(1) n control rounds, including observation of adherence to Ex.Order 26.4(b)(1) requirements for performing hand hygiene between PPE changes; wearing a gown in Ex.Order 26.4(b)(1) rooms; wearing a gown following CDC guidelines with the ties fastened in the back. Observations will occur weekly x 4 weeks and then monthly x 6 months or until compliance is met. The results of these observations will be submitted at QAPI	

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews, and review of pertinent facility documentation, it was determined that the facility failed to a.) maintain the required minimum direct care staff-to-resident ratios for the day, evening, and night shifts. The facility was deficient in CNA staffing for residents on 9 of 14 day shifts, deficient in total staff for residents on 2 of 14 evening shifts and deficient in total staff for residents on 3 of 14 overnight shifts, and b.) designate one direct-care staff employee to be trained for the LGBTQI+ (Lesbian, Gay, Bisexual, Transgender, Queer/questioning [one's sexual or gender identity], Intersex [person is born with a combination of male and female biological traits] positive) and HIV+ (Human Immunodeficiency Virus [a virus that attacks cells	S 560	Element 1: 1) The facility schedules were reviewed by the administrator and staffing was added to meet the minimum requirement of direct care staff to resident requirement. Additional recruitment efforts were employed including contracts with agencies, additional ads to attract nursing staff, generous incentives to attract staff of other facilities, referral and sign on bonuses. The facility has entered a new union contract which raised the rates / benefits for new and existing nursing staff. The facility is conducting weekly orientations which is more frequent than usual.	10/31/22

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

Electronically Signed | 10/14/22

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S 560	Continued From page 1 that help the body fight infection] positive) program. This deficient practice was evidenced by the following: 1. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. "Direct care staff member" means any registered professional nurse, licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021: One 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.	S 560	2) The facility designated two employees, including one employee representing management at the facility and one employee representing direct care staff at the facility, to receive in-person training of the LGBTQI+ Law. The training was provided by an entity that has demonstrated expertise in identifying the legal, social, and medical challenges faced by, and in creating safe environment for LGBTQI+ and HIV+ seniors who reside in our facility. Element 2: All residents have the potential to be affected by this deficient practice. The facility schedules were reviewed by the administrator and additional staff was added to meet the requirements for direct care staff to resident ratio. The facility appointed two staff members designated who are trained in identifying the legal, social, and medical challenges faced by, and in creating safe environment for LGBTQI+ and HIV+ residents. Element 3: The staffing coordinator was educated by the administrator on ensuring that adequate staffing levels are reached to comply with the NJ state requirement for direct care staff to resident ratio including a C.N.A. ration of 8:1 on day shift; 10:1 on evening shift; and 14:1 on night shift.	

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S 560	Continued From page 2 As per the "Nurse Staffing Report" completed by the facility for the weeks of 08/14/22-8/20/2022 and 08/21/22-8/27/2022, the staffing-to-resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift, 1 direct care staff member to every 10 residents for the evening shift, and 1 direct care staff member to every 14 residents for the night shift are documented below: -08/14/22 had 15 CNAs for 205 residents on the day shift, required 26 CNAs. -08/15/22 had 20 CNAs for 205 residents on the day shift, required 26 CNAs. -08/15/22 had 13 total staff for 205 residents on the overnight shift, required 15 total staff. -08/18/22 had 24 CNAs for 210 residents on the day shift, required 26 CNAs. -08/20/22 had 23 CNAs for 210 residents on the day shift, required 26 CNAs. -08/21/22 had 15 CNAs for 212 residents on the day shift, required 26 CNAs. -08/21/22 had 20 total staff for 212 residents on the evening shift, required 21 total staff. -08/22/22 had 18 CNAs for 210 residents on the day shift, required 26 CNAs. -08/22/22 had 14 total staff for 210 residents on the overnight shift, required 15 total staff. -08/23/22 had 25 CNAs for 210 residents on the day shift, required 26 CNAs. -08/26/22 had 25 CNAs for 207 residents on the day shift, required 26 CNAs. -08/26/22 had 13 total staff for 207 residents on the overnight shift, required 15 total staff. -08/27/22 had 17 CNAs for 207 residents on the day shift, required 26 CNAs. -08/27/22 had 19 total staff for 207 residents on the evening shift, required 21 total staff.	S 560	Audit tool were created to audit the daily schedules. All staff were educated on identifying the legal, social, and medical challenges faced by, and in creating safe environment for LGBTQI+ and HIV+ residents. This education was provided by an entity that has demonstrated expertise in this field. Element 4: The Administrator / Designee will audit schedules to ensure direct care staff to resident ratio requirement is met. Audits will be completed weekly x 4 weeks and monthly x three month. The Administrator / Designee will audit LGBTQI+ Training material to ensure the facility is in compliance with the new LGBTQI+ Law. Any findings will be brought to the monthly QA Meeting. The Administrator/Designee is responsible for this POC.	

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S 560	Continued From page 3 During an interview with the surveyor on 08/31/22 09:52 AM, CNA #3 stated that she has nine (9) residents on her assignment but "some days I may have up to 20." During an interview with the surveyor on 09/12/22 at 11:11 AM, the Staffing Coordinator stated that the staff-to-resident ratios were 1:8 on day shift, 1:10 on evenings and 1:15 on night shift. She further stated that we try our best, but the facility is not always within the ratios. During an interview with the surveyor on 09/12/22 at 1:22 PM, the Licensed Nursing Home Administrator stated that he believes the facility is meeting the staffing requirements and that he tries his best to meet the requirements. 2. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 04/19/22, "Statutory Amendments Regarding the Rights of LGBTQI+ and HIV+ Residents of Long-Term Care Facilities Pursuant to N.J.S.A. 26:2H-12.101-10 7." The memorandum concerned the rights of LGBTQI+ and HIV+ residents of long-term care facilities; N.J.S.A. 26:2G-12, 101-107 ("LGBTQI+ Law"), and a facility's responsibilities under the LGBTQI+ Law. The LGBTQI+ Law was signed on March 3, 2021 and took effect on August 30, 2021. The requirements of the LGBTQI+ Law will be included in N.J.A.C. 8:39 in future rulemaking. Specifically, the LGBTQI+ Law establishes specific rights and protections for lesbian, gay, bisexual, transgender, undesignated/non-binary, questioning, queer, and intersex ("LGBTQI+) older adults and people living with HIV ("HIV+) in	S 560		

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S 560	Continued From page 4 long-term care facilities ("Facilities"). The LGBTQI+ Law ensures that LGBTQI+ and HIV+ residents in facilities have equitable access to health care and provides the same legal protections as everyone else regardless of their sexual orientation or health status. Prohibited Actions The LGBTQI+ Law prohibits facilities from taking any of the following actions based on a person's sexual orientation, gender identity, gender expression, intersex status, or HIV status: 1. Denying admission to a facility, transferring or refusing to transfer a resident within a facility or to another facility, or discharging, or evicting a resident from a facility; 2. Denying a request by residents to share a room; 3. Where rooms are assigned by gender, assigning or reassigning a room based on gender, subject to the provisions of 42 C.F.R. 483.10(e)(5); 4. Forbidding a resident from, or harassing a resident who seeks to use or does use, a restroom available to other residents of the same gender identity, regardless of whether the resident is making a gender transition, has taken or is taking hormones, has undergone gender affirmation surgery, or presents as gender-nonconforming. For the purposes of this paragraph, harassment includes, but is not limited to, requiring a resident to show identity documents in order to gain entrance to a restroom available to other persons of the same gender identity; 5. Repeatedly failing to use a resident's chosen pronouns or the name the resident chooses to be called, despite being clearly informed of the	S 560		

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S 560	Continued From page 5 resident's choice; 6. Denying a resident from wearing preferred clothing, accessories, or cosmetics, or participating in grooming practices; 7. Restricting a resident's right to visit and have conversations with other resident's or with visitors including the right to have consensual sexual relations; 8. Denying, restricting, or providing unequal medical or non-medical care, which is appropriate to the resident's bodily needs and organs, or providing medical or nonmedical care that, to a similarly-situated resident, causes avoidable discomfort or unfairly demeans the resident's dignity; and 9. Declining to provide any service, care, or reasonable accommodation requested by the resident, subject to the provisions of 42 C.F.R. 483.10(c)(6). Resident Records Additionally, facilities are required to ensure that resident records include the resident's gender identity and the resident's chosen name and pronouns, as indicated by the resident. Confidentiality The LGBTQI+ Law also requires facilities to maintain the confidentiality of certain resident information. Unless required by state or federal law, personal identifying information regarding a resident's sexual orientation, whether a resident is transgender or undesignated/non-binary, a resident's gender transition status, a resident's intersex status, or a resident's HIV status shall not be disclosed. Further, facilities are required to take appropriate steps to minimize the likelihood of inadvertent or	S 560		

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S 560	Continued From page 6 accidental disclosure of such information to other residents, visitors, or facility staff, except to the minimum extent necessary for facility staff to perform their duties. Unless expressly authorized, facility staff not directly involved in providing direct care to a transgender, undesignated/non-binary, intersex, or gender-nonconforming resident, shall not be present during a physical examination of, or the provision of personal care to, that resident if the resident is partially or fully unclothed. Doors, curtains, screens, or other effective visual barriers to providing bodily privacy, when partially or fully unclothed, shall be used. Informed consent is required in relation to any non-therapeutic examination or observation of, or treatment provided to, a resident of the facility. Facilities shall also provide transgender residents with access to transition-related assessments, therapy, and treatments as having been recommended by the resident's health care provider, including, but not limited to, transgender-related medical care, including hormone therapy and supportive counseling. Violations A facility or an employee of a facility that violates the requirements of the LGBTQI+ Law is subject to civil or administrative action. Training Facilities shall designate two employees, including on employee representing management at the facility and one employee representing direct care staff at the facility, to receive in-person training within six months after the effective date of the LGBTQI+ Law. The required	S 560		

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S 560	Continued From page 7 training shall be provided by an entity that has demonstrated expertise in identifying the legal, social, and medical challenges faced by, and in creating safe and affirming environments for LGBTQI+ and HIV+ seniors who reside in long-term care facilities in New Jersey. The required training shall address: 1. Caring for LGBTQI+ seniors and seniors living with HIV; 2. Preventing discrimination based on sexual orientation, gender identity or expression of intersex status, and HIV status; 3. The definition of terms commonly associated with sexual orientation, gender identity and expression, intersex status, and HIV; 4. Best practices for communicating with or about LGBTQI+ and HIV+ seniors, including the use of a resident's chosen name and pronouns; 5. A description of the health and social challenges historically experienced by LGBTQI+ and HIV+ seniors, including discrimination when seeking or receiving care at long-term care facilities, and the demonstrated physical and mental health effects within the LGBTQ community; 6. Strategies to create a safe and affirming environment for LGBTQI+ and HIV+ seniors, including suggested changes to facility policies and procedures, forms, signage, communication between residents and their families, activities, and staff training and in-services; and 7. An overview of the provisions of LGBTQI+ Law. Facilities are responsible for maintaining records documenting the completion of the training, as well as the cost of providing the training.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060804	A. BUILDING: _____ B. WING _____	09/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEPTFORD CENTER FOR REHABILITATION AI	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

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S 560	Continued From page 8 During an interview with the surveyor on 09/06/22 at 10:30 AM, the Licensed Nursing Home Administrator (LNHA) stated that the Human Resources Director and the Director of Social Work were the two people designated to head the LGBTQI and HIV+ program. During an interview with the surveyor on 09/06/22 at 1:06 PM, the Human Resources Director stated that she was familiar with the LGBTQI and HIV+ program. When asked what her role in the program was, she stated that she would have to ask the LNHA. She stated that the Director of Social Work took the course but she did not. She indicated that the Director of Social Work and, she believes, one Certified Nursing Assistant were designated to handle the program. The Human Resources Director stated that she was not a designated person. During an interview with the surveyor on 09/07/22 at 9:01 AM, the Director of Social Services stated that she was aware of the LGBTQI and HIV+ program. When asked if she was the designated staff member, she stated "From what I understand, yes." The surveyor inquired if she had been trained and she stated, "No, I am waiting for the Administrator to tell me when my training is." During a follow up interview with the surveyor on 09/07/22 at 12:31 PM, the LNHA stated that he assigned the Recreation Director to be the designated staff management for LGBTQI and HIV+ program. The LNHA further stated that he had a Certified Nursing Assistant (CNA) in mind but had not told her yet. The LNHA stated that the CNA had not been trained, the Recreation Director had been trained and provided a	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060804	A. BUILDING: _____ B. WING _____	09/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 9 certificate of his training dated 03/04/22. During an interview with the surveyor on 09/07/22 at 1:45 PM, the Director of Recreation stated that he was the designated LGBTQI and HIV+ person. His role was that he was a resource for the facility, staff and residents and handled any questions or concerns that may come up, such as resident rights, and he was also a resource for education. He made sure that the residents were respected and felt safe in their home. The Director of Recreation confirmed that he received the training in March of 2022. He is not sure who the designated staff member that will be working with him.	S 560		

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
315174 Y1	A. Building B. Wing Y2	12/5/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

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 F0584	Correction	ID Prefix F0609	Correction	ID Prefix F0610	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.12(c)(1)(4)	Completed	Reg. # 483.12(c)(2)-(4)	Completed
LSC	10/31/2022	LSC	10/31/2022	LSC	10/31/2022
ID Prefix F0637	Correction	ID Prefix F0656	Correction	ID Prefix F0684	Correction
Reg. # 483.20(b)(2)(ii)	Completed	Reg. # 483.21(b)(1)	Completed	Reg. # 483.25	Completed
LSC	10/31/2022	LSC	10/31/2022	LSC	10/31/2022
ID Prefix F0688	Correction	ID Prefix F0689	Correction	ID Prefix F0690	Correction
Reg. # 483.25(c)(1)-(3)	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(e)(1)-(3)	Completed
LSC	10/31/2022	LSC	10/31/2022	LSC	10/31/2022
ID Prefix F0695	Correction	ID Prefix F0698	Correction	ID Prefix F0755	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	10/31/2022	LSC	10/31/2022	LSC	10/31/2022
ID Prefix F0760	Correction	ID Prefix F0761	Correction	ID Prefix F0802	Correction
Reg. # 483.45(f)(2)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(a)(3)(b)	Completed
LSC	10/31/2022	LSC	10/31/2022	LSC	10/31/2022

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

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
315174 Y1	A. Building B. Wing Y2	12/5/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

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 F0803	Correction	ID Prefix F0804	Correction	ID Prefix F0809	Correction
Reg. # 483.60(c)(1)-(7)	Completed	Reg. # 483.60(d)(1)(2)	Completed	Reg. # 483.60(f)(1)-(3)	Completed
LSC	10/31/2022	LSC	10/31/2022	LSC	10/31/2022
ID Prefix F0812	Correction	ID Prefix F0880	Correction		
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed		
LSC	10/31/2022	LSC	10/21/2022		

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?
9/20/2022	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060804 Y1	A. Building B. Wing Y2	12/5/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 10/31/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	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	
9/20/2022	☐ 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
	315174	A. BUILDING **01** B. WING _____	**09/20/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	**1511 CLEMENTS BRIDGE RD** **DEPTFORD, NJ 08096**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/19/22 and 09/20/22 and the Deptford Center for Rehabilitation and Healthcare was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Deptford Center for Rehabilitation and Healthcare is a two story, Type I Fire Resistant building that was built in January 1978. The facility is divided into 12 smoke zones.	K 000		
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 09/19/22, in the presence of facility management, it was determined that the facility failed to provide a battery backup emergency light above 1 of 1 emergency generator's transfer switch, independent of the building's electrical system and emergency generator in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was evidenced by the following:	K 291	Element 1. The Facility contracted a licensed electrician and installed a battery backup emergency light above the emergency generator□s transfer switch. Element 2: No residents have been affected. All residents had potential to be affected. The Maintenance Director conducted an audit on all emergency lighting and no	10/31/22

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

Electronically Signed | 10/14/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315174	A. BUILDING **01** B. WING _____	**09/20/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 291	Continued From page 1 During the survey entrance 09/19/22 at 8:57 AM, a request was made to the facility's Maintenance Director (MD) if the facility had an emergency generator. The MD said, "Yes, we have one." Later, during the building tour with the facility MD at approximately 9:57 AM, an inspection inside the Boiler/Main Electrical room, where the natural gas emergency generator is located, was performed. The surveyor observed no evidence of a battery back up emergency light inside the Boiler/Main Electrical room for the generator's transfer switch. At that time, the surveyor asked the MD if there was a battery back-up emergency light for the transfer switch. The MD looked around and said, "No." The MD confirmed the findings at the time of observations. The Licensed Nursing Home Administrator was notified of the deficiency at the Life Safety Code exit conference on 09/20/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	other deficient areas found. Element 3: The Maintenance Director was in-serviced on NFPA 101 pertaining to Emergency Lighting. This deficient practice was added to a monthly audit tool for the Maintenance Director/Designee to conduct monthly audits. Element 4: The Maintenance Director / Designee will conduct weekly audits for the first month followed by Monthly audits for the next three month to ensure all emergency lighting are in working condition. Any findings will be brought to the monthly QA Meeting. Element 5: Maintenance Director	
K 311 SS=D	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with	K 311		10/31/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315174	A. BUILDING **01** B. WING _____	**09/20/2022**

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K 311	Continued From page 2 construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 09/19/22 and 09/20/22, in the presence of facility management, it was determined that the facility failed to ensure that 1 of 11 exit access stairwell doors tested were capable of maintaining the one-hour fire rated construction. This deficient practice was evidenced by the following, Starting on 09/19/22 and continued on 09/20/22, a tour of the building, in the presence of the facility's Maintenance Director (MD), was performed. When the surveyor performed a closure test of the eleven (11) 3/4-hour fire rated doors leading into the stairwells, one (1) fire rated door did not positive latch into its frame, as required by code to maintain the fire rated construction in the following location: 1. On 09/20/22 at 11:20 AM, the surveyor observed on the First Floor stairwell (across from the public men's bathroom) one 3/4-hour fire rated door, when tested and allowed to self-close three times, the door did not positive latch into its frame. The surveyor observed this 3/4-hour fire rated door had no means to positive latch the door into its frame. The stairwell doors would need to positive latch into its frame to maintain the fire rated construction to prevent fire, smoke and	K 311	Element 1. The first-floor stairwell door was repaired to properly latch. Element 2: No residents have been affected. All residents had potential to be affected. The Maintenance Director conducted an audit on all fire rated doors and no other deficient areas were found. Element 3: The Maintenance Director was in-serviced on NFPA 101 pertaining to Enclosures. This deficient practice was added to a monthly audit tool for the Maintenance Director/Designee to conduct monthly audits. Element 4: The Maintenance Director / Designee will conduct weekly audits for the first month followed by Monthly audits for the next three month to ensure all fire doors are properly latching. Any findings will be brought to the monthly QA Meeting. Element 5: Maintenance Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315174	A. BUILDING **01** B. WING _____	**09/20/2022**

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K 311	Continued From page 3 poisonous gases to enter the exit stairwell in the event of a fire. The MD confirmed the findings at the time of observations. The Licensed Nursing Home Administrator was notified of the deficiency at the Life Safety Code exit conference on 09/20/22. Fire Safety Hazard. NJAC 8:39- 31.2(e)	K 311		
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 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)	K 321		10/31/22

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 321	Continued From page 4 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, interview, and review of other facility documentation on 09/19/22 and 09/20/22, in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was evidenced by the following: On 09/19/22 during the survey entrance at 8:57 AM, a request was made to the Maintenance Director (MD) to provide a copy of the facility layout which identified the various rooms and smoke compartments. Starting on 09/19/22 at 9:20 AM, in the presence of facility's MD, an inspection of the First and Second Floors was performed. During this inspection, the surveyor observed hazardous areas (rooms with multiple combustible products) in the following locations: 1) At 10:14 AM, the Second Floor Sensory Room was converted into a storage room. The surveyor observed inside the room were six	K 321	Element 1. The facility installed self-closing door closers in the following areas: 1) Second Floor Sensory Room. 2) "Closet" next to resident room [redacted]. 3) Second Floor Medical Records room, next to resident room [redacted]. Element 2: No residents have been affected. All residents had potential to be affected. The Maintenance Director conducted an audit on all hazardous areas and they were equipped with self-closing doors. Element 3: The Maintenance Director was in-serviced on NFPA 101 pertaining to Enclosures. This deficient practice was added to a monthly audit tool for the Maintenance Director/Designee to conduct monthly audits. Element 4: The Maintenance Director / Designee will conduct weekly audits for the first month	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 321	Continued From page 5 boxes of medical records and several combustible cardboard boxes. The surveyor observed that the fire-rated corridor door leading into the room had no means to self-close the door into its frame. The room was larger than 50 square feet. The door failed to self-close into its frame as required by code. 2) At approximately 10:44 AM, in a room labeled "Closet" next to resident room [redacted], the surveyor observed that the fire-rated corridor door leading into the room had no means to self-close the door into its frame. The surveyor observed over 33 cardboard boxes filled with combustible papers. The room was approximately eight feet wide by 16 feet deep (approximately 128 square feet). The door failed to self-close into its frame as required by code. 3) At 11:28 AM, on the Second Floor Medical Records room, next to resident room [redacted], the surveyor observed that the fire-rated corridor door, leading into the room, had no means to self-close the door into its frame. The surveyor observed three (3) filing cabinets, which contained six (6) open-shelves, were filled with combustible resident files. The surveyor further observed thirty-one (31) Banker-sized boxes (large cardboard box used to store file folders) filled with combustible Medical Records. The room was approximately eight feet wide by 16 feet deep (approximately 128 square feet). The door failed to self-close into its frame as required by code. A review of an evacuation diagram posted in the area identified that the three rooms in the wings were in the primary and/or secondary exit access	K 321	followed by Monthly audits for the next three month to ensure hazardous areas are equipped with self-closing doors. Any findings will be brought to the monthly QA Meeting. Element 5: Maintenance Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315174	A. BUILDING **01** B. WING _____	**09/20/2022**

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K 321	Continued From page 6 route to reach an exit in the event of a fire. This condition would allow fire, smoke and poisonous gases to pass from the three rooms into the exit access corridor in the event of a fire. The MD confirmed the findings at the time of observations. The Licensed Nursing Home Administrator was notified of the deficiency at the Life Safety Code exit conference on 09/20/22. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced	K 351		10/31/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315174	A. BUILDING **01** B. WING _____	**09/20/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	**1511 CLEMENTS BRIDGE RD** **DEPTFORD, NJ 08096**

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K 351	Continued From page 7 by: Based on interview and observation on 09/19/22, it was determined that the facility failed to properly install sprinklers as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition, and as required by the New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. The deficient practice is evidenced by the following: During the survey entrance on 09/19/22 at 8:57 AM, a request was made to the Maintenance Director (MD) to provide a copy of the facility layout which identified the various rooms and smoke compartments. A review of the facility provided layout identified there were two floors and a basement in the facility. Starting at approximately 9:20 AM, a tour of the facility with the MD was performed. Along the tour, the surveyor observed that the facility failed to provide proper fire sprinkler protection in the following locations: 1) At 10:35 AM, the surveyor observed, inside the Ex.Order 26.4(b)(1) Bath/ Shower room, one fire sprinkler was mounted above the room's drop ceiling tile. This fire sprinkler had no evidence of an escheon cap leaving a 3/8 of an inch gap around the sprinkler head. 2) At 10:48 AM, the surveyor observed, inside	K 351	Element 1. 1) The fire sprinkler was adjusted and is now mounted below the room's drop ceiling tile in the EX Order 26.4B1 Bath/ Shower room. This fire sprinkler now has an escheon cap. 2) The one missing ceiling tile was placed in the Second-Floor storage room next to resident room EX Order 26.4B1 3) The two ceiling tiles were placed in the Second Floor Storage Room next to resident room EX Order 26.4B1 Element 2: No residents have been affected. All residents had potential to be affected. The Maintenance Director conducted an audit on all sprinkler heads and no other deficient practice was found. A facility wide audit was completed to ensure there are no missing ceiling tiles and no other deficient practice was found. Element 3: The Maintenance Director was in-serviced on NFPA 101 pertaining to NFPA 13, Standard for the Installation of Sprinkler Systems. This deficient practice was added to a monthly audit tool for the Maintenance Director/Designee to conduct monthly audits. Element 4:	

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K 351	Continued From page 8 the Second Floor storage room next to resident room [redacted] one ceiling tile was missing leaving a two feet by four feet opening in the ceiling. 3) At 11:15 AM, the surveyor observed, inside the EX Order 26.4B1 Room next to resident room [redacted], two ceiling tiles were missing leaving a two feet by two feet and a two feet by four feet opening in the ceiling. With the openings in the ceiling, in the event of a fire, the heat would bypass the fire sprinkler in the room and not activate the sprinkler system. The MD confirmed the findings at the time of observations. The Licensed Nursing Home Administrator was notified of the deficiency at the Life Safety Code exit conference on 09/20/22. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351	The Maintenance Director / Designee will conduct weekly audits for the first month followed by Monthly audits for the next three month to ensure all sprinkler heads are properly placed to ensure there are no missing ceiling tiles. Any findings will be brought to the monthly QA Meeting. Element 5: Maintenance Director	
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of	K 374		10/31/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315174	A. BUILDING **01** B. WING _____	**09/20/2022**

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K 374	Continued From page 9 egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations on 09/19/22 and 09/20/22, it was determined that the facility failed to provide doors, in smoke barrier walls, that did not have gaps between the doors to resist fire for a minimum of twenty-minutes in accordance with NFPA 101, 2012 Edition, Section 19.3.7.6, 19.3.7.8 and 19.3.7.9. This deficient practice was identified for 1 of 12 double smoke barrier doors and was evidenced by the following: Starting on 09/19/22 and continued on 09/20/22, a tour of the building, with the facility's Maintenance Director (MD), was performed. Along the two-day tour, the surveyor observed and tested twelve (12) sets of double smoke doors in the corridors. On 09/20/22 at approximately 10:00 AM, when manual testing of the facility's smoke barrier doors, next to the first floor conference room, revealed it was not resistant to the transfer of fire, smoke and poisonous gasses with an observed gap greater than one inch gap between the meeting edges. At this time, the surveyor used a construction tape measure and recorded a one-inch gap between the doors edges. The MD confirmed the findings at the time of observations.	K 374	Element 1. A door company was contracted to replace the door closer to the smoke barrier door next to the first-floor conference room and ensure there is no gap. Element 2: No residents have been affected. All residents had potential to be affected. The Maintenance Director conducted an audit on all smoke barrier doors and no other deficient practice was found. Element 3: The Maintenance Director was in-serviced on NFPA 101, 2012 Edition, Section 19.3.7.6, 19.3.7.8 and 19.3.7.9. This deficient practice was added to a monthly audit tool for the Maintenance Director/Designee to conduct monthly audits. Element 4: The Maintenance Director / Designee will conduct weekly audits for the first month followed by Monthly audits for the next three month to ensure all smoke barrier doors don□t have any gaps. Any findings will be brought to the	

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K 374	Continued From page 10 The Licensed Nursing Home Administrator was notified of the deficiency at the Life Safety Code exit conference on 09/20/22. N.J.A.C. 8:39-31.1(c), 31.2(e)	K 374	monthly QA Meeting. Element 5: Maintenance Director	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview conducted on 09/19/22 and 09/20/22, in the presence of facility management, it was determined that the facility failed to a.)provide an exhaust system for 3 of 17 Resident bathrooms and b.) ensure that the facility's ventilation systems were being properly maintained for 6 of 17 resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: On 09/19/22 during the survey entrance at 8:57 AM, a request was made to the Maintenance Director (MD) to provide a copy of the facility layout which identified the various rooms and smoke compartments.	K 521	Element 1: The facility contracted an HVAC company to install a larger motor to produce more Cubic Feet per Minute (CFM) which will ensure all of the exhaust fans are functioning properly. This will correct the findings in rooms: EX Order 26.4B1 [redacted] Exhaust systems were installed in the following bathrooms: EX Order 26.4B1, and EX Order 26.4 [redacted]. Element 2: No residents have been affected. All residents had potential to be affected. The Maintenance Director conducted an	10/31/22

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K 521	Continued From page 11 Starting on 09/19/22 at 9:20 AM and continued on 09/20/22, in the presence of facility's MD, an inspection of 17 resident rooms was performed. This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation was present), the exhaust did not function properly in 6 of 17 resident bathrooms in the following locations: On 09/19/22: 1. At 11:17 AM, inside resident room EX Order 26.4B1 bathroom, when tested, the exhaust system did not function properly. At that time, the surveyor informed the MD that the exhaust system did not function properly. 2. At 11:25 AM, inside resident room EX Order 26.4B1 s bathroom, when tested, the exhaust system did not function properly. 3. At 11:34 AM, inside resident room EX Order 26.4B1 s bathroom, when tested, the exhaust system did not function properly. On 09/20/22: 4. At 10:08 AM, inside resident room EX Order 26.4B1 bathroom, the surveyor observed no evidence of an exhaust system or window with an operable area in the room. At that time, the surveyor asked the MD, do you see an exhaust system in the bathroom. The MD looked in the bathroom and said, "No." 5. At 10:11 AM, inside resident room EX Order 26.4B1	K 521	audit on all bathrooms to ensure that the ventilation systems were being properly maintained. No other deficient practice was found. Element 3: The Maintenance Director was in-serviced on NFPA 90A. This deficient practice was added to a monthly audit tool for the Maintenance Director/Designee to conduct monthly audits. Element 4: The Maintenance Director / Designee will conduct weekly audits for the first month followed by Monthly audits for the next three months to ensure that the bathroom ventilation systems are present and in working condition. Any findings will be brought to the monthly QA Meeting. Element 5: Maintenance Director	

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K 521	Continued From page 12 bathroom, the surveyor observed no evidence of an exhaust system or window with an operable area in the room. At that time, the surveyor asked the MD, do you see an exhaust system in the bathroom. The MD looked in the bathroom and said, "No." 6. At 10:47 AM, inside resident room [EX Order 26.4B1] bathroom, the surveyor observed no evidence of an exhaust system or window with an operable area in the room. At that time, the surveyor asked the MD, do you see an exhaust system in the bathroom. The MD looked in the bathroom and said, "No." 7. At 10:55 AM, inside resident room [EX Order 26.4B1] bathroom, when tested, the exhaust system did not function properly. 8. At 10:41 AM, inside resident room [EX Order 26.4B1]s bathroom, when tested, the exhaust system did not function properly. 9. At 11:03 AM, inside resident room [EX Order 26.4B1]s bathroom, when tested, the exhaust system did not function properly. All the bathrooms had no windows with an area that would open. The bathrooms would rely on mechanical ventilation. The MD confirmed the findings at the time of observations. The Licensed Nursing Home Administrator was notified of the deficiency at the Life Safety Code exit conference on 09/20/22.	K 521		

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K 521	Continued From page 13 NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA	K 918		10/31/22

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K 918	Continued From page 14 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 09/19/22, in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for 1 of 1 emergency generator was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice could affect all residents and was evidenced by the following: During the survey entrance on 09/19/22 at 08:57 AM, a request was made to the facility's Maintenance Director (MD) if the facility had an emergency generator. The MD said, "Yes we have one." Later during the building tour with the facility MD at approximately 9:57 AM, an inspection inside the Boiler/Main Electrical room, where the natural gas emergency generator was located was performed. At that time, the surveyor asked the MD, where is the remote emergency shut off for the generator. The MD told the surveyor that it's on the generator. The surveyor observed that the emergency shut off was located on the generator's control panel. The MD confirmed the findings at the time of observations. The Licensed Nursing Home Administrator was notified of the deficiency at the Life Safety Code exit conference on 09/20/22.	K 918	Element 1. The Facility contracted a licensed electrician to install the wiring and a Generator company to install the remote kill switch for the Generator. Element 2: No residents have been affected. All residents had potential to be affected. Element 3: The Maintenance Director was in-serviced on NFPA 110 pertaining to Electrical Systems. This deficient practice was added to a monthly audit tool for the Maintenance Director/Designee to conduct monthly audits. Element 4: The Maintenance Director / Designee will conduct weekly audits for the first month followed by Monthly audits for the next three month to ensure the remote shut off switch to the generator is in working condition. Any findings will be brought to the monthly QA Meeting. Element 5: Maintenance Director	

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K 918	Continued From page 15 NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918		

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
315174 Y1	A. Building 01 - GREENBRIAR EAST HCC B. Wing Y2	12/5/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

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 K0291	10/31/2022	LSC K0311	10/31/2022	LSC K0321	10/31/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	10/31/2022	LSC K0374	10/31/2022	LSC K0521	10/31/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	10/31/2022	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
9/20/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO